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State/Territory Name: California

State Plan Amendment (SPA) #: 16-011

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Financial Management Group

JUN 21 2016

Mari Cantwell
Chief Deputy Director, Health Care Programs
California Department of Health Care Services
P.O. Box 997413, MS 0000
Sacramento, CA 95899-7413

RE: California State Plan Amendment 16-011

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 16-011. This State Plan Amendment (SPA) is the annual update to the DRG parameters, which includes updating the wage area neutrality adjustment, setting the labor share percentage for hospitals with a wage area index equal to or less than 1.00 to 62%, and updating the Remote Rural and Statewide DRG Base Price, Outlier Thresholds and Outlier Percentage Upper Bound, Discharge Status Values, and the DRG and HAC Grouper versions. It also adds language to Appendix 6 to Attachment 4.19A to clarify that losing California Children's Services (CCS) approval designation as a Regional or Community NICU will result in that facility losing eligibility for the NICU policy adjustor. All updates are effective July 1, 2016.

We conducted our review of your submittal according to the statutory requirements at sections 1902(a)(13), 1902(a)(30), 1903(a), and 1923 of the Social Security Act and the implementing Federal regulations at 42 CFR 447 Subpart C. This is to inform you that Medicaid State plan amendment TN 16-011 is approved effective July 1, 2016. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Blake Holt at (415) 744-3754.

Sincerely,

[redacted]

Kristin Fan
Director

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **16-011**

2. STATE: CA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2016

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447, Subpart C. 1902(a)(13) of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2016 $0
b. FFY 2017 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages 17.41, 17.48- 17.55

Appendix 6 to Attachment 4.19A, pages 1-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 17.41, 17.48- 17.55

Appendix 6 to Attachment 4.19A, pages 1-4

10. SUBJECT OF AMENDMENT:

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
The Governor's Office does not wish to review the State Plan Amendment.

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
Mari Cantwell

MAY 20 2016

14. TITLE:
State Medicaid Director

15. DATE SUBMITTED:

16. RETURN TO:

Department of Health Care Services
Attn: State Plan Coordinator
1501 Capitol Avenue, Suite 71.326
P.O. Box 997417
Sacramento, CA 95899-7417

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

18. DATE APPROVED: JUN 21 2016

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2016

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Kristen Fan

22. TITLE: Director, FMG

23. REMARKS:

FORM HCFA-179 (07-92)

miles in driving distance from the nearest GAC hospital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.

21. "Remote Rural Border Hospital" is a border hospital that is defined as a rural hospital by the federal Medicare program, is at least fifteen (15) miles in driving distance from the nearest GAC hospital that has a basic level emergency room, and does not operate under a combined license or bill under a common National Provider Index (NPI) number with a non-remote rural hospital.

22. "State Fiscal Year" (SFY) is California state government's fiscal year which begins on July 1 and ends the following June 30.

23. "Hospital-Specific Wage Area Index Values" are hospital-specific geographic adjustments that Medicare uses (from the Medicare hospital impact file) further adjusted by the California Wage Area Neutrality Adjustment of 0.9690 for California hospitals.

B. Applicability

1. Except as specified below in Paragraph 2, for admissions dated July 1, 2013 for private hospitals, and after and commencing on admissions dated January 1, 2014, and after for NDPHs, the Department of Health Care Services (DHCS) will reimburse "DRG Hospitals" through a prospective payment methodology based upon APR-DRG.

2. The following are "Exempt Hospitals, Services, and Claims" that are not to be reimbursed based upon APR-DRG:

   a. Psychiatric hospitals and psychiatric units
   b. Rehabilitation hospitals, rehabilitation units, and rehabilitation stays at general acute care hospitals
   c. Designated Public Hospitals
   d. Indian Health Services Hospitals
   e. Inpatient Hospice
   f. Swing-bed stays
   g. Managed Care stays

receive a percentage increase that would result in a transitional base price above the statewide base price.

k. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2013-14 were sent to private hospitals January 30, 2013.

l. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2013-14 were sent to NDPHs June 17, 2013.

m. The DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2014-15 and SFY 2015-16 was provided to hospitals on July 31, 2013. Transitional APR-DRG Base Prices are subject to change based on changes to the Medicare Wage Index, hospital characteristics or other reasons. The updated DRG Hospital Specific Transitional APR-DRG Base Price for SFY 2015-16 were sent to private hospitals and NDPHs on May 29, 2015, June 2, 2015, and June 3, 2015.

4. DRG Hospital Specific APR-DRG Base Prices for SFY 2016-17

The DRG Hospital Specific Transitional APR-DRG Base Price will cease starting SFY 2016-17. DRG payment rates will no longer receive transition based adjustments to the DRG payment rate. All hospitals will receive the statewide base price.

5. Wage Area Adjustor

a. Hospital-Specific Wage Area Index values will be used to adjust the APR-DRG Base Price for DRG Hospitals and Border Hospitals. The Hospital-Specific Wage Area Index Value for a California hospital or Border hospital shall be the same hospital specific wage area index value that the Medicare program applies to that hospital, further adjusted by the California Wage Area Neutrality Adjustment of 0.9690. In determining the hospital-specific wage area index values for each SFY, DHCS will utilize data from the latest Medicare Impact file published prior to the start of the state fiscal year, including wage area boundaries, any reclassifications of hospitals into wage index areas, wage area index values, and any other wage area or index value adjustments that are used by Medicare Out of state hospitals that are not Border hospitals will receive a wage area adjustor of 1.00. The wage area adjustor is applied to the labor share percentage, as specified in Appendix 6, of the statewide base price or

the remote rural base price. The labor share percentage for a SFY shall be the same percentage that the Medicare program has established according to the latest published CMS final rule and notice published prior to the start of the state fiscal year, with the exception for hospitals having wage area index less than or equal to 1.00 will have the labor share percentage applied at 62.0% Medicare published the Medicare impact file for FFY 2016 in October 2015 and it was used for the base prices for SFY 2016-17. Similarly, final changes to all DRG hospitals wage area, index value, or labor share calculation published for future federal fiscal years will be used for the state fiscal year beginning after the start of each respective federal fiscal year. All wage area index values can be viewed on the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

b. The wage area adjustor is not applied to the hospital-specific transitional base price (determined in paragraph C.3 above).

6. Policy Adjustors

The implementation of APR-DRG Payment includes the functionality of policy adjustors. These adjustors are created to allow the DHCS to address any current, or future, policy goals and to ensure access to care is preserved. Policy adjustors may be used to enhance payment for services where Medi-Cal plays a major role. This functionality of policy adjustors allows DHCS the ability to ensure access to quality care is available for all services. A list of the current policy adjustors is reflected in Appendix 6 of Attachment 4.19-A. These policy adjustors are used to adjust payment weights for care categories. The projected financial impact of the policy adjustors was considered in developing budget-neutral base prices.

7. Cost Outlier Payments

Outlier payments are determined by calculating the DRG Hospital's estimated cost and comparing it to the APR-DRG Payment to see if there is a loss or gain for the hospital for a discharge claim. The DRG Hospital's estimated cost on a discharge claim is determined by the following: The DRG Hospital's estimated cost may be determined by multiplying the Medi-Cal covered charges by the DRG Hospital's most currently accepted cost-to-charge ratio (CCR) from a hospital's CMS 2552-10 cost report. The CCR is calculated from a hospital's Medicaid costs (reported on worksheet E-3, part VII, line 4) divided by the Medicaid charges (reported on worksheet E-3, part VII, line 12). All hospital CCRs will be updated annually with an effective date of July 1, after the acceptance of the CMS 2552-10 by DHCS. In alternative, a hospital (other than a new hospital or an out-of-state border or

non-border hospital) may request that DHCS use a different (higher or lower) CCR based on substantial evidence presented by the hospital to more accurately represent its current year cost and charge experience, resulting in more accurate outlier claims payment amounts. A corresponding request for use of an alternative CCR for Medicare outlier reimbursement purposes must first be approved by CMS; the Medicare approval must affect the same period as requested for Medicaid and use the same underlying evidential cost and charge data. This method would allow hospitals to submit once each year projected Medicaid costs and projected Medicaid charges on relevant CMS-2552 worksheets, along with any necessary supporting documentation. The DRG Hospital's estimated cost on a discharge claim would then be determined by multiplying the Medi-Cal covered charges by the DRG Hospital's approved alternative CCR. The submission deadline for the request to be accepted by DHCS is no later than December 31, annually. For hospitals that have submitted a cost report request by the December 31 deadline and received approval from DHCS, the approved alternative CCR will only be applied toward the following fiscal year's annual update. There will be no retroactive adjustment to hospital's CCR. Hospitals are still required to complete and annually file the CMS 2552-10 cost report at the end of their respective cost reporting periods. Notwithstanding the pre- and post payment review provisions in paragraph (E), all approved projected costs and charges and alternative CCRs will be subject to 100% reconciliation based on the final audited CCRs for the cost reporting period(s) covering the actual payment year, and any resulting outlier overpayments will be recouped and FFP returned to the federal government in accordance with 42 CFR 433, Subpart F.

For new California hospitals for which there is no accepted prior period cost report to calculate a hospital specific CCR (or for other hospitals that can document that the apportionment data reported by the hospital in the cost report cannot be used to calculate a hospital specific CCR) and for non-border out-of-state hospitals, a CCR is assigned that is equal to the sum of (a) the Medicare reported average CCR of operating costs for California urban hospitals and (b), the Medicare reported average CCR of capital cost for California hospitals. Assigned CCRs will be updated annually with an effective date of July 1. Border hospitals will be assigned their state-specific CCR that is equal to the sum of (a) the unweighted average of the Medicare reported average urban CCR and the Medicare reported average rural CCR of operating costs for hospitals in the state in which the border hospital is located, and (b) the Medicare reported average CCR of capital costs for hospitals

in the state in which the border hospital is located. The average Medicare urban CCR and average Medicare rural CCR for operating costs shall be determined from Table 8A associated with the Hospital Inpatient Prospective Payment System (PPS) Final Rule and the Average CCR for capital costs shall be determined from Table 8B associated with the Hospital Inpatient PPS Rule. Border hospital state-specific CCRs will be updated annually with an effective date of July 1.

a. Subtracting the APR-DRG Payment from the DRG Hospital's estimated cost on a given discharge claim gives the estimated loss. If the Estimated Loss is greater than the High Cost Outlier Threshold 1, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1.

b. For extreme outlier cases, if the Estimated Loss on a discharge claim is greater than the High Cost Outlier Threshold 2, then the Cost Outlier Payment is the Estimated Loss less the High Cost Outlier Threshold 1 (but to a maximum of High Cost Outlier Threshold 2 less High Cost Outlier Threshold 1) multiplied by the Marginal Cost Factor 1, plus the Estimated Loss less High Cost Outlier Threshold 2 multiplied by the Marginal Cost Factor 2.

c. APR-DRG Payment also utilizes a low-side outlier similar to the high side outlier adjustment calculations. The estimated gain is determined by subtracting the APR-DRG Payment from the DRG Hospital's estimated cost. If the Estimated Gain is greater than the Low Cost Outlier Threshold, payment will be decreased by the Estimated Gain less the Low Cost Outlier Threshold, and then multiplied by the Marginal Cost Factor 1.

d. Values for High Cost Outlier Threshold 1, High Cost Outlier Threshold 2, Low Cost Outlier Threshold, Marginal Cost Factor 1, and Marginal Cost Factor 2 are reflected in Appendix 6 of Attachment 4.19-A.

8. Transfer Adjustments

When a Medi-Cal beneficiary is transferred from a DRG Hospital (DRG Hospital 1), to another hospital, DRG Hospital 1's payment for the transfer is determined by calculating a per diem payment amount for the assigned APR-DRG and multiplying it by: one plus the actual length of stay. The per diem amount is calculated by pricing the stay at its assigned APR-DRG payment and dividing by the nationwide average length of stay for the assigned APR-DRG. If DRG Hospital 1's actual length of stay plus one is greater than the nationwide average length of stay, payment for this particular transfer would pay the full DRG. If the receiving hospital is a DRG Hospital, they would receive an APR-DRG payment based on a final discharge claim. Discharge status values defining an acute care transfer are reflected in Appendix 6 of Attachment 4.19-A. The various relative weights, including average length of stay are published in the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

9. Interim Payments

For stays exceeding twenty- nine (29) days, a DRG Hospital may submit an interim claim for payment every thirty (30) days. For example, if a stay is for sixty-one (61) days, two interim claims may be submitted for payment, as well as one final claim. Interim claims are paid a per diem amount for each day of service. When the Medi-Cal beneficiary is discharged, the DRG Hospital submits a full admit through discharge claim. The final discharge claim is priced as any other final discharge claim and will be paid accordingly. All previously paid interim payments related to the final discharge claim are removed from the DRG Hospital's next check-write through the remittance advice detail (RAD). The interim per diem amount is reflected in Appendix 6 of Attachment 4.19-A.

10. Separately Payable Services, Supplies, and Devices

a. A separate outpatient claim may be submitted for certain services, supplies, and devices as determined by DHCS, reflected in Appendix 6 of Attachment 4.19-A, and will be reimbursed in accordance with Attachment 4.19-B.

b. Professional services furnished by provider-based physicians and practitioners should be billed as professional claims and are reimbursed outside of the DRG reimbursement. All physician professional services should be billed as professional claims.

11. Out-of-State Hospital Reimbursement

a. For admissions beginning July 1, 2013, when acute inpatient medical services are provided out-of-state pursuant to Section 2.7 of the State Plan and have been certified for payment at the acute level of an emergency nature for which prior Medi-Cal authorization has been obtained, then such inpatient services are reimbursed utilizing the statewide APR-DRG Base Price for the services provided.

b. When Medi-Cal is required to provide acute inpatient services that are not available in the State to comply with paragraph (3) of part 431.52(b) of Title 42 of the Code of Federal Regulations, and the out-of-state hospital refuses to accept the APR-DRG rate, then DHCS may negotiate payment in excess of the APR-DRG rate for the acute inpatient services provided but no more than what the out-of-state hospital charges the general public.

c. DHCS will adjust payment to out-of-state inpatient hospitals for provider preventable conditions, as described in Attachment 4.19-A. When treating a Medi-Cal

beneficiary, out-of-state providers must comply with the reporting provisions for provider preventable conditions described in Attachment 4.19-A pages 52 through 54, OMB No. 0938-1136.

D. Updating Parameters

1. DHCS will review all base prices, policy adjustors, and other payment parameters as needed to ensure projected payments for any given year are kept within the parameters as defined in Welfare & Institutions Code section 14105.28, as the law was in effect on July 1, 2013. Any needed changes may be implemented as outlined in paragraph 4 of this section.

2. The APR-DRG HSRVs are specific to the APR-DRG Grouper version and are released annually. DHCS will perform a review of each released version to determine if an update to the current grouper and hospital acquired condition (HAC) utility are necessary. The APR-DRG Grouper version and HAC Utility version DHCS is utilizing is reflected in Appendix 6 of Attachment 4.19-A. Changes to the APR-DRG Grouper version and HAC Utility version may be implemented pursuant to an approved State Plan Amendment.

3. DHCS will review and update Appendix 6 of Attachment 4.19-A as necessary and pursuant to an approved State Plan Amendment. When reviewing, DHCS shall consider: access to care for specific and overall care categories, hospital coding trends, and any other issues warranting review.

4. The effect of all APR-DRG base rates, policy adjustors and values as referenced in Appendix 6 of Attachment 4.19A will be monitored by DHCS on a quarterly basis. If DHCS determines that adjustments to any values or parameters specified in

Appendix 6 of Attachment 4.19-A are necessary to ensure access for all Medi-Cal beneficiaries, program integrity, or budget neutrality, DHCS may adjust those values or parameters upon approval of a State Plan Amendment.

E. Pre-Payment and Post-Payment Review

1. All claims paid using the APR-DRG Payment methodology are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

2. Outlier claims may be subject to post-payment review and adjustment in accordance with the following protocols:
    i. Amounts paid for services provided to Medi-Cal beneficiaries shall be audited by the department in the manner and form prescribed by the department as defined in Welfare and Institutions Code 14170.

    ii. When there is a material change between the reported CCR and the final audited CCR, outlier payments may be subject to recalculation based upon the audited CCR. A material change is defined as a change that would result in outlier payment adjustments exceeding $10,000.00 in a hospital's fiscal year.

F. Final Audited CCR shall be taken from the audited cost report which overlaps the hospital fiscal year meeting the material change parameters defined in Pre-Payment and Post-Payment Review section E(2)(ii).

G. End of the Selective Provider Contracting Program

Effective July 1, 2013, for private hospitals and January 1, 2014, for NDPHs, the Selective Provider Contracting Program (SPCP) will be discontinued. Reimbursement for hospital inpatient services provided to Medi-Cal beneficiaries will be based on the new diagnosis-related group (DRG) methodology. As part of this, the SPCP will no longer be in effect and is discontinued upon DRG implementation. Additionally, hospitals will no longer be designated as contract or non-contract facilities.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

Appendix 6

1. APR-DRG Payment Parameters

Parameter	Value	Description
Remote Rural APR-DRG Base Price	$12,832	Statewide Remote Rural APR-DRG Base Price
Statewide APR-DRG Base Price	$6,320	Statewide APR-DRG Base Price (non-Remote Rural)
Policy Adjustor - Age	1.25	Policy Adjustor for claims whose patients are less than 21 years old with a DRG in the 'miscellaneous pediatric' or 'respiratory pediatric' care categories.
Policy Adjustor – NICU services	1.25	Policy Adjustor for all NICU DRGs (i.e. DRGs assigned to the 'neonate' care category, except for those receiving the NICU Surgery policy adjuster below).
Policy Adjustor – NICU surgery	1.75	Enhanced Policy Adjustor for all designated NICU facilities and surgery sites recognized by California Children's Services (CCS) Program to perform neonatal surgery. For all DRGs assigned to the neonate care category
Policy Adjustor- Obstetrics	1.06	Policy adjustor value for obstetric care
Policy Adjustor – Each other category of service	1.00	Policy adjustor for each other category of service.
Wage Index Labor Percentage	69.6%	Percentage of DRG Base Price or Rehabilitation per diem rate adjusted by the wage index value.
High Cost Outlier Threshold 1	$46,800	Used to determine Cost Outlier payments
High Cost Outlier Threshold 2	$150,800	Used to determine Cost Outlier payments
Low Cost Outlier Threshold 1	$46,800	Used to determine Cost Outlier payments
Marginal Cost Factor 1	60%	Used to determine Cost Outlier payments
Marginal Cost Factor 2	80%	Used to determine Cost Outlier payments
Outlier Percentage, upper bound	19%	Outlier payments as percentage of total
Outlier Percentage, lower bound	16%	Outlier payments as percentage of total
Casemix Corridor, upper bound	0.6684	Projected upper bound of patient acuity
Casemix Corridor, lower bound	0.6484	Projected lower bound of patient acuity
Discharge Status Value 02	02	Transfer to a short-term general hospital for inpatient care
Discharge Status Value 05	05	Transfer to a designated cancer center

Discharge Status Value 63	63	Transfer to a long-term care hospital
Discharge Status Value 65	65	Transfer to a psychiatric hospital
Discharge Status Value 66	66	Transfer to a critical access hospital (CAH)
Discharge Status Value 82	82	Transfer to a short-term general hospital for inpatient care with a planned acute care hospital inpatient readmission
Discharge Status Value 85	85	Transfer to a designated cancer center or children's hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 91	91	Transfer to a Medicare certified Long Term Care Hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 93	93	Transfer to a psychiatric distinct part unit of a hospital with a planned acute care hospital inpatient readmission
Discharge Status Value 94	94	Transfer to a Critical Access Hospital with a planned acute care hospital inpatient readmission
Interim Payment	$600	Per diem amount for Interim Claims
APR-DRG Grouper Version	V.33	3M Software version used to group claims to a DRG
HAC Utility Version	V.33	3M Software version of the Healthcare Acquired Conditions Utility
Pediatric Rehabilitation Rate	$1,841	Daily rate for rehabilitation services provided to a beneficiary under 21 years of age on admission.
Adult Rehabilitation Rate	$1,032	Daily rate for rehabilitation services provided to a beneficiary 21 years of age or older on admission.

2. Separately Payable Services, Devices, and Supplies

Code	Description
Bone Marrow	
38204	Management of recipient hematopoietic progenitor cell donor search and acquisition
38204	Unrelated bone marrow donor
Blood Factors	
J7180	Blood factor XIII
J7183/J7184/Q2041	Blood factor Von Willebrand –injection
J7185/J7190/J7192	Blood factor VIII
J7186	Blood factor VIII/ Von Willebrand
J7187	Blood factor Von Willebrand
J7189	Blood factor VIIa

J7193/J7194/J7195	Blood factor IX
J7197	Blood factor Anti-thrombin III
J7198	Blood factor Anti-inhibitor
C9134	Blood Factor XIII Antihemophilic factor
J7199	Alprolix and Factor VIII
Long Acting Reversible Contraception Methods	
J7300	Intrauterine Copper (Paraguard)
J7301	Skyla
J7302	Levonorgestral-releasing intrauterine contraceptive system (Mirena)
J7307	Etonogestrel (Implanon, Nexplanon)

3. **List of Hospitals Eligible to receive the "DRG- NICU- Surgery Policy Adjustor"**

1) California Hosp Medical Center of Los Angeles
2) California Pacific Medical Center - Pacific
3) Cedars Sinai Medical Center
4) Children's Hospital & Research Center of Oakland (UCSF Benioff Oakland)
5) Children's Hospital of Central California
6) Children's Hospital of Los Angeles
7) Children's Hospital of Orange County
8) Citrus Valley Medical Central – Queen of the Valley
9) Community Regional Medical Center Fresno
10) Good Samaritan – Los Angeles
11) Good Samaritan - San Jose
12) Huntington Memorial Hospital
13) Kaiser Anaheim
14) Kaiser Downey
15) Kaiser Fontana
16) Kaiser Foundation Hospital - Los Angeles
17) Kaiser Permanente Medical Center - Oakland
18) Kaiser Foundation Hospital – Roseville
19) Kaiser Permanente – Santa Clara
20) Loma Linda University Medical Center
21) Lucille Salter Packard Children's Hospital – Stanford
22) Miller Children's at Long Beach Memorial Medical Center
23) Pomona Valley Hospital Medical Center
24) Providence Tarzana
25) Rady Children's Hospital - San Diego
26) Santa Barbara Cottage Hospital
27) Sutter Memorial Hospital

For purposes of receiving the NICU policy adjustor, the hospital listed above must:

- Be performing services assigned to the neonate care category;
- Have been approved by California Children's Services (CCS) and continue to meet the standards of either a Regional NICU as defined in the CCS Manual of Procedures Chapter 3.25.1 or a Community NICU with a neonatal surgery as defined in Chapter 3.25.2;
- Have been approved by CCS and continue to meet the neonatal surgery standards set forth in CCS Manual of Procedures Chapter 3.34; and
- Pass periodic CCS review. Hospital review may be conducted annually or as deemed necessary by CCS. These reviews will determine whether the hospital continues to meet all applicable neonatal surgery standards.

If the CCS NICU-surgery approval/status of a hospital on the above list is revoked or otherwise terminated, then that hospital will not receive the DRG NICU-Surgery Policy Adjustor, effective the date approval/status ceases. Removal from the above list for failure to meet CCS NICU-surgery standards is not a prerequisite to no longer qualify to receive the DRG NICU-Surgery Policy Adjustor. Once the CCS NICU-surgery approval/status of a hospital on the above list is revoked or otherwise terminated, the hospital will subsequently be removed from the above list. Being listed in the State Plan does not guarantee payment of the DRG NICU-Surgery Policy Adjustor. In the event that a hospital remains listed, but has otherwise been deemed to have lost its neonatal surgery approval/status, it will not receive the DRG NICU-Surgery Policy Adjustor.