

# RECENT MEDICARE AND MEDI-CAL ISSUES FOR HOSPITALS

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**HLB**

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# MEDICARE DSH

**RECENT PRRB AND CMS  
ADMINISTRATOR DECISIONS RE  
MEDICARE DISPROPORTIONATE  
SHARE PAYMENTS and CURRENT  
HOT ISSUES**

## DSH – Genl. Assistance Days

- *Adena Regional Medical Center v Leavitt*, 527 F. 3d 176 (D.C. Cir. 2008)
  - Pertained to services provided under Ohio’s Hospital Care Assurance Program (HICAP)– should those days be included in numerator of Medicaid fraction?
  - HICAP services must be provided free of charge to indigents, but these days impact Medicaid DSH calculation
  - D.C.Circuit reversed lower court, concluded that HICAP patients “not eligible for Medical Assistance” under the State Plan

## DSH – Genl. Assistance Days

- *Beverly Hospital*, CMS Adm. Dec., Nov. 21, 2008
  - Massachusetts Uncompensated Care Days – Hospitals received Medicaid DSH payments for these days; patients not eligible for Medicaid
  - Administrator Reversed Favorable PRRB Decision
- Pending in D.C. District Court, under name *Northeast Hosp. Corp. v. Johnson*

## DSH – Genl. Assistance Days

- *Southwest Consulting 1999-2002 Uncompensated Care Days Group*, PRRB Dec. No. 2009-D38, Aug. 28, 2009

Massachusetts Uncompensated Care Days  
Decision unfavorable to provider

PRRB reversed previous decision (in *Beverly Hosp.* case)  
due to ruling in *Adena Regional Med. Ctr. v. Leavitt*

## DSH – Genl. Assistance Days

- *Banner Health System 2000 DSH Calculation Group*, PRRB Dec. No. 2009-D6, Dec. 23, 2008
  - Arizona State Plan Days
    - PRRB Decision Favorable to Provider
- CMS Administrator Dec., Feb. 24, 2009
  - Reversed PRRB – claimed these days were solely State-funded and not included in waiver
- Pending in D.C. District Court
  - Provider claims that days are included in overall federal payments for Arizona's programs

## DSH – Genl. Assistance Days

- *Connecticut 94-98 DSH Group*, PRRB 2009-D25, June 17, 2009
  - Provider argued GA days should be included because they were included in Medicaid DSH calculation
  - UNFAVORABLE decision, based on *Adena* decision
  - Case pending in District Court in CT

## DSH – Genl. Assistance Days

- *St. Cloud Hosp.*, PRRB Dec. 2009-D19, April 15, 2009
  - FYs 1997-2000
  - Minnesota Genl. Assistance Days
  - Provider sought “hold harmless” relief pursuant to Prog. Mem. 99-62, because some GA days had erroneously been included in prior years
  - Decision UNFAVORABLE to Provider

## DSH – Subacute, Part A Exhausted Days

- *Sharp Coronado Hosp.*, PRRB Dec. 2009-D32, July 15, 2009
  - Applied to FYs 2000 and 2001
  - Favorable to Provider
- **CMS Admin. Dec., Sep. 9, 2009 – Reversed PRRB**
  - No Part A exhausted days in Medicaid fraction
  - CMS inconsistent in settling this issue
  - Subacute units must be adjacent to IPPS instead of hospital
  - No such distinction in *Alhambra* case

## DSH – Part A Exhausted Days

- *Allina Health System*, PRRB 2009-D35, July 30, 2009
  - FYs 1993 - 2003
  - PRRB held days should be included in Medicaid fraction
- CMS Admin. Dec., Sept. 21, 2009
  - Reversed
  - Exhausted days not included in either DSH fraction for years prior to 2004; after that, include in Medicare fraction (pursuant to change in regulations)

## DSH – Part A Exhausted Days

- *St. Mary's Hosp.*, PRRB Dec. 05-1370, June 24, 2009
  - 365 days, one patient, FY 1999
  - Favorable decision
  - Reversed by CMS Administrator
  - Pending in D.C. District Ct. under name *Columbia St. Mary's Hosp. v. Sebelius*
- *Auburn Memorial Hosp., et al. v. Sebelius*
  - Filed in D.C. District on 10/29/2009
  - Multiple hospitals; all FYs prior to 2004

## DSH – Observation Bed Days

- *College Station Med. Ctr.*, PRRB Dec. 2009-D31, July 9, 2009
  - FY 1999
  - Issue re 100-bed threshold - Should days beds used for observation services be eliminated from bed count?
  - Favorable to provider, consistent with court decisions
- CMS Admin. Dec., Sept. 1, 2009
  - Reversed PRRB

## DSH – Observation and Swing Bed Days

- *Cleveland Regional Med. Ctr.*, PRRB Dec. 2009-D33, July 16, 2009
  - FY 2001 – Issue re 100 bed threshold
  - PRRB Decision favorable to provider
- CMS Admin. Dec., Sept. 21, 2009 – Reversed PRRB
  - Also focused on facts re availability of certain beds

## DSH – Late Appeals

- *SRI 1987-1994 DSH SSI% Group*, PRRB Dec. 2009-D12, March 5, 2009
  - FYs 1987–1994 – seeking relief from *Baystate* case re errors in calculation by CMS of SSI Percentage
  - Filed Sept. 2008
  - Provider sought to establish “equitable tolling” based on Government’s misleading conduct and false statements re SSI percentage
  - Decision UNFAVORABLE to Provider

## DSH – Late Appeals

- *Valley Presbyterian Hosp.*, PRRB 2009-D18, Apr. 9, 2009
  - FYs 1987 – 1997, SSI Percentage Issue
  - Reopening requested in 2008, denied as untimely
  - Provider argued 3 year limits for reopenings or appeals should not apply
  - Decision UNFAVORABLE
  - Case pending in D.C. District Court

## DSH – Late Appeals

- Many other cases recently filed in D.C. District Court on issue re late appeals challenging DSH SSI percentage based on *Baystate*
  - *Arroyo Grande Comm. Hosp. v. Sebelius*
  - *Daughters of Charity v. Sebelius*
  - *Regents of Univ. of CA v. Sebelius*
  - *Etc.,*

## DSH – Medicare HMO Days

- Should Medicare Advantage Days (formerly, Medicare + Choice days) be included in the Medicare fraction or Medicaid fraction?
- Such days (HMO days) are authorized by Part C of the Medicare Act.
- Usually more beneficial to include such days in Medicaid fraction.

## DSH – Medicare HMO Days

- Statutory language re Medicaid fraction:
  - Numerator: number of days for patients “eligible for medical assistance under a State plan,” but who “were not entitled to benefits under Part A”
- Statutory language re Medicare fraction:
  - Numerator: number of days for patients “entitled benefits under Part A” and “entitled” to SSI
- Courts have interpreted “entitled” to mean having right to payment, distinguishing it from “eligible”

## DSH – Medicare HMO Days

- Argument for inclusion in Medicaid fraction: Medicare HMO patients are not “entitled” to payment under Part A, because they are only “entitled” to payment under Part C when they have enrolled in a Part C plan
- Argument for inclusion in Medicare fraction: Part C defines eligible individual as one who is “entitled” to payments under Part A
- Rebuttal argument: Individual no longer entitled to payments under Part A once he/she enrolls in Part C Plan

## DSH – Medicare HMO Days

- *SRI 1998 DSH Medicare Part C Days Group*, PRRB Dec. 2009-D30, July 9, 2009
  - Provider sought Part C days to be included in Medicaid fraction
  - Decision UNFAVORABLE, PRRB said days should be in Medicare fraction
  - Held that Part C statute states bennies can only receive Part C benefits if “entitled” to Part A
- CMS Admin. Dec., Sept. 11, 2009
  - Admin. modified but upheld PRRB decision

## DSH – Medicare HMO Days

- FFY 2007 SSI percentage data released June 24, 2009
- CMS ordered that no NPRs using this data be issued pending further review
- Interim payments/settlements still based on such data
- Possible appeal from publication of data, but unclear due to delay in use of data

## DSH – Labor Days

- *QRS-CHW DSH Labor Room Days Groups*, PRRB Dec. 2009-D11, Feb. 27, 2009
  - FYs 1998-2001
  - Included only days in LDRP rooms, licensed beds
  - FAVORABLE decision
- CMS Admin. Dec., Apr. 13, 2009
  - Affirmed PRRB decision. based on *Alhambra*, only for Ninth Circuit and only for years prior to 2003

## DSH – Labor Days

- Recent CMS directive requires settlement of labor days issue, for discharges prior to October 1, 2003 for hospitals in 9<sup>th</sup> Circuit
- Applies to both LDRP days and traditional labor days
- Applies to FYs for which no NPR has yet been issued and to jurisdictionally proper appeals
- Will not apply to reopening requests

## DSH – Labor Days

- Recent CMS directive re Labor Days (cont.)
- Will not apply to hospitals located outside of Ninth Circuit
- *Northeast Hosp. Corp.* case in D.C. Circuit raises issue outside of 9<sup>th</sup> Cir.
- What about groups that include hospitals outside 9<sup>th</sup> Circuit, but could be brought within 9<sup>th</sup> Circuit?

# UPDATE ON MEDI-CAL RATE LITIGATION

## ***MISSION HOSPITAL***

- About 100 hospitals challenge limit on Medi-Cal reimbursement for inpatient hospital services not under CMAC contract for State FY 2004-05 -- Payments limited to audited cost per diem for hospital fiscal year ending in 2003
- Court of Appeals reverses in November 2008
  - Holds freeze enacted in violation of Medicaid Act because no public process, rather enacted as part of a budget trailer bill without meaningful public participation

## ***MISSION HOSPITAL (cont.)***

- State unsuccessfully asks State Supreme Court to review
- But, State is refusing to pay retroactively, argues “sovereign immunity”
- Hospitals move to enforce writ and are successful, but trial court order is now under appeal

## AB 5 -- *Independent Living Case*

- Challenge to Medi-Cal 10% rate reductions that became effective July 1, 2008
  - For hospitals: Non-CMAC inpatient; outpatient; DP-NF; subacute
- District Court issued injunction on Aug. 18, 2008, but only for physician, dental, pharmacy and ADHC services
- Injunction for home health and non-emergency transportation issued November 2008
- Injunctions upheld by Ninth Circuit

## AB 5 -- *Independent Living Case* (cont.)

- 10% rate reductions, except non-CMAC inpatient, expired March 1, 2009
- Case continues for retroactive payments
  - Retro period for hospital services, except non-CMAC inpatient, would be 7/1/08 to 2/28/09
  - Retro payments possible because case originated in state court
- Settlement discussions ongoing
  - State motivated to settle due to current temporary increase in federal share of Medi-Cal payments

## AB 1183 Rate Reductions

- Enacted September 16, 2008
- Sunset most 10% cuts in AB 5 on March 1, 2009
- Replaced with different cuts
  - DP/NF and Hospital subacute -- 5%
  - Hospital outpatient -- 1%
- Retained 10% cut on noncontract inpatient hospital services
- Effective 10/1/08, reimbursement limited to 95% of the regional average CMAC rates of tertiary or non-tertiary hospitals, as applicable

## AB 1183 Rate Reductions (cont.)

- *California Pharmacists Association v. Shewry*
  - CHA, CPHA, ADHCs, CMA, CDA and individual providers sue to challenge AB 1183 cuts
  - District Court denies hospital injunction, finds no irreparable harm, although finds strong likelihood of success on merits
  - Ninth Circuit grants emergency relief, enjoins AB 1183 hospital cuts effective 4/6/2009, except 10% reduction on non-contract inpatient services

## Other Pending Medi-Cal Rate Cases

- CHA Lawsuit Challenging Emergency and Post-Stabilization Rates (Rogers Amendment) – filed May 22, 2009
  - Discovery proceeding
- DP/NF Rate Case
  - Computation of median cost per day by excluding low Medi-Cal utilization facilities from calculation
  - 2001 to 2006 rate years
  - Unfavorable decision, now on appeal

## Assembly Bill 1383

- Attempting to Enhance Medi-Cal Reimbursement to Hospitals By a Quality Assurance Fee (aka Provider Tax)
- Signed by Governor on October 11, 2009

## BIG PICTURE

- Substantial room between federal upper payment limits and Medi-Cal hospital payments
- Need non-federal expenditures to draw down federal funds
- There are no state general fund monies available
- Where can we get the non-federal share?
- Answer: “tax” hospitals

## FEDERAL UPPER PAYMENT LIMITS

- Aggregate annual limits for a class of hospitals and a class of services
- Hospital classes include:
  - Private hospitals
  - State-owned public hospitals
  - Non-state owned public hospitals
- Services include inpatient and outpatient
- Leads to six limits
- UPL room available primarily for private hospitals

## FEDERAL RESTRICTIONS

- Health care related taxes deducted from state Medicaid expenditures matched by feds unless requirements met
- Broad Based
- Uniform
- No hold harmless
- Leads to winners and losers

# PLAYERS AND POLITICS

- Hospitals
  - Sponsors, winners, losers, and the “competitively disadvantaged”
- The Legislature
  - Author
  - The Republicans
- The Administration
- Health Plans
- CMS

## TIME FRAME

- Effective through 12/31/2010 (generally)
- Higher FMAP until 12/31/2010
- Beginning date is now unclear
- Idea to take advantage of as much UPL room as possible—up to 3 federal fiscal years
- Effective date of State Plan Amendment
- Effective date of federal waiver for fee

## STATIC MODEL

- Payments and fee are based on old data
- Nothing changes with current Medi-Cal utilization
- Hospitals wanted certainty for the short-term model

# HOSPITAL PROTECTIONS

- CHA Board approved subject to protections for hospitals
- Afraid state would use fee to plug a portion of the budget hole
- Language in bill restricting use of proceeds
- But, how do we bind future legislatures?
- Contractual obligation language

## State Flexibility

- Big issue with Administration and among hospitals
- State wants flexibility to change the model to deal with CMS approval issues
- Hospitals want a fixed deal—don't entirely trust DHCS to do the right thing
- Compromise:
  - 2% window per hospital
  - Can make modest adjustment to fee structure

## FEE vs TAX

- 2/3 vote required for tax
- Simple majority required for fee
- Republicans won't vote for a tax
- Also wanted 2/3 vote for urgency designation
- Legislative Counsel decided key factor was whether exaction was voluntary
- So, made participation in state health insurance programs contingent of fee payment

## FEE vs TAX (cont.)

- Last minute, Republicans refuse to vote for anything requiring 2/3 vote
- AB 1383 passed on a simple majority vote, without urgency designation
- Governor threatens veto because concerned QA fee might be a tax—at least 4 legal opinions sought
- Note tension with federal requirement that the QA fee be mandatory to be a permissible tax

# POISON PILLS

- Final judicial determination that:
  - Fee or payments are invalid
  - Fee is subject to Prop 98
- No federal approval
- Preliminary Injunction resulting in financial disadvantage to the state
- Director of DHCS determines implementation has resulted in financial disadvantage to the state

## POISION PILLS (cont.)

- Financial disadvantage:
  - Loss of FFP
  - Cost to the General Fund  $\geq$   $\frac{1}{4}$  of 1% of GF expenditures in most recent Budget Act
- Hospitals get no supplemental payments if sue
- Retroactive recoupment

## THE DPH PROBLEM

- The Designated Public Hospitals (counties and UCs) do not want 1383 to adversely impact current or future Medi-Cal waivers
- 1383 requires new waiver to be negotiated concurrently with 1383 approvals
- Delays implementation for FFYs 2010 and 2011 until 5/1/2010
- Note that waiver prohibits hospital fee

## DOLLARS—ANNUAL TOTALS

- Fees -- \$2,055,667,327
- FFP \$2.3 billion
- Total suppl. pmts. \$3,711,708,740
- Total net increase \$1,966,041,413
- Children's coverage \$320,000,000
- DPH grants \$310,000,000

# Overview

- Nuts and Bolts of AB 1383
  - Article 5.21: Medi-Cal Hospital Provider Rate Stabilization Act
  - Article 5.22: Quality Assurance Fee Act

## Article 5.21: Medi-Cal Hospital Provider Rate Stabilization Act

- Supplemental Fee-for-service Payments to Hospitals
- Supplemental Managed Care Payments to Hospitals
- Supplemental Mental Health Payments to Hospitals

## Article 5.21: Supplemental FFS Payments

- Intent of supplemental payments is to make payments at the level of the federal upper payment limit

# AFFECTED HOSPITALS

- Private general acute care hospitals
  - Excludes psych hospitals
  - Excludes LTACs
  - Excludes OSHPD report designated specialty hospitals, except City of Hope
- Non-designated Public Hospitals (districts)
- Designated Public Hospitals

## HOSPITAL OUTPATIENT PAYMENTS

- Each private hospital paid a percentage of 2007 Medi-Cal payments for hospital outpatient services
- Percent for a FFY is amount needed to get to the UPL for which FFP is available
- No supplemental outpatient payments for public hospitals—no UPL room

## PRIVATE HOSPITAL INPATIENT

- 2008 general acute care days x \$647.70
- If Medicaid inpatient utilization rate < 41.1% for 2008-09 DSH year and at least 5% high acuity days, get additional \$1350 per high acuity day
- If Medicaid inpatient utilization rate < 41.1% and a trauma center, get additional \$1350 x “high acuity days” in 2008
- If Medicaid inpatient utilization rate > 5.0% and < 26.10% get 50% of Medi-Cal subacute payments received in 2008
- Scaled for each FFY based on available FFP

## NONDESIGNATED PUBLIC HOSPITAL INPATIENT

- 2008 general acute care days x \$218.82
- Scaled for each FFY based on available FFP

# DESIGNATED PUBLIC HOSPITALS

- Paid Direct Grants
- No FFP
- Divide up \$310,000,000 for each full FFY
- Scaled based on availability of FFP for private hospital inpatient payments

## TIMING OF FFS PAYMENTS

- Made quarterly
- Begin 45 days after federal approval
- First payment is a catch-up payment going back to effective date of federal approval
- Last payment (in first quarter of FFY 2011) hopefully will include more than one quarter's worth of payments

## Article 5.21: Supplemental Managed Care Payments

- Monthly enhanced payments to managed care plans as part of their monthly capitation payments
- Amounts of enhanced payments determined by the department
- Federal law requires capitation payments to be actuarially sound

## Article 5.21: Supplemental Managed Care Payments

- Enhanced payments to plans are to be used exclusively for making supplemental payments to hospitals
- No administrative fees to plans but plans get to keep interest on enhanced payments
- Total amounts of payments to each hospital from all managed care plans per month equal to each hospital's individual hospital managed care supplemental payment

## Article 5.21: Supplemental Managed Care Payments

- “Individual hospital managed care supplemental payment”
  - For private hospitals and designated public hospitals = number of Medi-Cal managed care days for the hospital x \$1,341.89 / 12
  - For nondesignated public hospitals = number of Medi-Cal managed care days for the hospital x \$375.00 / 12

## Article 5.21: Supplemental Managed Care Payments

- Medi-Cal managed care days = total number of general acute care days, including well baby days, listed for county organized health system and prepaid health plans in final Medi-Cal Utilization Statistics for the 2008-09 state fiscal year, as calculated by the department on September 15, 2008, except that the general acute care days for the Santa Barbara Health Care Initiative shall be derived from data from the 2007-08 state fiscal year

## Article 5.21: Supplemental Managed Care Payments

- Timing of enhanced payments to plans:
  - Commence one month after QA Fee is first paid. First payment encompasses payments for all prior months
  - Subsequent payments are made on a monthly basis until December 2010
  - December 2010 payment includes payments for December 2010 through September 2011

## Article 5.21: Supplemental Managed Care Payments

- Managed care plans must make supplemental payments to hospitals, as directed by the department, within 30 days of receiving enhanced payments
- Exception for months from January 2011 through September 2011 during which plans shall make payments during each month to which the payment relates

## Article 5.21: Supplemental Managed Care Payments

- Enhanced payments to managed care plans not to impact any other payments from the department to the plans
- Supplemental payments to hospitals not to impact hospital contract negotiations or the amounts of any other payments to hospitals
- Delegation/subcapitation does not relieve a plan of its obligations to make payments to hospitals

## Article 5.21: Supplemental Managed Care Payments

- Managed care plans to submit documentation to the department to demonstrate actual payments to hospitals.
- The department and each managed care plan to make available to each hospital, within 15 days of receipt of a written request, documentation demonstrating the amount that the plan paid to the subject hospital for a subject month

## Article 5.21: Supplemental Managed Care Payments

- Department has the authority to recoup enhanced payments from plans if it determines that the plan failed to pay any enhanced payment it received from the department to hospitals

## Article 5.21: Supplemental Mental Health Payments

- Structure similar to supplemental managed care payments except:
  - Enhanced payments made to county mental health plans
  - Enhanced payments made on a quarterly basis
  - Mental health plans only responsible for making supplemental payments to hospitals in the county
  - Counties receive an administrative fee

## Article 5.21: Supplemental Mental Health Payments

- “Individual hospital managed care supplemental payment” = number of acute psychiatric days for the hospital for which a mental health plan was financially responsible x \$485.00 / 4

## Article 5.21: Supplemental Mental Health Payments

- Timing of enhanced payments to plans:
  - Commence on later of last day of the second month of the quarter in which federal approval is granted or the 45<sup>th</sup> day following the day on which federal approval is granted. First payment encompasses payments for all prior quarters
  - Subsequent payments are made on a quarterly basis until November 2010
  - November 2010 payment includes payments for remaining quarters in FFY 2011

## Article 5.21: Supplemental Mental Health Payments

- Mental health plans must make supplemental payments to hospitals, as directed by the department, within 30 days of receiving enhanced payments
- Exception for quarters from January 2011 through September 2011 during which plans shall make payments during each quarter to which the payment relates

## PROTECTIONS AGAINST SUPPLANTATION

- Do not want state to be able to reduce normal payments as a consequence of making supplemental payments
- Establish base minimum rates:
  - CMAC contract rates cannot be reduced below amount on effective date
  - Non-CMAC contract inpatient payments cannot be less than under methodology in place on effective date

## Article 5.22: Quality Assurance Fee

- QA Fee assessed from January 1, 2010 until December 31, 2010
  - Note – that it will not be assessed until January 1, 2010, is a mistake due to the deletion of the urgency legislation provision

## Article 5.22: Quality Assurance Fee

- Assessed on general acute care hospitals that are not exempt facilities
  - Exempt facilities = public hospitals, specialty hospitals, long-term care hospitals and small and rural hospitals
- Assessed as a condition of participation of state-funded health insurance programs, other than Medi-Cal

## Article 5.22: Quality Assurance Fee

- Amount of QA Fee
  - Based on hospital data submitted to OSHPD for calendar year 2007
  - Calculated on an annual basis
  - Non-Medi-Cal FFS fee = \$233.66/day
  - Non-Medi-Cal managed care fee = \$27.25/day
  - Medi-Cal fee (FFS or HMO) = \$293/day
  - Amounts assume Feds fully approve

## Article 5.22: Quality Assurance Fee

- Prior to federal approval, hospitals required to certify that they are prepared to pay the QA Fee
- Upon federal approval, hospitals required to pay amounts they previously had certified to pay multiplied by fee percentage.

## Article 5.22: Quality Assurance Fee

- Enforcement of QA Fee provisions
  - 10% interest (or interest rate on Medi-Cal overpayments) begins to accrue on due date
  - Payments overdue by more than 60 days will be assessed a penalty equal to the interest charge
  - After 60 days, department may deduct unpaid amounts from Medi-Cal or other state payments after written notice

## Article 5.22: Quality Assurance Fee

- All QA Fees collected will be deposited into a separate Hospital Quality Assurance Revenue Fund
- Funds to be used exclusively for (in priority order):
  - Pay for the costs to DHCS for the administration of AB 1383
  - Increase funds for children's health insurance by approximately \$320 million annually
  - Increase Medi-Cal fee-for-service payments to hospitals
  - Enhance payments to managed care plans
  - Enhance payments to mental health plans

## Article 5.22: Quality Assurance Fee

- Article 5.22 becomes inoperative if CMS denies approval for, or does not approve by January 1, 2012, the implementation of Articles 5.21 and 5.22 and either or both article cannot be modified by the department to meet the requirements of federal law/to get CMS approval
- Releases hospitals from any certifications/obligation to pay
- Total amount of the QA Fee limited to amount permitted by federal law

## Article 5.22: Quality Assurance Fee

- Changes in methodology to attain CMS approval:
  - Must be in consultation with the hospital community, be only to the extent necessary to meet the requirements of federal law or regulations to obtain federal approval or to enhance probability of federal approval, and must be within the spirit of intent of AB 1383
  - Cannot change supplemental payments or fees by more than 2% - except
    - ❖ Managed care fee may be increased or decreased \$5
    - ❖ FFS fee may be decreased by \$6
    - ❖ Medi-Cal fee may be increased by \$2

## GRANT PLAN

- CHA foundation will accept grants from winners
- Foundation will make grants to losers