

Waiver Application Submission Requirements, Processes and Procedures

Overview

This section addresses the following topics:

- Use of the Version 3.6 HCBS Waiver Application;
- Policies concerning the submission of new and renewal waiver applications;
- Policies concerning the submission and CMS review of waiver amendments; and,
- Related topics

Submission of Applications

A state must submit a new or renewal waiver application using the Version 3.6 application by employing the web-based application.

Making a Submission Using the Web-Based Application

There are several benefits in employing the web-based application to prepare and submit new and renewal applications. These benefits include:

- The web-based application automatically links interrelated parts of the application. Where appropriate, information that is entered in one part of the application is automatically entered in other parts of the application that use the same information. For example, the information about waiver services that is entered in Appendix C is used to populate the Factor D tables in Appendix J. This feature ensures internal consistency within the application. In addition, the web-based application turns off parts of the application that do not apply to a request.
- The web-based application employs validation checks to ensure that selections made in one part of the application are consistent with selections made in other parts. For example, the selection of Medicaid eligibility groups in Appendix B-4 is tightly linked to the selections concerning post-eligibility treatment of income in Appendix B-5. These validation checks ensure that the application has been completed appropriately and expedite CMS review. In addition, the web-based application prevents the submission of incomplete applications.
- The web-based application also supports internal CMS processing of applications. Both the CO and ROs are notified electronically when an application is submitted and there is tracking of where the application stands in the review/approval process. This enables more efficient and timely review of applications.
- Once an application that has been submitted via the web is approved, it will be easier for states to submit amendments by making changes to the application on the web. Moreover, both CMS and states will have continuous access to the most up-to-date version of the approved waiver.

Use of the web-based application facilitates both state preparation and CMS review of applications. Separate technical instructions have been issued for using the web-based application.

When the web-based application is used, a new waiver, renewal or amendment is considered submitted when the State Medicaid Director (or designee) submits the application using the submission feature, which is reserved for use only by the Medicaid Director. Submission of the application by the State Medicaid Director is equivalent to signature of the application by the State Medicaid Director. When the application is submitted via the web, the date on which the State Medicaid Director submits the application is considered to be the official submission date for the purpose of starting the 90-day “clock” for CMS review and disposition of the request (see below for further discussion of the 90-day clock). The application is not submitted separately in printed hard copy form when the web-based application is used.

Making Changes to a Submitted Application

Once a waiver application or amendment has been submitted, it may be necessary to make changes. For example, CMS review of a waiver application or amendment may result in CMS suggesting that the state modify the application or amendment. If the state concurs, the state must make the change to the application or amendment and resubmit the affected portions of the application to CMS. ***Under no circumstances can CMS personnel modify a waiver application or amendment request.***

Once an application is submitted via the web, the application is “locked” and cannot be modified unless unlocked by CMS. Locking the application preserves the integrity of the original submission. If it is necessary to modify the application, CMS will unlock the application so that the state may make changes. Once the state has made the changes and resubmitted the application to CMS, the application will be locked again.

Joint Central Office/Regional Office Waiver Review Process

All waiver applications, renewals, and specific amendments are reviewed jointly by CMCS/DEHPG/DLTSS and the appropriate RO. The CO waiver analyst and RO staff work together to review the application to ensure that it is complete and to assess the waiver’s design by applying the CMS review criteria. As necessary, other CMS personnel participate in the review process. The joint CO/RO waiver review process is designed to identify and resolve as expeditiously as possible problems or issues that may surface. CMS strives to ensure that relevant federal policies are applied consistently across all types of waiver requests and CMS regions. CMS also seeks to work collaboratively with states to resolve issues. In addition, as part of the waiver application redesign, CMS has developed “*Instrument for Reviewing State 1915 (c) HCBS Waiver Applications*” has been developed to assist CMS CO/RO waiver analysts in their review of waiver applications and to build consistency into the application review process. This tool is available on the CMS website.

Requesting Division Review

From time to time, issues may arise where the state believes that the resolution of an issue proposed by the RO/CO review team is problematic. When this situation arises, the state may request that the issue be referred to the DLTSS Director at CMCS/DEHPG for further review. The state should

delineate why it regards the proposed resolution to be problematic and the state's preferred resolution of the issue. The DLTSS Director will examine the issue and, as necessary, consult with the state and the RO/CO review team to resolve the issue. The Director will transmit the proposed disposition of the issue to the state and the RO/CO review team.

Policies Concerning New and Renewal Waiver Applications

This section provides information about the policies that apply to the submission of and CMS action on new and renewal waiver applications.

90-Day Clock

In accordance with 42 CFR §430.25(f)(3), CMS has no more than 90 calendar days within which to approve or deny an initial waiver application, a waiver renewal or an amendment request or alternatively issue a written request for additional information (RAI). The 90-day period within which CMS must act on a waiver request is known as the "90-day clock." The 90-day clock starts on the day that CMS receives the request. It is extremely important to keep the 90-day clock in mind when preparing new or renewal waiver applications or amendment requests. In particular:

- **In the case of an initial or new waiver application, the application must be submitted at least 90 calendar days in advance of the proposed waiver effective date.** If a request to launch a new waiver is received fewer than 90-days in advance of the proposed effective date, CMS may not be able to complete its review in time to permit the waiver to be implemented when desired by the state. States should consider submitting new waiver applications six-months in advance of the proposed effective date. Submitting a new application well in advance of the proposed effective date increases the likelihood that the waiver can be approved on or before the desired effective date, and takes into account the possibility of an RAI. It is important to keep in mind that a new waiver may only be approved with a prospective effective date. New waivers may not take effect retroactively.
- **In the case of a waiver renewal application, the application also must be submitted at least 90 calendar days in advance of the approved waiver's expiration date.** If a waiver renewal request is received fewer than 90-days in advance of the expiration date, CMS may not be able to complete its review by the waiver's expiration date. As with new waiver requests, the state should consider submitting a renewal application six months in advance of the waiver's expiration date so that there is time to resolve any questions that might arise during the CMS review of the renewal request.

As a general matter, CMS attempts to resolve problems with a waiver application through informal dialogue with the state. Informal requests for additional information (which might be made by telephone or e-mail) do not stop the 90-day clock. CMS attempts to identify any serious problems in an application within 45-days of its receipt.

If significant problems are identified in the waiver application, the state may take the application "off-the-clock" by notifying CMS that its submission is incomplete. Once the state has addressed the problems, it may resubmit the application, whereupon a new 90-day clock will start. The state also has the option to formally withdraw a request. This option should be considered when the state determines that it is no longer interested in pursuing the request as submitted.

In the case of either a new waiver application or a renewal request, CMS may issue a formal, written “Request for Additional Information” (RAI) in the event that CMS identifies issues or problems in the application that are sufficiently serious that CMS may have to disapprove the application unless the problems are resolved satisfactorily.

Only a single RAI will be issued during the waiver review period. When an RAI is issued, the 90-day clock is stopped. The clock remains stopped until the state submits its response to the RAI. Once the response is received, a new 90-day clock starts. In the case of a new waiver application, the issuance of an RAI may make it difficult to complete the review of the application by the state’s desired effective date, depending on how far in advance of the proposed effective date the application was submitted and how quickly and satisfactorily the state responds to the RAI. In the case of a renewal application, the issuance of an RAI may pose significant difficulties for completing the review of the renewal application in advance of the expiration date, especially if the application was submitted only 90-days in advance of the expiration date.

The state may wish to stop the clock by notifying CMS that its submission is incomplete if CMS determines that the state’s response to an RAI does not satisfactorily resolve the problems in the application. Stopping the clock on an application avoids CMS having to disapprove the application. CMS does not have the authority to suspend its consideration of a waiver request absent a state request to stop the clock.

CMS makes every effort to complete its review of a waiver application on a timely basis and avoid stopping the clock so that new waivers can be implemented when planned by the state and renewals are approved in advance of the waiver’s expiration date. Meeting this objective is aided when the state responds promptly to CMS requests to clarify the application. When CMS approves a new waiver, waiver renewal or amendment, it will formally notify the state in writing.

New Waiver Applications

When a state wants to launch a new waiver, it submits an initial waiver application. Under the Act, CMS may approve a new waiver program for a period of three-years or, if the waiver serves individuals who are dually eligible for Medicare and Medicaid, five years at the state’s option. The new waiver year period starts on the effective date of the waiver. **A new waiver may not go into effect until the effective date proposed by the state or the date that CMS approves the waiver, whichever is later.** Again, the state must propose a prospective effective date. A new waiver is never approved retroactively. As noted above, an application for a new waiver must provide for an effective date at least 90-days after the date of submission. If CMS does not approve the waiver request until after the effective date proposed by the state, CMS will ask the state whether it wishes the effective date to be the date that CMS approved the waiver or another date (e.g., the first of the following month to facilitate waiver reporting).

When a new waiver is approved but the state experiences a delay in implementing the waiver on the approved effective date, the state may submit an amendment to move forward the initial effective date (as long as no waiver services have been provided or claimed), in order to start the three or five year waiver period on the date that the state actually implements the waiver.

Special Considerations: §1915(c) Waivers that Operate with Concurrent Managed Care

A state may apply for a §1915(c) waiver to operate with a concurrent Medicaid managed care authority. Concurrent waivers can be used by a state to combine the delivery of HCBS waiver services with the provision of other state plan services through a managed-care service delivery system. The managed care authority permits a state to waive provisions of the Act beyond the waivers that may be requested under the §1915(c) waiver authority. For example, a state may request a waiver of §1902(a)(23) of the Act, the free choice of providers requirement, under authority of §1915(b)(4) in order to selectively contract with entities that furnish waiver and specified state plan services through a managed care arrangement.

In order to operate managed care/§1915(c) concurrent waivers, a state must complete and submit separate managed care and §1915(c) waiver applications (or amendments). Each application has different requirements because each waiver authority is governed by distinct provisions of the Act and is subject to different federal regulations. Where appropriate, the Version 3.6 HCBS Waiver Application takes into account the limited number of areas where requirements and features of Medicaid managed care authorities and §1915(c) waivers intersect.

When a state applies to operate managed care/§1915(c) concurrent waivers, CMS must review each application or amendment to ensure that it meets the relevant statutory and regulatory requirements that attach to the waiver authority under which they will operate. Both applications are subject to a 90-day clock. CMS internally coordinates the review of both applications.

Since the approval of managed care/§1915(c) concurrent waivers hinge on the approval of both applications, CMS may not approve the §1915(c) application until the managed care authority has been determined to be approvable and/or vice versa. Because significant problems might surface in the review of either application, it is especially important that a state submit a request to operate managed care/§1915(c) concurrent waivers at least six months in advance of the proposed waiver effective date. The two applications may need to be submitted simultaneously so that they can move forward under the same 90-day clock and be effective on the same date.

Special Considerations: §1915(a) Authority Concurrently with a 1915(c) Waiver

A state may operate a §1915(c) waiver in conjunction with §1915(a) authority, which permits a state to waive statewideness, comparability, or free choice of provider under certain circumstances. Typically, states have used §1915(a) authority to provide for voluntary managed care for all or some HCBS waiver participants. As the effect on a HCBS waiver varies with the authority sought under §1915(a), and since combination §1915(a)/(c) waivers are not common, these instructions do not discuss options available under §1915(a) throughout. See the Appendix I instructions for a discussion of the §1915(a) authority regarding managed care contracts. Contact CMS to discuss a HCBS application that will include §1915(a) authority.

New Waiver to Replace an Approved Waiver

There are circumstances when a state may or must submit a new waiver application to replace an approved waiver:

- **State Election.** A state may decide to submit a new waiver rather than renew an approved waiver because the state wants to redesign the waiver. The submission of a replacement waiver may be advantageous when the revisions that the state wants to make are substantial

and affect many elements of the waiver. When a state decides to replace an existing waiver, the proposed effective date of the new waiver must coincide with the expiration or termination date of the approved waiver (e.g., if the approved waiver expires on June 30, the new waiver should be made effective on July 1 to ensure continuity of participant services). The submission of a new application to replace an existing waiver does not affect the expiration date of the approved waiver. Also, in this circumstance, a state is required to prepare a transition plan to describe how the transition between the existing and the new waiver will be accomplished (see the detailed instructions for the Application (Module 1) for a discussion of what to include in the transition plan).

- **CMS Requires the Submission of a New Application.** When CMS determines that there are serious problems in the operation of an approved waiver, CMS may require that the state replace the approved waiver with a new waiver. This circumstance may arise when the CMS review of waiver operations reveals substantial problems in assuring waiver participant health and welfare or when other serious operational deficiencies are identified. In the application for the replacement waiver, the state is expected to propose a waiver redesign that effectively addresses the shortcomings that CMS has identified. In addition, CMS may require the state to periodically report its progress in implementing corrective actions to correct waiver operational deficiencies.

Except in the foregoing circumstances, CMS will not generally require that a state submit a new waiver to replace an approved waiver even when significant changes are proposed to the approved waiver either via waiver amendment or in a renewal application. However, if major changes are proposed that might adversely affect current participants (e.g., by altering a waiver's target population or eliminating services that are provided in the approved waiver), CMS may require the state to provide additional justification and/or submit a transition plan that describes the steps that the state will take to address the impact of the changes on current waiver participants. Again, see the instructions for the Application (Module 1) for a more detailed discussion of transition plans.

Renewal Applications

Waivers that have not been formally renewed by the end of the waiver period automatically expire. The Act does not provide for the automatic extension of an approved waiver. In order to ensure the continuous operation of a waiver, a waiver renewal application should be submitted to CMS at least 90 but preferably 180 calendar days prior to the end of the waiver period.

There are two conditions that must be met in order for CMS to consider a waiver renewal application. These are:

- The state must have submitted, and CMS accepted the required HCBS annual waiver financial and statistical reports (the CMS-372(S) through the end of the next-to-last waiver year. The annual waiver report(s) must demonstrate that the waiver has been cost-neutral and must also provide information on the quality of services. Cost neutrality and assuring health and welfare are fundamental statutory and regulatory requirements. Failure to prepare and submit acceptable and timely annual waiver reports can jeopardize continuation of the waiver and/or delay the renewal of the waiver.
- In order to consider a renewal application, CMS must determine that the waiver has been operated in accordance with the approved waiver, all applicable federal requirements, and

the waiver assurances. About one year prior to the waiver expiration date, the RO will issue a report to the state summarizing its findings and conclusions concerning the operation of the waiver. The report may include recommendations concerning the operation of the waiver. If the RO identifies serious problems in the operation of the approved waiver, the state must propose remedial steps that are satisfactory to CMS to correct the problems. CMS must be confident that the measures that the state has undertaken or plans to implement will effectively address the problems before CMS can approve the waiver renewal request. It is important to note that CMS is revamping its waiver oversight methods to provide for annual reporting by states concerning performance in meeting the waiver assurances and expects that there will be increased dialogue between the state and the RO throughout the waiver period about performance. The RO report on state waiver operations in advance of renewal will rely principally on evidence submitted by the state, the annual waiver report that the state submits each year to CMS, and the information obtained through the on-going dialogue between CMS and the state.

If within 90 days of receipt of the renewal request, CMS is unable to conclude that the waiver application satisfactorily addresses each assurance, including problems that may have surfaced during the RO review of the approved waiver and/or that the waiver is not cost neutral, CMS may either formally request additional information or disapprove the renewal request.

Other Changes to Approved Waivers

There are other types of changes to approved waivers that merit additional discussion. In particular:

- **Splitting a Waiver.** A state may decide that it would be appropriate to divide an approved waiver into two waivers. For example, when a single waiver serves both older persons and individuals with disabilities under the age of 65, the state may determine that dividing the waiver into two waivers may better meet the needs of each target group. When the state proposes to make this change at the time of waiver renewal, the waiver requests will be treated as renewals rather than as new waiver applications. That is, each waiver can be made effective for another five-year period. When the split is accompanied by significant changes in the services that will be provided to one or both of the target groups or other changes that might substantially affect waiver operations, the state may be required to submit a transition plan and/or additional information.

When the state wants to create two distinct waiver programs to serve the approved waiver's target population (for example, by dividing a waiver for persons with developmental disabilities into separate waivers based on participant living arrangement), the state should revise the approved waiver to encompass one of the desired configurations and submit a new waiver application to implement the other configuration.

Splitting an approved waiver prior to its expiration date cannot be accomplished by the submission of a waiver amendment. Instead, a state should discuss with CMS the intended target populations to determine whether two new waivers will be required, or whether an amendment to the existing waiver and one new waiver will be sufficient.

- **Combining Waivers.** Alternatively, a state may determine that it would be more efficient to combine two approved waivers that serve the same or very similar target populations. If both

waivers expire on the same date, the combination of the two programs may be accomplished by submitting a renewal application for the waiver that would continue and allowing the other program to expire. The state should alert CMS when it plans to follow this course. In addition, when the two waivers cover different services, CMS may require the state to prepare and submit a transition plan if the effect of combining the waivers would be to reduce the services provided in one or both waivers.

If the waivers have different expiration dates, the state should notify CMS that it intends to combine the two programs and seek instructions.

- **Converting a Model Waiver to a Regular Waiver.** A waiver that has been approved as a “model waiver” may be converted to a regular waiver when the state decides to serve more than 200 individuals at any point in time. The conversion of a model waiver to a regular waiver is not considered a request for a new waiver. The conversion may be accomplished at the time of waiver renewal or by the submission of a waiver amendment.
- **Participant Limit Reductions.** When the state submits a request to replace an existing waiver, renew an approved waiver or amend an approved waiver that would reduce the number of unduplicated individuals who may be served in the waiver, it must inform CMS whether the reduced participant cap would have an adverse impact on current waiver participants, as provided in CMS Olmstead Letter #4 (included in Attachment D). When a request reduces the participant limit, the state may:
 - Provide an assurance that, if the waiver request is approved, there will be sufficient service capacity to serve at least the number of current participants enrolled in the waiver as of the effective date of the new waiver, renewal or amendment. That is, the lower participant limit has the effect of eliminating unassigned “slots.”
 - Assure CMS that no current waiver participants will be removed from the program or institutionalized inappropriately due to the lower participant limit. For example, the State may achieve a reduction through attrition rather than terminating current waiver participants.
 - Provide an assurance and methodology demonstrating how individuals currently served by the waiver will not be adversely affected by the lower participant limit. For example, if the waiver is no longer required because the principal service(s) provided through the waiver have been added to the state plan, the state may specify a method to transition waiver participants to the state plan service. Individuals subject to removal from a waiver are entitled to the opportunity to request a Fair Hearing under Medicaid law.
 - Provide a plan whereby affected individuals will transition to other HCBS waivers without loss of Medicaid eligibility or loss of services. Any loss of services would be subject to notice of Medicaid fair hearing rights.
 - Provide for other means to assure the health and welfare of affected individuals, including arranging for services that may be available under the state plan or through other programs.

Extensions

Regulation Authority: 42 CFR 441.304(a)(2)(c)

CMS will consider requests for temporary 90-day waiver extensions only in very limited circumstances. A temporary extension permits the state to continue to operate an approved waiver beyond its original expiration date. Extensions are not granted solely for administrative convenience (e.g., to give the state extra time to prepare a waiver renewal request). Extensions may be granted for various reasons:

- The state wants to align the period of the waiver to a state fiscal year;
- The state intends to combine the waiver with another waiver that is under review but has not been approved by CMS;
- The state plans to terminate a waiver and requires additional time to phase out the waiver in an orderly fashion;
- CMS has identified through its review of the waiver renewal application that there are substantial problems in the waiver's design that cannot be rectified by the state prior to the expiration of the waiver; or,
- The state requires additional time to satisfactorily resolve quality or financial issues identified by CMS during RO waiver review.

A state must formally submit a request for an extension in writing to CMS in advance of the approved waiver's expiration date. Extension requests are reviewed by CMCS/DEHPG, which makes the determination whether to approve the request. Extensions are considered on a case-by-case basis. When a request for extension arises out of the need to address significant waiver design problems identified by CMS during its review of the waiver renewal application or rectify quality or financial issues previously identified by the RO, CMS will not approve the temporary extension request unless and until the state submits a satisfactory action plan with specific milestones to resolve the problems. CMS also will require the state to report its progress in implementing the action plan during the extension period. Temporary extensions are only granted for a period of up to 90-days.

All or part of the temporary extension approved by CMS may be subsumed into the period of the waiver renewal. For example, if the waiver was due to expire June 30 but a 90-day temporary extension was approved through September 30, the state may request that the renewal be effective on July 1 or October 1. Please note that a state may not amend a waiver that is on a temporary extension and the state is required to implement the waiver as last approved.

Policies Concerning Waiver Amendments

Amendments to an approved waiver may be submitted at any time. As is the case with new or renewal waiver applications, CMS has 90 calendar days within which to approve or disapprove the amendment or formally request additional information in order to address problems that have been identified in the amendment request. When an RAI is issued concerning an amendment, the clock is stopped and only restarted (with a full 90-day clock) once the state responds to the RAI.

Whenever there is a change that affects an element of the approved waiver, the state must submit an amendment to the waiver. The approved waiver must be kept in synchronization with state waiver policies, practices, procedures and operations. For example, if a state wants to alter a limit that it has imposed on the amount, frequency or duration of a waiver service, an amendment must

be submitted. The revised waiver application is designed to minimize to the extent possible the need to submit amendments. For example, the revised application does not require states to submit (and thereby make part of the application) various waiver forms. Hence, states no longer will have to submit a “technical” amendment when, for example, the service plan form is modified.

States also are alerted that CMS no longer provides for the practice of a state’s notifying CMS by letter that it is making budget-driven changes to the waiver participant cap. All changes in the approved waiver must be made via the submission of a waiver amendment. For example, if a state finds it necessary to reduce the waiver participant cap because state appropriations will not support the number of persons specified in the waiver, the state must submit an amendment to reduce the participant cap specified in Appendix B-3 of the application.

A state may propose that an amendment take effect prospectively on some future date. An amendment also may be made retroactive to the first day of a waiver year (or another date after the first day of the waiver year) in which the amendment is submitted unless the amendment includes changes that are substantive. Per 42 CFR 441.304(d)(2), waiver amendments that include changes that are substantive may take effect only on or after the date of CMS approval. Per 42 CFR 441.304(d)(1) Substantive changes include but are not limited to: Revisions to services available under the waiver including elimination or reduction of services or reduction in the scope, amount, and duration of any service; A change in the qualifications of service providers (this includes a reduction of providers); Changes in rate methodology, or a constriction in the eligible population (for example, a reduction in the number of persons served, slots available, or adding reserved capacity without also increasing number of persons served/slots). Some additional examples of substantive changes include consolidating waivers, adding services, changes to settings, and changes in the quality improvement system such as adding or deleting sub-assurances or adding or deleting reporting requirements. Please note that typically, an increase in the unduplicated number of participants is not considered to be a substantive change. A retroactive effective date is permissible in a waiver amendment that only includes changes that are not substantive such as for the purpose of increasing the unduplicated number of participants. The state is required to establish a public input process specifically for HCBS waiver changes that are substantive in nature. Substantive changes must be accompanied by information on how the state has assured smooth transitions and minimal adverse impact on individuals impacted by the change. When an amendment would have the effect of reducing the number of waiver participants, the state also should review CMS guidance in Olmstead Letter #4 (located in Attachment D to the instructions).

As a result of its review of the annual waiver report (CMS-372), CMS may instruct the state to submit a waiver amendment when the CMS review reveals that the state is serving a significantly greater number of persons than provided in the approved waiver, actual waiver expenditures substantially diverge from the amounts in the approved waiver, or the state is providing services not included in the approved waiver. When the annual waiver report reveals that the waiver may not be cost-neutral, CMS may require the state to take remedial actions to correct the problem (see the next part of the instructions).

Related Topics

CMS Technical Assistance

States are encouraged to confer with CMS when preparing preliminary initial and renewal waiver applications or significant amendments in advance of their formal official submission to CMS. Such informal consultation prior to the formal submission may expedite CMS review of the formal submission. States also may request technical assistance concerning waiver operations. Technical assistance should be requested through the Regional Office, which will confer with DEHPG as necessary to address questions or technical aspects of the proposed waiver.

Administrative Claiming

Some activities such as case management, supports broker, and financial management services may be provided as a Medicaid administrative activity rather than as a waiver service. States must ensure that any such administrative costs, necessary for the efficient administration of the Medicaid State Plan, are in accordance with a CMS-approved cost allocation plan. Please note that cost allocation plans are not approved via approval of a 1915(c) HCBS waiver application.

Waiver Termination

There are three potential processes for terminating waivers, depending on the circumstance:

1. A state may elect to terminate the operation of an approved waiver before its expiration date:
 - As provided by 42 CFR Section 441.307, when the state elects to terminate the waiver prior to its expiration date, the state must notify CMS in writing, in the form of a waiver amendment, at least 30-days in advance before terminating services to waiver participants.
 - ✓ Under the ‘purpose of the amendment’, the state should indicate that the waiver is being terminated and should indicate the termination date.
 - ✓ A transition plan should be included in Attachment #1. If phasing into another authority, this transition plan should be accounted for in the accepting authority.
 - ✓ If the state is phasing out the waiver, there should be a phase-out schedule, factor c should be adjusted/and or the phase out of slots should be addressed in the transition plan and estimates in Appendix J updated.
 - ✓ If this is the first action submitted to the waiver between March 17, 2014 and March 17, 2015, the amendment must include an HCB Settings Transition Plan (Attachment #2). In this case, the amendment would trigger the 120-day statewide HCB Settings Transition Plan.
 - As provided in 42 CFR 431.210, the state must notify waiver participants at least 30 days in advance of the change.
2. A state may elect to terminate the operation of an approved waiver and allow it to expire at the end of the approved waiver cycle:
 - The state is required to notify CMS at least 30 days in advance via a letter to the RO when individuals are all transitioned at one time. A waiver amendment for closing the waiver is not required.

- ✓ The state must include in their notice to CMS what will happen to current participants when the waiver ends.
 - ✓ In most cases, they may have been transitioned to another waiver or authority, or the state may have phased out the waiver.
 - Please note that a waiver amendment is required when individuals are being transitioned over a period of time, when waivers are being combined, subsumed, or participants are being transitioned to other authorities. If an amendment is required, if this is the first action submitted to the waiver between March 17, 2014 and March 17, 2015, the amendment must include an HCB Settings Transition Plan (Attachments #2). In this case, the amendment would trigger the 120-day statewide HCB Settings Transition Plan.
 - In transitioning individuals, requirements for notice to participants must be met. The state must notify waiver participants at least 30 days in advance of the change.
3. As provided in 42 CFR §441.304(d), CMS may terminate a waiver when it finds that the state is not meeting one or more waiver requirements (e.g., the state has not assured the health and welfare of waiver participants or the waiver is not cost neutral). CMS may terminate a waiver for one or more of the following reasons:
- The health and welfare of waiver participants has been jeopardized;
 - The waiver is not cost-neutral;
 - The state has not submitted required annual waiver reports;
 - Accurate financial records have not been maintained to document the cost of waiver services;
 - The waiver has not been operated in a manner consistent with the approved waiver; and/or,
 - The waiver has not been operated in accordance with other applicable federal requirements.

When CMS determines that it is necessary to terminate a waiver, it gives the state notice of its findings and the opportunity for a hearing to rebut these findings. After the notice and hearing, CMS may terminate the waiver. As provided in 42 CFR §441.308, the procedures specified in Subpart D of 42 CFR §430 apply to a state's request for a hearing concerning a waiver termination. If CMS terminates the waiver, the state must notify affected waiver participants at least 30-days in advance before terminating their services.