The Committee would like a written explanation of the procedure difference between a Medicaid Waiver and a State Plan Amendment as far as Mandates? Obligations of the state? Match requirements? Terms and Conditions? FMAP? Administrative Costs?

1915(c) HCBS Waiver	CFC State Plan Amendment {1915(k)}
Institutional Level of Care Requirement	Institutional Level of Care Requirement
Medicaid Financial Eligibility Criteria	Medicaid Financial Eligibility Criteria
Allows state to offer waiver services that are not provided to other Medicaid beneficiaries	Services must be available to all eligible Medicaid beneficiaries
Permits the state to limit to specific geographic areas of the state	Must be provided statewide
Allowed to cap the number served	No cap on the number served
Allows state to apply institutional income and resources	Available to individuals eligible for medical assistance under the Arkansas State Plan and are in an eligibility group that includes nursing facility services or are below 150% of federal poverty level if they are not in an eligibility group that includes nursing facility services.
Annual beneficiary functional reassessment requirement	Annual beneficiary functional reassessment requirement
Requires a person-centered service plan based on assessment	Requires a person-centered service plan based on assessment
Allows beneficiary to self-direct services	Allows beneficiary to self-direct services
Requires Quality Assurance plan	Requires Quality Assurance plan
HCBS Settings rule compliance requirement	HCBS Settings rule compliance requirement
Must be submitted to CMS for renewal every 5-years	No expiration date
Regular State FMAP	Regular State FMAP plus a 6% enhanced match
Match rate for Administrative costs 50/50	Match rate for Administrative costs 50/50

The Committee would like to get a copy of the Waiver Request that DHS sent to CMS on CFCO.

Attached – CFCO SPA submitted to CMS

The new 1915(c) HCBS Waivers have not been submitted to CMS.