Dateline: April 29, 2011

PA Rally on May 3 Calls for Increased Funding for Home & Community Based Services

Preparations continued throughout the week for the May 3 legislative rally in support of adequate funding for people with intellectual disabilities. The rally organized by the Pennsylvania Association of Rehabilitation Facilities (PARF) in partnership with The Arc of PA, PA Waiting List Campaign, and Vision for EQuality aims to obtain legislative support for adequate funding for community programs for people with intellectual disabilities. The legislature is being petitioned to provide state funding to meet emergency needs and to maintain community services. For more information on the May 3 Legislative Day and Rally, contact PARF at parfmail@parf.org.

PA Coalition Asks Legislature to Fund Brain Injury Services and Protections

The Pennsylvania Brain Injury Coalition, including PARF and other statewide organizations advocating for increased funding and legislation for people with brain injury rallied on April 26 in the Capitol Rotunda in Harrisburg. Representatives of PARF, the Brain Injury Association of Pennsylvania, the Acquired Brain Injury Network of Pennsylvania, and Disability Rights Network participated in the rally. The coalition advocated for the Safety in Sports Act, a continuation of previous years’ funding for home and community-based programs, an advisory board at the state level, and the incorporation of brain injury screenings for persons in state programs or facilities. The event was attended by numerous legislators. State Senator Andrew E. Dinniman (District 19 – Chester and Montgomery Counties), Representative Tim Briggs (District 149 – Montgomery County), Representative Richard Stevenson (District 8 – Butler and Mercer Counties), and Representative Peter Daley (District 49 - Fayette County and Washington County) called for legislative action. Advocates, including Tracy Yatsko, Denny Minori, Sheryl Rought, and Barb Dively also addressed the rally.

Options for adultBasic Members

On April 26 the Pennsylvania Insurance Department issued a reminder to former adultBasic health insurance program enrollees that two important deadlines are approaching. Blue Cross/Blue Shield companies agreed to waive their normal coverage restrictions on pre-existing conditions for those moving from adultBasic to the Blues’ SpecialCare plans. Former adultBasic members who enroll directly into SpecialCare by May 2 will have no condition exclusions. After that date, pre-existing conditions may not be covered. Former enrollees were urged to act now if they wish to enroll in SpecialCare. In addition, former enrollees whose incomes have decreased, who have become disabled or have had significant health conditions develop since their most recent application or renewal for adultBasic were encouraged to look at the state’s Medical Assistance options. These and other options are explained at www.insurance.pa.gov. On May 31, the adultBasic helpline, 1-800-GO-BASIC, will close. The helpline is currently staffed Monday through Friday, 7:00 a.m. to 7:00 p.m., and Saturday, 9:00 a.m. to 3:00 p.m. After May 31, former enrollees will continue to be able to access insurance contractors for help and information.
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PARF Comments on Definition of Settings for Delivery of HCBS Services

On April 25 PARF submitted comment to the Centers for Medicare & Medicaid Services (CMS) on rules that CMS had proposed on February 25, 2011 establishing a definition of settings in which Medicaid (HCB) home and community-based services can be provided. PARF focused its comments on a provision within the CMS rule that seeks to define for the first time what a home- and community-based (HCB) setting can be under the Medicaid program. PARF members are concerned that the definitions of Medicaid HCB settings that CMS has proposed to date might exclude important options for services that will assist people with disabilities, especially cognitive disabilities related to severe brain injuries, to live in the community and be part of the community. PARF said that the CMS proposed definition of HCB setting could deny access to residential rehabilitation services needed by some individuals currently receiving Medicaid benefits and being served by post-acute brain injury rehabilitation service programs that are enrolled in Medicaid programs and other state programs serving people with brain injury. PARF asked that standards for community integration services be established in lieu of rules on geographical segregation and that community integration should be a primary goal of individual service plans developed through person centered planning. PARF also asked that proposed standards be clarified, noting that terms used to establish geographical requirements were not defined. The proposed rule states “that certain settings are clearly outside of what would be considered home and community-based because they are not integrated into the community . . . home and community settings would not include a building that is also a publicly or privately operated facility which provide inpatient institutional treatment or custodial care; or in a building on the grounds of, or immediately adjacent to, a public institution or disability-specific housing complex, designed expressly around an individual’s diagnosis that is geographically segregated from the larger community, as determined by the Secretary.” FMI: See the section entitled Setting” on page 10740 of the February 25, 2011 edition of the Federal Register. Contact PARF at parfmail@parf.org.

ODP Survey on Provider Monitoring Process Due by May 9

The PA Office of Developmental Programs’ (ODP) has issued ODP Communication Number: Alert 058-11. The alert requests that direct service providers complete a brief survey by May 9 in order for ODP to collect contact information. The contact information provided during this survey process will enable direct service providers to access data, resources, and receive targeted communication to support the Provider Monitoring process. On December 30, 2010, ODP released Bulletin #00-10-14, which communicated that a standardized monitoring process would be in effect July 1, 2011. The ODP Provider Monitoring process includes information and data collection documents which are to be utilized by Administrative Entities (AEs) to conduct provider monitoring. ODP expects the Provider Monitoring process to begin on July 1, 2011. ODP says that there will be training in the coming months. The new process will require providers to submit information via the internet to support the Provider Monitoring process. Direct service providers will use a secure login that will be unique to each organization. All direct service providers of waiver funded services currently serving at least one person should access the survey by May 9, 2011 and complete the survey. The individuals identified as contacts during the survey completion process will serve as the primary and secondary contacts for the Provider Monitoring process. FMI: See www.odpconsulting.net.
**PARF NEWS**

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**PA House Approves Legislation Establishing Drug Testing Program in Public Assistance**

On April 27 House Bill 1297, which would establish a drug testing program for public assistance recipients who have been convicted of a drug-related felony, was passed by the House of Representatives with a vote of 164 to 23. The bill would require the administration of a drug test to individuals who have a felony drug conviction in the previous five years, or those who are currently on probation for a felony drug conviction. Every six months, 20 percent of that group would be tested. A refusal to take the test results in a loss of benefits. The public assistance programs that apply in this care are the Temporary Assistance to Needy Families, food stamps, General Assistance and state supplemental assistance. Medical Assistance is not impacted by federal eligibility requirements. The bill contains a specific provision that anyone having to take this test that has a positive result will not have eligibility for Medical Assistance-paid drug and alcohol treatment revoked. FMI: See [www.legis.state.pa.us](http://www.legis.state.pa.us)

**PA Senate Legislation on Health Care Clinics and Government Reform**

On April 26 the PA Senate Appropriations Committee passed unanimously several bills to the Senate floor for a vote. The bill reported to the full Senate include Senate Bill 5, which would create the Community-Based Health Care Program in the PA Department of Health to provide grants to community-based health care clinics; Senate Bill 104, which would set requirements for state vehicle use; Senate Bill 109, which would alter the state's requirements for disclosure when taxpayer dollars are used for advertising; and Senate Bill 907, which would reestablish certain investment powers and responsibilities of the State Workers' Insurance Board.

**PA Senate Passes Bill to Streamline Routine HIV Screening**

On April 27 legislation to implement recommendations of the Centers for Disease Control and Prevention (CDC) to streamline HIV testing in Pennsylvania was approved by the Senate. Senate Bill 260 amends Act 148 of 1990, the "Confidentiality of HIV-Related Information Act.” In September of 2007, the CDC issued its "Revised Recommendations for HIV Testing" which called for routine HIV screening of all persons in a healthcare setting. SB 260 addresses the informed consent provisions of Act 148 which are viewed as an impediment to Pennsylvania's ability to meet the CDC recommendations. SB 260 would eliminate the requirement for pre-test counseling, and provide for an "opt-out" provision, whereby a patient is advised that a blood test will include testing for HIV unless he or she refuses. SB 260 will be sent to the House of Representatives for consideration. FMI: See [www.legis.state.pa.us](http://www.legis.state.pa.us).

**HB 1362 Requires Baseline Concussion Screening of Student Athletes**

On April 20 PA Representative Brandon Neuman (District 48 – Washington County) introduced legislation (H.B. 1362) that would give school districts, medical professionals and certified athletic trainers a method to assess whether a student athlete has sustained a concussion. HB 1362 would require each student athlete to receive a baseline concussion screening at the start of the season. This would include all athletes participating in interscholastic athletics, regular and non-competitive cheerleading, and school- and club-sponsored sport activities FMI: See [www.legis.state.pa.us](http://www.legis.state.pa.us). An interview with Representative Neuman on his concussion legislation is available on his website [www.pahouse.com/Neuman](http://www.pahouse.com/Neuman) under the video tab.
**Funding Available for Rural Health Information Technology**

On April 29, the Office of Rural Health Policy (ORHP) announced the release of the Rural Health Information Technology (HIT) Grant Program (HRSA-11-137). ORHP anticipates that this program will assist rural communities in addressing the challenge of accessing capital for adopting health information technology. The rural HIT program was developed out of the Network Development Program legislation (330a authority), keeping the focus on rural networks. To download the funding opportunity, please visit the links below: For funding opportunity see: [http://apply07.grants.gov/apply/UpdateOffer?id=50273](http://apply07.grants.gov/apply/UpdateOffer?id=50273). For funding opportunity synopsis, see [http://www.grants.gov/search/search.do;jsessionid=kqm8N4cF3Z3STSzYZ8VkJ0B2zsG8hWt9Zy8Cwn7QyzeHJIK2z6V2KI-210279180?oppId=90039&mode=VIEW](http://www.grants.gov/search/search.do;jsessionid=kqm8N4cF3Z3STSzYZ8VkJ0B2zsG8hWt9Zy8Cwn7QyzeHJIK2z6V2KI-210279180?oppId=90039&mode=VIEW). The deadline to submit an application in grants.gov is May 27th, 2011. ORHP strongly recommends that applicants submit their applications prior to the due date to avoid any technological problems. All applications have to be submitted electronically in [www.grants.gov](http://www.grants.gov).

**Technical Assistance Call for Rural Health Information Technology Grant**

There will be a technical assistance call for the Rural Health Information Technology (HIT) Grant Program (HRSA-11-137) which will be held May 10th at 2:00 p.m. Eastern Time. The toll-free number to call in is 1-888-577-8992. The Pass code is HIT. For your reference, the Technical Assistance call will be recorded and available for playback within one hour of the end of the call and will be available until June 10, 2011 11:59 PM (ET). The phone number to hear the recorded call is: 1-866-420-5718. For further questions on this funding opportunity, please contact the program coordinator, Marcia Green at 301-443-3261 or mgreen@hrsa.gov. Also contact Pennsylvania Office of Rural Health at (814) 863-8214 if you have any questions or need more information.

**IRF PPS PC Pricers Published for FY 2010-FY 2011**

On April 29 the Centers for Medicare and Medicaid Services (CMS) published the FY2010 and FY2011 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (PPS) PC Pricers which have been updated with the latest provider data. The PC Pricers are ready for download from the Centers for Medicare & Medicaid Services (CMS) web page at [http://www.cms.hhs.gov/PCPricer/06_IRF.asp](http://www.cms.hhs.gov/PCPricer/06_IRF.asp). If you use the IRF PPS PC Pricers, click on [http://www.cms.hhs.gov/PCPricer/06_IRF.asp](http://www.cms.hhs.gov/PCPricer/06_IRF.asp) and download the latest version of the FY2010 and FY2011 Pricers that were posted on April 29, 2011 in the Downloads section.
Medicare IRF PPS Rules and Quality Measures for FY 2012 Published

On April 29 the Centers for Medicare and Medicaid Services (CMS) published CMS-1349-P, entitled Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2012; Changes in size and Square Footage of Inpatient Rehabilitation Units and Inpatient Psychiatric Units. The proposed rule includes a proposal to revise and rebase the rehabilitation, psychiatric and long term care hospital market basket. It also indicates two initial quality measures for quality data reporting starting in FY 2014 were selected with a third under development. CMS says that the rule will result in an increase in payments by an estimated $120 million compared to FY 2011. Comments will be accepted if received on or by June 21. The changes to the IRF PPS will be effective for discharges on or after October 1, 2011 and before September 30, 2012. FMI: See www.cms.hhs.gov/InpatientRehabFacPPS

CMS Proposed Rule for IRF PPS

In the April 29 proposed rule for the FY 2012 Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS) the Centers for Medicare and Medicaid Services (CMS) not only makes changes and adjustments in the payment system but also identifies new quality measures and clarifies various IRF rules and criteria. Under the rule, the standard payment rate conversion factor is increased by 1.5% to $14,528 from the FY 2011 amount of $13,860. This amount is the result of a 2.8% market basket increase based on the new revised and rebased market basket minus a market basket adjustment from the Affordable Care Act (ACA) of 0.1% and a productivity adjustment estimated to be 1.2%. In addition, the rule accounts for budget neutrality factors for the wage index and labor related share of 0.9989, for the CMG weight revisions of 0.9989, for the update to the rural adjustment factor of 0.9989, for the LIP update of 1.0327, and for the change to the teaching factor of 1.0024. The proposed rule updates the CMG weights and lengths of stay and updates the average lengths of stay per CMG. The proposed labor related share is 70.334, down from last year’s final level of 75.271. With respect to area wage adjustments, CMS is continuing with its prior policy. CMS also proposes adjusting the outlier threshold to $11,822 in FY 2012 from $11,410 in FY 2011, maintaining the outlier payments at 3% of total payments. CMS proposes to update all three facility level adjustments using the most recent three years of data. CMS is also changing the methodology by which it calculates the adjustment factors. To measure quality, CMS said that beginning October 1, 2012 data would be collected on two quality measures: (a) pressure ulcers that are new or have worsened and (b) catheter associated urinary tract infections. A third item under consideration is “30 –day comprehensive All-Cause Risk-Standardized Readmission Measure.” CMS is also inviting comments on the use of a standardized assessment instrument. The rule also reorganizes the classification criteria for IRFs by moving all the classification criteria from 412.23(b) to 412.29. It combines the inpatient rehabilitation hospital section with the special criteria for units as well as addressing new rehabilitation hospitals and units, new rehabilitation beds, and clarifying and simplifying the rules regarding change of ownership or leasing and mergers. CMS proposes to clarify that, as in the coverage requirements, IRH/U preadmission screenings must be reviewed and approved by a rehabilitation physician prior to each patient’s admission. It also incorporates the requirement for physician visits at least 3 times a week. Finally, it reasserts that discharge planning and assessment of goals and progress is integral to the interdisciplinary team approach. The proposed rule can be accessed at http://edocket.access.gpo.gov/2011/2011-10159.htm.
CMS Clarifies Billing Instructions for Non-Outlier Period

On April 22 the Centers for Medicare and Medicaid Services released Transmittal 2193 entitled “Updates to Pub 100-04, Medicare Claims Processing Manual, Chapter 3: Inpatient Hospital Billing.” CMS Transmittal 2193 clarifies billing instructions for the non-outlier period after regular benefit days are exhausted in Section 40 - Billing Coverage and Utilization Rules for PPS and Non-PPS Hospitals. Transmittal 2193 also clarifies application of the Code First policy in Section 190.5.2- Application of Code First. CMS Transmittal 2193 corrects hemophilia diagnosis code descriptions in Section 20.7.3 - Payment for Blood Clotting Factor Administered to Hemophilia Inpatients. The effective date and date for implementation are July 23, 2011. This regulation affects Hospitals. View complete text of Transmittal 2193 at http://www.cms.gov/transmittals/downloads/R2193CP.pdf

CMS Issues Instructions on Remittance Advice

On April 22 the Centers for Medicare and Medicaid Services released Transmittal 2194, entitled “Claim Adjustment Reason Code (CARC), Remittance Advice Remark Code (RARC), and Medicare Remit Easy Print (MREP) Update,” was published. This regulation affects all Providers. This Change Request (CR) instructs the contractors to update Claim Adjustment Reason Code (CARC) and Remittance Advice Remark Code (RARC) reported on the Remittance Advice (RA). It also instructs VMS to update Medicare Remit Easy Print (MREP) software. This Recurring Update applies to chapter 22, sections 60.1 and 60.2 of the Medicare Claims Processing Manual. The change is effective on July 1, 2011 and to be implemented on July 5, 2011. View complete text of Transmittal 2194 at http://www.cms.gov/transmittals/downloads/R2194CP.pdf.

CMS Approves Accreditation of Outpatient PT and SPT Services

In the April 22, 2011 edition of the Federal Register (Volume 76, Number 78) the Centers for Medicare and Medicaid Services (CMS) published a final notice on pages 22709-22711 announcing its decision to approve the American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) for recognition as a national accreditation program for organizations that provide outpatient physical therapy and speech-language pathology services seeking to participate in the Medicare or Medicaid programs. The final notice is effective April 22, 2011 through April 22, 2015. CMS-2332-N is entitled “Medicare and Medicaid Programs; Approval of the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. for Deeming Authority for Organizations That Provide Outpatient Physical Therapy and Speech-Language Pathology Services.” The regulation affects Ambulatory Surgical Centers. View CMS-2332-N at http://edocket.access.gpo.gov/2011/2011-9176.htm
CMS Invites Comment on New Rules on Home and Community Based Services

On April 15 the Centers for Medicare and Medicaid Services (CMS) published CMS-2296-P, entitled “Medicaid Program; Home and Community-Based Services (HCBS) Waivers.” This regulation affects Medicaid. The proposed rule was published in the April 15, 2011 Federal Register (Volume 76, Number 73), pages 21311-21317. This proposed rule would revise the regulations implementing Medicaid home and community-based services (HCBS) waivers under section 1915(c) of the Social Security Act by providing States the option to combine the existing three waiver targeting groups as identified in Sec. 441.301. To be assured consideration, comments must be received at CMS no later than 5 p.m. on June 14, 2011. CMS said that the proposed regulations would for the first time allow states to target multiple groups in a single home and-community based (HCBS) waiver demonstration. Under current rules, states must serve one target group per waiver. The three target groups whose services could be combined into one demonstration are "aged or disabled", persons with developmental disabilities, and those with mental illness. In addition, CMS is proposing other changes to the HCBS waiver provisions to convey expectations regarding person-centered plans of care, to provide characteristics of settings that are not home and community-based, to clarify the timing of amendments and public input requirements when States propose modifications to HCBS waiver programs and service rates, and to describe the additional strategies available to CMS to ensure State compliance with the statutory provisions of section 1915(c) of the Act. The proposed rule seeks to clarify what constitutes a HCBS setting and sets out new requirements for person-centered care plans. Home and community based settings under the proposal cannot be located on the campus of a facility that provides institutional treatment or custodial care. The proposal also would prohibit housing complexes designed expressly for persons with disabilities to qualify as "home and community based settings. For a copy of the rule see http://edocket.access.gpo.gov/2011/2011-9116.htm.

HHS-OIG Reviews Drugs Commonly Used By Dual Eligibles

The US Department of Health and Human Services Office of Inspector General (HHSOIG) has issued a report on drugs commonly used by dual eligibles in Medicare Part D Plans. HHS OIG found that the rate of Part D plan formularies' inclusion of the 191 drugs commonly used by dual eligibles is high, with some variation. On average, Part D plan formularies include 96 percent of the 191 commonly used drugs. In fact, 90 percent of dual eligibles are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. HHS OIG also found variation in the rate at which Part D plan formularies apply utilization management tools to the drugs commonly used by dual eligibles. Some Part D plan formularies apply these tools to none of the commonly used drugs, whereas others apply these tools to 45 percent of the commonly used drugs. See Part D Plans Generally Cover Drugs Commonly Used by Dual Eligibles (OEI-05-10-00390) at http://oig.hhs.gov/oei/reports/oei-05-10-00390.asp.
CMS Publishes Regulations for Medicare Community-Based Care Transitions Program

On April 15 the Centers for Medicare and Medicaid Services (CMS) published CMS-5055-N2, entitled “Medicare Program; Solicitation for Proposals for the Medicare Community-Based Care Transitions Program” was published. This regulation affects all Providers. View CMS-5055-N2 at [http://edocket.access.gpo.gov/2011/2011-9126.htm](http://edocket.access.gpo.gov/2011/2011-9126.htm). The regulation was published in the April 15, 2011 Federal Register (Volume 76, Number 7, Pages 21372-21373). The notice informs interested parties of an opportunity to apply to participate in the Medicare Community-based Care Transitions Program, which was authorized by section 3026 of the Affordable Care Act. Proposals will be accepted on a rolling basis. Acceptable applicants will be awarded on an ongoing basis as funds permit. FMI: Contact Juliana Tiongson, (410) 786-0342 or by e-mail at CareTransitions@cms.hhs.gov. The Affordable Care Act authorized the Medicare Community-based Care Transitions Program (CCTP). The goals of the CCTP are to improve the quality of care transitions, reduce readmissions for high risk Medicare beneficiaries, and document measurable savings to the Medicare program by reducing unnecessary readmissions. The CCTP is part of Partnership for Patients, a national patient safety initiative through which the Administration is supporting broad-based efforts to reduce harm caused to patients in hospitals and improve care transitions. CMS is seeking eligible organizations which are a subsection (d) hospital, as defined in section 1886(d)(1)(B) of the Social Security Act (the Act), with high readmission rates that partner with community-based organizations (CBOs) or CBOs that provide care transition services. CBOs are defined as community-based organizations that provide care transition services across the continuum of care through arrangements with subsection (d) hospitals and whose governing bodies include sufficient representation of multiple health care stakeholders, including consumers. This program creates a source of funding for care transition services that effectively manage transitions from acute to community-based settings and report specified process and outcome measures on their results. CBOs will be paid on a per eligible discharge basis for eligible Medicare beneficiaries at high risk for readmission, including those with multiple chronic conditions, depression, or cognitive impairments. In selecting CBOs to participate in the program, preference will be given to eligible entities that are Administration on Aging (AoA) grantees that provide concurrent care transition interventions with multiple hospitals and practitioners or entities that provide services to medically-underserved populations, small communities, and rural areas. The program will run for 5 years beginning April 11, 2011; however, participants will be awarded 2-year agreements that may be extended on an annual basis for the remaining 3 years based on performance. Applicants must identify root causes of readmissions and define their target population and strategies for identifying high risk patients. Applicants must also specify care transition interventions including strategies for improving provider communications in care transitions and improving patient activation. Lastly, applicants will be required to provide a budget including a per eligible discharge rate for care transition services, provide an implementation plan with milestones, and demonstrate prior experience with effectively managing care transition services and reducing readmissions. A competitive process will be used to select eligible organizations. We will accept proposals on a rolling basis. The program will continue through 2015. For specific details regarding the CCTP and the application process, refer to the solicitation on the CMS Web site at [http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313](http://www.cms.gov/DemoProjectsEvalRpts/MD/itemdetail.asp?itemID=CMS1239313).
DOL Announces 2011 National Disability Employment Awareness Month

On April 28 the U.S. Department of Labor's Office of Disability Employment Policy announced the official theme for October's National Disability Employment Awareness Month: "Profit by Investing in Workers with Disabilities." DOL said that the theme honors the contributions of workers with disabilities and emphasizes that they represent a highly skilled talent pool that can help employers compete in today's global economy. DOL said that early announcement of the theme helps communities nationwide plan a series of announcements, events and meetings to begin in October. Such activities include proclamations, public awareness programs and job fairs that showcase the assets of workers with disabilities. FMI: Contact Carol Dunlap in ODEP at 202-693-7902.

DOL Secures Court Ruling for Payment to Workers with Disabilities at Iowa Turkey Farm

On April 27 the U.S. Department of Labor announced that it had obtained a partial summary judgment requiring Hill Country Farms, doing business as Henry's Turkey Service, and president Kenneth Henry to pay more than $1.76 million in back wages and liquidated damages for violating the minimum wage and overtime provisions of the federal Fair Labor Standards Act. The experience of people with disabilities who were working at the Iowa turkey processing plant has received national attention. The judgment partially resolves a lawsuit filed by the Labor Department following an investigation by the Des Moines District Office of its Wage and Hour Division. The judgment, issued by the U.S. District Court for the Southern District of Iowa in Davenport, concluded that the defendants willfully violated the FLSA by failing to properly pay 31 workers with disabilities. Henry's Turkey Service supplied the workers to the West Liberty Foods turkey processing plant in West Liberty, where most worked on the plant's processing line. Henry's Turkey Service, based in Goldthwaite, Texas, paid the workers $65 a month in cash wages even when company time sheets reflected that they worked more than 40 hours a week. Besides employing the workers, the company provided in-kind care, room and board, serving as the workers' caretaker as well as the designated representative payee of their Social Security benefits. Henry's Turkey Service claimed credit for the food, housing and care against its wage obligation; however, the company also reimbursed itself for those expenses using the workers' Social Security benefits. The court found that the company failed to show that it incurred any costs above the amount received from the Social Security benefits and denied the credit toward the workers' wages. The judgment requires that the defendants pay $880,777 in back wages, along with an equal amount in liquidated damages, for a total of $1,761,554. Information is also available on the Internet at http://www.dol.gov/whd.