

Requirements Concerning the Specification of the Scope of Servicesⁱ

As provided in 42 CFR 441.301(b)(4), a state is required to: “describe the services to be furnished so that each service is separately defined.” The definition of each waiver service must describe in concrete terms the goods and services that will be provided to waiver participants, including any conditions that apply to the provision of the service. The definition of the service (including any conditions that apply to its provision) is termed the “scope” of the service. When specifying the scope of a service do not use terms such as "including but not limited to . . .," "for example . . .," "including . . .," "etc.” CMS will not approve vague, open-ended or overly broad service definitions. The scope of a service must be readily ascertainable from the state’s service definition – that is, the nature of what is provided to a waiver participant is expressed in understandable terms. It is important to keep in mind that FFP is only available for the performance of activities or the provision of goods that fall within the scope of the approved waiver service.

The scope of a service may be defined in one of two ways. An exhaustive service definition may be employed. An exhaustive definition specifies in detail the types of activities that are undertaken on behalf of a waiver participant or the goods that may be provided to a participant. For example, if a waiver includes the coverage of medical equipment, the service definition could include a detailed list of each item of medical equipment that may be provided. Items not included in the list will not be provided or reimbursed. If a state wishes to alter an exhaustive service definition, it must submit an amendment request to CMS.

In the alternative, a service may be defined as to its purpose. For example, a state may elect to cover "only those medical supplies needed for the respirator-related needs of a respirator-dependent patient" without listing the specific supplies that might be furnished. When a service is defined as to its purpose, it is not necessary to submit a waiver amendment to reflect changes in the exact nature of the service that might occur post-approval. At the same time, when a service is defined as to its purpose, the service definition may not be expressed in open-ended terms. In addition, when a service is defined as to purpose, the service definition should specify at least the component elements of the service. Many of the core service definitions included as an attachment to the instructions for this Appendix are examples of how services may be defined as to their purpose.

As previously noted, states have the option of using the suggested core service definitions that are included in the attachment, modifying those definitions to meet their needs or developing their own service definitions. If a new service is proposed, its definition must use commonly accepted terms and may not be open ended in scope. When new services are proposed, CMS reviews the proposed service to ascertain whether the service:

- Contributes to the community functioning of waiver participants and thereby avoids institutionalization;
- Is reasonably related to addressing waiver participant needs that arise as a result of their functional limitations and/or conditions; and/or,
- Falls within the scope of §1915(c) of the Act and is not at odds with other provisions of the Act.

Services that are diversional/recreational in nature fall outside the scope of §1915(c) of the Act. In addition, with some exceptions, waiver funds may not be employed to pay for room and board expenses or to acquire goods and services that a household that does not include a person with a

disability would be expected to pay for as household expenses (e.g., subscription to a cable television service).

The scope of the individual services included in a waiver may overlap. For example, the provision of personal assistance often is a common element in the delivery of many waiver services. It would be unreasonable and inefficient for CMS to require that services be defined in a fashion to eliminate overlapping activities by requiring that all forms of personal assistance be furnished under a single personal assistance service. At the same time, there must be mechanisms to prevent duplicate billing of services. When, for instance, a state provides for the “free-standing” coverage of personal assistance but includes the provision of personal assistance as an integral element of the delivery of a residential or day service, the state must prohibit the billing of the free-standing coverage for personal assistance activities that are performed during periods when the waiver participant receives the residential or day service that already includes the provision of personal assistance and payment for personal assistance activities have been included in the payment for the residential or day service.

In a similar vein, the situation may arise when a waiver participant may be concurrently receiving two services that are nominally duplicative or overlapping. For example, when a participant is directing waiver services, the participant may be concurrently receiving both case management and information and assistance in support of participant direction (a.k.a., support brokerage). The performance of both services may entail performing similar functions (e.g., assisting the participant to locate service providers). CMS does not require that service definitions be fashioned to eliminate all potential overlap (e.g., by only permitting support brokers or case managers to provide assistance in locating providers but not both). However, service definitions should be structured so that they prevent the duplicative performance of and billing for the same activity undertaken on behalf of a waiver participant by multiple providers. For example, it is permissible for a case manager to bill for the time that the case manager spends in developing a service plan and for a support broker to bill for the time spent advising the participant during the service plan development process. It would not be permissible for both the case manager and the support broker to bill for the preparation of the service plan. When there is the potential for duplicative billing for the performance of overlapping functions, states are advised to specify clearly in the relevant service definitions how the underlying activities are distinct and/or how duplicative billing will be prevented.

42 CFR §441.301(b)(4) also provides that “multiple services that are generally considered to be separate services may not be consolidated under a single definition.” The chief reasons why services may not be “bundled” are to: (a) ensure that waiver participants can exercise free choice of provider for each service and (b) ensure that participants have access to the full range of waiver services. Bundling means the combining of disparate services with distinct purposes (e.g., personal care and environmental modifications) under a single definition and providing that the combined services will be furnished by a single provider entity (e.g., one provider would furnish both personal care and environmental modifications) that is paid one rate for the provision of the combined services. CMS will consider a combined or bundled service definition only when it is established that the bundling of services will result in more efficient delivery of services but not compromise an individual's access to services or free choice of providers. When a bundled service definition is proposed, the costs of each component service must be separately identified in the estimate of Factor D in Appendix J-2 and utilization/costs must be tracked during the period that the waiver is in effect (i.e., encounter-type data must be compiled).

A service usually is not deemed to be a “bundled” service in the following circumstances:

- When the tasks/activities that are conducted on behalf of a participant are closely related or require similar provider skills (e.g., the provision of homemaker, chore and personal care services by an “in-home supports” service worker);
- The state groups related services under a single broad service title (e.g., “employment-related services”) but clearly provides that: (a) each component service (e.g., prevocational, supported employment and supports for self-employment) is separately authorized in the service plan; (b) the participant may exercise free choice of providers for each component service; and, (c) each component service is separately billed. When services are grouped under a broad service title, the costs and expected utilization of each component service must be separately identified in the estimate of Factor D in Appendix J-2 and utilization/costs of each component service must be tracked during the period that the waiver is in effect; and,
- The service normally involves the co-provision of several services through a single provider in order to achieve the purpose of the service. Residential services typically fall into this category because of their round-the-clock nature.

ⁱ Centers for Medicare & Medicaid Services. (2008) *Application for a §1915(c) Home and Community-Based Waiver [Version 3.5]: Instructions, Technical Guide and Review Criteria*