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

SEP 29 2015

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 15-020

Dear Ms. Cantwell:

We have reviewed the proposed amendment to Attachment 4.19-A of your Medicaid state plan submitted under transmittal number (TN) 15-020. This amendment updates Year 3 Diagnosis Related Group (DRG) payment parameters for general acute inpatient services provided by hospitals to include border hospitals, defined as those hospitals located outside of California that are within 55 miles driving distance from the California border, effective for inpatient services with dates of admission on or after July 1, 2015. It also allows for Remote Rural Border hospitals, defined as a rural hospital by Medicare that is at least 15 miles in driving distance from the nearest General Acute Care hospital that has a basic level ER, to receive the remote rural APR-DRG base prices from Appendix 6, effective for inpatient services with dates of admission on or after July 1, 2015.

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 15-020 is approved effective July 1, 2015. We are enclosing the HCFA-179 and the amended plan pages.

If you have any questions, please call Blake Holt at (415) 744-3754 or Mark Wong at (415) 744-3561.

ORIGINAL SIGNED

Timothy Hill
Director

PARTMENT OF HEALTH AND HUMAN SERVICES
EALTH 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: **15-020**

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, 2015

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), ~~1923,1861(v)(1)(G)~~ of the Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2014/2015 ~~$684,146~~ $171,037
b. FFY 2015/2016 $684,146

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A pages ~~17.38-17.63~~ 17.39-17.41,17.43,17.45,17.48-17.50,17.53, 17.54, 17.61, 17,62
Appendix 6 to Attachment 4.19-A, pages ~~1-4~~
3-4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A pages 17.39-17.41, 17.43, ~~17.46~~, ~~17.49~~, ~~17.51~~ 17.45 17.48-17.50 17.53, 17.54, 17.61, 17.62
Appendix 6 to Attachment 4.19-A, pages 3-4

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.

16. RETURN TO:

ORIGINAL SIGNED

State Medicaid Director

15. DATE SUBMITTED:

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

4. "APR-DRG Payment" is the payment methodology for acute inpatient services provided to Medi-Cal beneficiaries at DRG Hospitals for admissions on or after July 1, 2013, for private hospitals and for admissions on or after January 1, 2014, for NDPHs.

5. " APR-DRG Hospital-Specific Relative Value" (HSRV) is a numeric value representing the average resources utilized per APR-DRG. The relative weights associated with each APR-DRG are calculated from a two-year dataset of 15 million stays in the Nationwide Inpatient Sample, which includes general acute care hospitals including freestanding children's hospitals.

6. "DRG Hospital Specific Transitional APR-DRG Base Price" is a DRG Hospital specific APR-DRG Base Price calculated to assist DRG Hospitals to adapt to the change in payment methodologies. Transitional base prices are used during the three year implementation phase for qualifying hospitals.

7. "DRG Hospitals" are private general acute care hospitals reimbursed for acute inpatient services based on APR-DRG pricing for admissions dated on or after July 1, 2013, and NDPHs reimbursed for acute inpatient services based on APR-DRG pricing for admissions dated on or after January 1, 2014. "DRG Hospitals" are currently all private and nondesignated public general acute care hospitals not excluded as outlined in (Section B; paragraph 2).

8. "Nondesignated public hospital" means a public hospital defined in paragraph (25) of subdivision (a) of Section 14105.98, excluding designated public hospitals as that section reads as of of January 1, 2014.

9. "Private hospital" means a nonpublic hospital, nonpublic converted hospital, or converted hospitals, as those terms are defined in paragraphs (26) to (28) of subdivision (a) Section 14105.98 as that section reads as of July 1, 2013.

10. "Border Hospitals" are hospitals located outside the State of California that are within fifty five miles driving distance from the nearest physical location at which a road crosses the California border as defined by the US Geological Survey.
11. "Estimated Gain" is the amount a DRG Hospital is estimated to gain on a final discharge claim for which the final APR-DRG Payment exceeds estimated costs.
12. "Estimated Loss" is the amount a DRG Hospital is estimated to lose on a final discharge claim for which the final APR-DRG Payment does not exceed estimated costs.
13. "Exempt Hospitals, Services, and Claims" are those hospitals, services, and claims as listed in Paragraph B.2.
14. "High Cost Outlier Threshold 1" is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 1.
15. "High Cost Outlier Threshold 2" is the amount that an estimated loss for a single complete discharge claim must exceed to be paid an outlier payment at the Marginal Cost Factor 2.
16. "Low Cost Outlier Threshold" is the amount that the Estimated Gain needs to be greater than to have the gained amount reduced by Marginal Cost Factor 1.
17. "Marginal Cost Factor 1" is the factor used for payment reductions and for determining outlier payments to DRG Hospitals for claims that have estimated losses between High Cost Outlier Threshold 1 and High Cost Outlier Threshold 2.
18. "Marginal Cost Factor 2" is the factor used for determining outlier payments to DRG Hospitals for claims that have estimated losses greater than High Outlier Threshold 2.
19. "Medi-Cal" is the name of California's Federal Medicaid program.
20. "Remote Rural Hospital" is a California hospital that is defined as a rural hospital by the Office of Statewide Health Planning and Development (OSHPD), is at least fifteen (15)

miles in driving distance from the nearest GAC hopital 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 a factor of 0.9797 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

calculated from a Nationwide Inpatient Sample. Each version of the APR-DRG grouping algorithm has its own set of APR-DRG specific HSRVs assigned to it. The APR-DRG HSRVs are published in the Medi-Cal DRG Pricing Calculator posted on the DHCS website at http://www.dhcs.ca.gov/provgovpart/Pages/DRG.aspx.

2. APR-DRG Statewide Base Prices Beginning SFY 2016-17

   i. In determining the APR-DRG Payment, California DRG Hospitals and out-of-state hospitals, including Border Hospitals, will utilize the statewide APR-DRG Base Price, except for California Remote Rural Hospitals and Remote Rural Border Hospitals, which will utilize the remote rural APR-DRG Base Price as reflected in Appendix 6 to Attachment 4.19-A.

3. DRG Hospital Specific Transitional APR-DRG Base Prices for SFYs 2013-14 through 2015-16

   a. Similar to implementation of DRGs in Medicare, DHCS is implementing a three-year transition period to allow California DRG Hospitals moving to the APR-DRG Payment methodology to adapt to the change in payment methodologies. A DRG Hospital Specific Transitional APR-DRG Base Price is utilized for qualifying DRG Hospitals for each of SFYs 2013-14, 2014-15, and 2015-16, in accordance with this section. The statewide APR-DRG base rates will be fully utilized by all DRG Hospitals beginning SFY 2016-17. Hospitals located outside of the State of California, including Border Hospitals and Remote Rural Border Hospitals do not receive a Transitional APR-DRG Base Price.

   b. First year DRG Hospital Specific Transitional APR-DRG Base Prices apply to DRG hospitals that were projected in general to see a change in estimated payments of no more than five percent for private hospitals and no more than 2.5 percent for NDPHs from their projected baseline payments. Some DRG Hospitals will receive a

area index value reflecting the various hospital-specific adjustments that Medicare uses (from the Medicare hospital impact file).

e. A shadow base price was calculated for each hospital that would result in the same level of projected payments in 2013-14 for each hospital under DRGs as projected under the prior methodology. The wage index was not relevant to this calculation because it was based on setting a final price at a level that results in the same amount of projected payments as under the prior methodology.

f. DRG Hospitals that would have a minimal projected impact will be assigned to the statewide base price or remote rural base price (adjusted by the wage area index value) during the transition period if any of the following apply:

i. The estimated impact (up or down) on total projected payments of APR-DRG Payment is less than five percent for private hospitals and 2.5 percent for NDPHs.
ii. If the estimated impact (up or down) on total projected payments of APR-DRG Payment is less than $50,000.
iii. If the DRG Hospital had fewer than 100 Medi-Cal Fee for Service stays and these stays were estimated to represent less than two percent of the DRG Hospital's total inpatient volume based on data submitted to OSHPD.
iv. If there were no stays in the simulation dataset for a particular DRG Hospital.

g. For remaining DRG Hospitals that had a shadow base price that results in projected payments above projected payments at the statewide base price (adjusted for their wage area index value), a hospital specific base price was calculated that resulted in a 5 percent reduction in projected payments for private hospitals a one percent reduction in projected payments for NDPHs. The wage index was not relevant to this calculation because it was based on setting a final price at a level that results in projected payments that are 5 percent less than projected under the prior methodology

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. Beginning in 2016-17 all hospitals will receive the statewide base price.

4. 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 .9797. 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 hospital 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. Medicare published the Medicare impact file for FFY 2015 in January, 2015 and it was used for the transitional base prices for SFY

2015-16. 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).

5. 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.

6. 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 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 on July 1, after the acceptance of the CMS 2552-10 by DHCS.

For new California hospitals for which there is insufficient cost data 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. CCRs for new California hospitals for which there is insufficient cost data to calculate a hospital specific CCR and for non-border out-of-state hospitals will be updated annually with an effective date of July 1.

Border hospitals will be assigned a 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 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.

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 transition 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

   iii. 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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: CALIFORNIA

REIMBURSEMENT TO HOSPITALS FOR REHABILITATION SERVICES

Notwithstanding any other provision of this State Plan, for admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, reimbursement for Rehabilitation Services that are provided to Medi-Cal beneficiaries is described and governed by this segment of Attachment 4.19-A.

A. Definitions

1. "Rehabilitation Services" are defined as acute inpatient intensive rehabilitation services provided to Medi-Cal beneficiaries, in accordance with Sections 14064 and 14132.8 of the Welfare and Institutions Code as the laws were in effect on July 1, 2013.

B. Applicability

For admissions dated July 1, 2013, and after for private hospitals and commencing on January 1, 2014, and after for NDPHs, the Department of Health Care Services' (DHCS) will reimburse Rehabilitation Services, through a per diem rate for Rehabilitation Services provided to a Medi-Cal beneficiary.

C. Rehabilitation Reimbursement

Provided all requirements for prepayment review have been approved by DHCS, Rehabilitation Services are paid a per diem amount for each day of service that is authorized, unless otherwise specified in Attachment 4.19-A. The specific per diem rates for pediatric and adult rehabilitation services are specified in Appendix 6 and are statewide rates. The specific pediatric and adult rehabilitation per diem rates were set at a level that is budget neutral on a statewide basis for both adult and pediatric rehabilitation services based on rates in effect June 30, 2013. The specific per diem rate for a hospital that provided services to both the adult and pediatric population is based on the blend of pediatric and adult rehabilitation services provided at that specific hospital. A facility-specific blended rate is the weighted average of the statewide adult and statewide pediatric per diem rates, weighted by the individual facility's number of adult and pediatric rehabilitation days in the base period used to determine the statewide per diem rates. The labor portion (69.6%) of all rehabilitation rates are further adjusted by the Medicare Wage Index value for each specific hospital.

D. Updating Parameters

DHCS will review and update the Rehabilitation Services payment parameters through the State Plan Amendment process. When reviewing and updating, DHCS shall consider: access to care related to Rehabilitation Services provided, and any other issues warranting review.

E. Pre-Payment and Post Payment Review

All claims paid under the rehabilitation per diem are subject to DHCS' pre-payment medical necessity review and discretionary post-payment review.

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 to receive the "Policy Adjustor – NICU Surgery"**

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) Earl & Lorraine Miller Children's Hospital
11) Good Samaritan – Los Angeles
12) Good Samaritan - San Jose
13) Huntington Memorial Hospital
14) Kaiser Anaheim
15) Kaiser Downey
16) Kaiser Fontana
17) Kaiser Foundation Hospital - Los Angeles
18) Kaiser Permanente Medical Center - Oakland
19) Kaiser Foundation Hospital – Roseville
20) Kaiser Permanente – Santa Clara
21) Loma Linda University Medical Center
22) Lucille Salter Packard Children's Hospital – Stanford
23) Miller Children's at Long Beach Memorial Medical Center
24) Pomona Valley Hospital Medical Center
25) Providence Tarzana
26) Rady Children's Hospital - San Diego
27) Santa Barbara Cottage Hospital
28) Sutter Memorial Hospital

For purposes of receiving the NICU policy adjustor, the hospital stay must be assigned to the neonate care category. For purposes of receiving the enhanced NICU Surgery

policy adjustor, the hospital must meet the definition of a Regional NICU as defined in the CCS Manual of Procedures, Section 3.25.1 or a Community NICU with a neonatal surgery as defined in the CCS Manual of Procedures Sections 3.25.2.

Periodic reviews of CCS-approved NICUs may be conducted on an annual basis or as deemed necessary by the CCS program. If a NICU does not meet CCS program requirements, the NICU may be subject to losing CCS approval. If a hospital loses CCS approval as a designated NICU, the hospital will no longer qualify for the enhanced DRG Policy Adjustor – Regional NICU or Community NICU with Neonatal Surgery and be dropped from the list above. Additionally, California hospitals and Border hospitals that apply and receive NICU approval from CCS will be added to the list above.