State/Territory: Nebraska

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

X Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State/Territory: Nebraska

Citation	3.1(a)(2)	Amount, Duration, and Scope of Services: Medically Needy (Continued) 1905(a)(26) and 1934
	X	Program of All-Inclusive Care for the Elderly (PACE) services, as described and limited in Supplement 4 to Attachment 3.1-A.

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage -that is in excess of established service limits- for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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State/Territory: Nebraska

Citation

42 CFR 435.914 1902(a)(34) of the Act

2.1 (b) (1) Except as provided in items 2.1(b)(2) and (3) below, individuals are entitled to Medicaid services under the plan during the three months preceding the month of application, if they were, or on application would have been, eligible. The effective date of prospective and retroactive eligibility is specified in Attachment 2.6-A.

1902(e)(8) and 1905(a) of the Act

(2) For individuals who are eligible for Medicare cost-sharing expenses as qualified Medicare beneficiaries under section 1902(a)(10)(E)(i)of the Act, coverage is available for services furnished after the end of the month which the individual is first determined to be a qualified Medicare beneficiary. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

1902(a)(47) and

☒ (3) Pregnant women are entitled to ambulatory prenatal care under the plan during a presumptive eligibility period in accordance with section 1920 of the Act. Attachment 2.6-A specifies the requirements for determination of eligibility for this group.

42 CFR 438.6

(c) The Medicaid agency elects to enter into a risk contract that complies with 42 CFR 438.6, and that is procured through an open, competitive procurement process that is consistent with 45 CFR Part 74. The risk contract is with (check all that apply):

☐ Qualified under Title XIII 1310 of the Public Health Service Act.
☒ A Managed Care Organization that meets the definition of 1903(m) of the Act and 42 CFR 438.2.
☐ A Prepaid Inpatient Health Plan that meets the definition of 42 CFR 438.2.
☐ A Prepaid Ambulatory Health Plan that meets the definition of 42 CFR 438.2.
☐ Not applicable.

42 CFR 435.217

☒ 4. A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the Waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.

☒ This includes PACE enrollees who reside in the community who are eligible using institutional rules.

*Agency that determines eligibility for coverage.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☒ Provided: ☐ Not provided

26. Personal assistance services are those services provided to a Medicaid client who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, institution for mental disease, or prison, which are authorized on a written service plan according to individual needs identified in a written assessment.

Personal assistance services are A) authorized by a Social Services Worker or designee, B) provided by qualified providers who are not legally responsible relatives, and C) are furnished inside the home, and outside the home with limitations.

☒ Provided:
- ☒ State Approved (Not Physician) Service Plan Allowed
- ☒ Services Outside the Home Also Allowed
- ☒ Limitations Described on Attachment

☐ Not Provided

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

___ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations ☐ None licensed or approved

Please describe any limitations:
Facilities must:

(a) Be specifically approved by Department of Health and Human Services, Division of Public Health to provide birthing center Services.

(b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE
AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☒ With limitations (please describe below)
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e. physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. X The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

1902(a)(10)(A)(ii)(XI) of the Act
1902(a)(10)(A)(ii)(X) and 1902(m)(1) and (3) of the Act
42 CFR 435.310
42 CFR 435.320
42 CFR 435.322
42 CFR 435.324

The State will use the actual maximum monthly allowable Special Needs Nursing Facility rate to reduce an individual's income to an amount at or below the medically needy income limit (MNIL) for persons who are medically needy with a Share of Cost.

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II - Compliance and State Monitoring of the PACE Program.

C. X The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

D. X Spousal impoverishment eligibility rules are being applied.

Regular Post Eligibility

1. X SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726--States which do not use more restrictive eligibility requirements than SSI.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

1. Allowances for the needs of the:
   (A.) Individual (check one)
      1. ___ The following standard included under the State plan (check one):
         (a) _____ SSI
         (b) _____ Medically Needy
         (c) _____ The special income level for the institutionalized
         (d) _____ Percent of the Federal Poverty Level: ____
         (e) _____ Other (specify):_____

      2. ___ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.

      3. _X_ The following formula is used to determine the needs allowance:
         (a) For waiver clients receiving Assisted Living Services: The State protects the SSI standard.
         (b) For clients receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

   Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

   (B.) Spouse only (check one):
      1 .___ SSI Standard
      2. ___ Optional State Supplement Standard
      3. ___ Medically Needy Income Standard
      4. ___ The following dollar amount: $_____
      Note: If this amount changes, this item will be revised.
      5. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
      6. ___ The amount is determined using the following formula:
      7. _X_ Not applicable (N/A)

   (C.) Family (check one):
      1. ___ AFDC need standard
      2. _X_ Medically needy income standard

   The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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3. ___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. ___ The amount is determined using the following formula:
6. ___ Other
7. ___ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726.

Regular Post Eligibility

2. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) 42 CFR 435.735--States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1. __ The following standard included under the State plan (check one):
(a) __ SSI
(b) __ Medically Needy
(c) __ The special income level for the institutionalized
(d) __ Percent of the Federal Poverty Level: _____%
(e) __ Other (specify):_____
2. ___ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):
1. __ The following standard under 42 CFR 435.121:
2. __ The Medically needy income standard
3. __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Nebraska

4. __ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. __ The amount is determined using the following formula:
6. __ Not applicable (N/A)

(C.) Family (check one):
1. __ AFDC need standard
2. __ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.
4. __ The following percentage of the following standard that is not greater than the standards above:_____% of_____ standard.
5. __ The amount is determined using the following formula:
6. __ Other
7. __ Not applicable (N/A)

(b) Medical and remedial care expenses specified in 42 CFR 435.735.

Spousal Post Eligibility

3. X State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act. There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a.) Allowances for the needs of the:
1. Individual (check one)
(A). __ The following standard included under the State plan (check one):
1. __ SSI
2. __ Medically Needy
3. __ The special income level for the institutionalized
4. __ Percent of the Federal Poverty Level: ____
5. __ Other (specify):_____

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(B). __ The following dollar amount: $_____
Note: If this amount changes, this item will be revised.

(C). _X_ The following formula is used to determine the needs allowance:
(1) For waiver clients receiving Assisted Living Services: The State protects the SSI standard.
(2) For clients receiving waiver services in other eligible living arrangements: The State protects the medically needy income standard.

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____
_____
_____

II. Rates and Payments

A. The State assures that the capitated rates will be equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State will ensure that rates are less than the cost in fee-for-service.

1. ___ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date)(please describe)
3. ___ Adjusted Community Rate (please describe)
4. _X_ Other (please describe) Rates are set at a percent of Upper Payment Limits.

The State contracts with an actuarial company to develop PACE Upper Payment Limits (UPLs). The UPLs are developed based on historical Nebraska Medicaid fee-for-service (FFS) costs for individuals aged 55 and over who were either nursing home residents or eligible for HCBS waiver services based on meeting nursing facility level of care criteria. Projection factors are applied to the UPLs to reflect utilization changes, historical and prospective Medicaid program changes, and provider rate changes. The UPLs are then summarized into rate cells by eligibility category and defined geographic area. The State ensures that rates paid to PACE provider organizations are less than the cost in FFS by negotiating a rate for each rate cell set at 95% of the UPL for that cell.

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State/Territory: Nebraska

B. The State Medicaid Agency assures that the rates were set in a reasonable and predictable manner. Please list the name, organizational affiliation of any actuary used, and attestation/description for the initial capitation rates.

The State contracted with Milliman, Inc., to develop its initial UPLs for calendar year 2012. The initial UPLs were developed by Shelly S. Brandel, FSA, MAAA, Actuary, and David F. Ogden, FSA, MAAA, Principal and Consulting Actuary. The UPLs are an estimate of what costs would have been to Nebraska Medicaid for PACE participants if they had not enrolled in PACE. Within each eligibility category (dually Medicaid and Medicare eligible, Medicaid only, and dually Medicaid and Medicare (Part B only) eligible), Milliman developed separate UPLs for nursing home residents and HCBS waiver participants who meet nursing facility level of care criteria (aka PACE eligibles) by geographic area. Milliman then weighted these UPLS by the estimated distribution of individuals in each service category (based on the distribution of 2009 eligible months) to calculate the overall UPLs. The distribution of individuals for Part B only eligibles was assumed to be the same as for dual eligibles.

Data Reliance and Important Caveats

In developing the UPLs, Milliman relied on data and other information provided by the State. Since the source of the data was the State's Medicaid Management Information System (MMIS), the State takes responsibility for the accuracy and validity of the base data. The following data and information was used:

- Medicaid claims and eligibility data for individuals ages 55 and older, including a description of each data field and its potential use in classifying individuals into eligibility groupings of service use and Medicare eligibility;
- Summary of Medicaid fee and program changes in SFY 2008 and later; and
- Quarterly CMS-64 Medicaid Administrative Cost reports for SFY 2010.

Base Data and Adjustments

The State provided claims and eligibility data for Medicaid individuals ages 55 and over for the period January 1, 2007, through the most recent date available at the time, August, 2010.

1. Excluded Data

Milliman excluded the following data:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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- Managed care enrollees;
- Partial Medicare eligibility: Claims and eligibility data for individuals with partial Medicare eligibility (Part A or Part B only) were excluded. (Note: Milliman developed UPLs for Part B only eligibles based on the projected results for Medicaid only and dual eligibles due to a small number of individuals in the data with Part B only eligibility.)
- Individuals with claims but no eligibility; and
- Claims and eligibility for individuals for whom the county of residence was outside the State of Nebraska.

2. UPL Categories

Milliman separated the data into eligibility groupings or "cells" as follows:

- Dual eligible versus Medicaid only;
- Nursing home residents versus HCBS waiver participants; and
- Urban versus rural geographic areas.

Regarding Medicare eligibility, individuals with full Medicare coverage (Part A and B) or no Medicare coverage were included in the analysis. As noted above, individuals with partial Medicare coverage (Part A or Part B only) were excluded from the analysis (Part B only UPL projections are based on the UPL results for Medicaid only and dual eligibles due to the small number of Part B only individuals in the data.)

Nursing home residents were flagged as such for each month within each individual's total eligibility segment(s) if the total nursing home payments for the month were greater than $0.00. If an individual was identified as both a nursing home resident and a HCBS waiver participant for a given month, the individual was classified by Milliman as a nursing home resident for purposes of their analysis.

Milliman classified data as "rural" or "urban" based on the county of residence in the eligibility file as follows:

Urban: Douglas, Lancaster, Gage, Otoe, Saline, Sarpy, Saunders, Seward, and Washington counties (counties surrounding Omaha and Lincoln, Nebraska); and

Rural: Remaining counties in Nebraska.

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3. Data Adjustments

The following were taken into consideration regarding the claims and eligibility data, and adjustments were made as appropriate:

- Disproportionate Share Hospital (DSH) payments;
- Critical Access Hospitals;
- Graduate Medical Education (GME);
- Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) payments;
- Third Party Liability (TPL);
- Copayments;
- Organ Transplants;
- Prescription Drug Rebates;
- Historical Program Changes: The base experience data was adjusted to reflect historical Medicaid program changes that became effective during the experience period. The program changes include:
    - CHIP eligibility to 100% of the Federal Poverty Limit (9/1/2009
    - Hospital Inpatient DRG Reimbursement Structure (10/1/2009); and
    - Radiology Management (11/1/2009); and
- Claims Completion Factors.

PACE UPL Development

Milliman used 2009 experience as a base to project a UPL for CY 2012. They applied the following projection factors to project 2009 experience for each rate category to CY 2012:

- Trend factors;
- Prospective Nebraska Medicaid program changes;
- Prospective provider rate changes; and
- PACE administrative costs.

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1. Trend Factors

Milliman developed the trend factors by reviewing the following information:

- Historical trends from 2007 to 2009 for the PACE eligibles in the data;
- Information about changes in the Nebraska Medicaid program (historical and projected) to better understand provider fee and program changes during the experience period to interpret non-fee based trends; and
- Knowledge about Medicaid trends in other states and Medicare trends for representative service categories.

2. Prospective Medicaid Program Changes

Milliman adjusted the PACE UPLs to reflect the impact of Nebraska Medicaid program changes taking place between the experience period (CY 2009) and the projection period (CY 2012). They relied on Mercer's Data Book dated December 1, 2009, to estimate the appropriate adjustment for each program change which includes:

- Facility/Non-Facility pricing; and
- Outpatient Hospital Cost Ratio decrease.

3. Prospective Provider Rate Changes

The PACE UPL projections reflect the following anticipated future changes to Nebraska Medicaid provider payment rates:

- A 0.5% rate increase for all services effective for SFY 2011 beginning on July 1, 2010).
- A 5% rate decrease for all services except primary care for SFY 2012 and SFY 2013.

Note the following regarding future Medicaid provider rate changes:

- Milliman assumed that Medicaid provider rate changes would have no impact on pharmacy costs. Therefore, the provider rate change factor for pharmacy services was 1.000.

- Although the FFS data did not indicate primary care versus specialty care services, Milliman expected the level of primary care services in the PACE population to be very small given the amount of chronic care services. Therefore they did not make an adjustment to the SFY 2012 and SFY 2013 Medicare rate decreases to exclude primary care services.
- For dual eligibles, the impact of Medicaid provider rate changes is difficult to predict since a significant amount of costs for many services are paid by Medicare. Milliman assumed the Medicaid provider rate change increases would be dampened by a factor of ½ for dual eligibles for the following services: inpatient hospital; outpatient hospital; physician; other practitioner; radiology and laboratory; clinic; DME/supplies; and transportation.

4. PACE Administrative Costs

Milliman added a 3.9% allowance (as a percentage of projected 2012 claims) for PACE administrative services based on the CMS-64 data the State provided for SFY 2010. The CMS 64 reports reflect the State's current Medicaid administrative costs as a percentage of claim payments. School-based administrative costs were excluded from the calculation.

There were very few individuals in the FFS with Part B only Medicare eligibility, therefore the historical data was not credible for purposes of UPL development. Milliman calculated the Part B only UPLs by setting the projected 2012 UPL for each service category equal to either the dual eligible UPL or the Medicaid only UPL. They linked the following service categories to the dual eligible UPL (meaning they expected that Medicare coverage would decrease the expected costs PEPM for Part B eligibles): outpatient hospital; physician; other practitioner; radiology and laboratory; clinic; pharmacy; DME/supplies; and transportation. All other service categories were linked to the Medicaid only UPL.

C. The State will submit all capitated rates to the CMS Regional Office for prior approval.

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State/Territory: Nebraska

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and will implement procedures for the enrollment and disenrollment of participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment was based and the actual number of participants in that month.

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AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

25. Home and Community Care for Functionally Disabled Elderly Individuals. as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

☒ Provided ☐ Not Provided

26. Personal assistance services are those services provided to a Medicaid client who is not an inpatient or resident of a hospital, nursing facility, intermediate cafe facility for the mentally retarded, institution for mental disease, or prison, which are authorized on a written service plan according to individual needs identified in a written assessment.

Personal assistance services are A) authorized by a Social Services Worker or designee, B) provided by qualified providers who are not legally responsible relatives, and C) are furnished inside the home, and outside the home with limitations

☒ Provided

☐ Not Provided

☒ State Approved (Not Physician) Service Plan Allowed
☒ Services Outside the Home Also Allowed*
☒ Limitations Described on Attachment

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 4 to Attachment 3.1-A.

X Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

— No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No Limitations ☒ With Limitations ☐ None licensed or approved
☐ Not Applicable (there are no licensed or State approved Freestanding Birth Centers

Please describe any limitations:
Facilities must:
(a) Be specifically approved by Department of Health and Human Services, Division of Public Health to provide birthing Center Services, and
(b) Maintain standards of care required by Department of Health and Human Services, Division of Public Health for licensure.

* Exception described on attachment

State/Territory: Nebraska

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): All groups

28. (ii) Licensed or Otherwise Sate-Recognized covered professionals providing services in the Freestanding Birth Centers

Provided: ☐ No Limitations ☒ With Limitations (please describe below)

Please check all that apply:

☒ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the Sate plan (i.e., physicians and certified nurse midwives.

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife).*

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*