Maryland
DEPARTMENT OF HEALTH
Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

March 20, 2020

Jackie Glaze
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MARYLAND REQUEST FOR SECTION 1135 WAIVER FLEXIBILITIES RELATED TO NOVEL CORONAVIRUS DISEASE (COVID-19) NATIONAL EMERGENCY AND PUBLIC HEALTH EMERGENCY

Dear Ms. Glaze,

The Maryland Department of Health (the Department) hereby submits a request, pursuant to Section 1135 of the Social Security Act (42 U.S.C. §1320b-5) , from the Centers for Medicare and Medicaid Services (CMS) to prevent the transmission of the Coronavirus Disease (COVID-19) to the extent possible. The COVID-19 outbreak was declared a national emergency on March 13, 2020, and was previously declared a nationwide public health emergency on January 31, 2020 (retroactive to January 27, 2020).

The below list represents Maryland's initial requested flexibilities under the Section 1135 authority in connection with the COVID-19 outbreak and emergency. Because circumstances surrounding the COVID-19 emergency remain quite fluid, the Department may subsequently request approval for additional flexibilities, which we commit to requesting promptly when the need is discovered. Consistent with Section 1 of the President's March 13, 2020, national emergency declaration, the Department requests a retroactive effective date of January 27, 2020, for the requested Section 1135 flexibilities to coincide with the effective start date of the Public Health Emergency, unless otherwise specified. The Department requests that this waiver authority extend through the termination of the National Emergency, the Public Health Emergency, or 60 days from the date of approval of the waiver or subsequent modification, whichever is later.

In addition, the Department requests confirmation that any approved flexibility granted with respect to fee-for-service Maryland Medicaid benefits and providers would apply equally, to the extent applicable, to our various federally approved delivery systems, including HealthChoice, Maryland's managed care program.

1. **Waiver of Prior Authorization Requirements and Utilization Controls**

The Department's priority is to ensure that Medicaid members' access to care is not interrupted due to restrictions on travel for participants due to social distancing practices as well as reduced staff at the Department, reduced availability of contracted vendors, and limited resources available to providers. As such, the Department requests waivers with respect to prior authorization and utilization control requirements for accessing covered State plan and/or waiver benefits (for example outpatient drugs pursuant to 42 U.S.C. §1396r–8(d)(5)) as needed by the Department pursuant to Section 1135(b)(1)(C). The Department anticipates that submission of medical necessity documentation may be difficult, impractical, or impossible in certain circumstances, including but not limited to: relocation or isolation of Maryland Medicaid participants; inaccessibility of resources normally provided by facilities such as nursing facilities; relocation, reassignment, or isolation (due to illness) of pharmacy staff, primary care prescribers and staff, and/or specialty prescribers and staff. Prior authorization and utilization management controls the Department requests the discretion to waive as needed to respond to the COVID-19 emergency declaration include, but are not limited to, those listed in Attachment A.

Additionally, the Department requests the following:

- To extend all prior authorizations that are currently in place until fifteen (15) days following the termination of the COVID-19 emergency declaration.
- With respect to COVID-19 medications, waiver of Section 1927 of the Social Security Act requiring documentation of published studies documenting the safety and effectiveness of unlabeled medication use, or recommendations for use by experts in the disease field in order to approve a treatment authorization request for unlabeled use. The Department is requesting authority to cover and reimburse unlabeled medications shown to be safe and effective, but not yet having the required published documentation for use in treating COVID-19.

2. **Temporarily suspend pre-admission screening and annual resident review (PASRR) Level and Level II Assessments for 30 days**

The Department requests a waiver for Pre-Admission Screening and Annual Resident Review (PASRR) Level I and Level II Assessments as required pursuant to 42 C.F.R. § 483.106 for 30 days. All new admissions would be treated like exempted hospital discharges. After 30 days, new admissions for mental illness or intellectual disability would receive a Resident Review as soon as resources become available.

3. **Flexibility in Performance of Required Activities**

The Department requests flexibility with respect to deadlines and timetables for performance of required activities conducted by the Department, HealthChoice managed care organizations (MCOs), the Department's behavioral health administrative services organization (ASO), the Department's dental benefits administrator (DBA), Local Health Departments (LHDs), Local Departments of Social Services (LDSS), and other related entities to permit all Parties to prioritize COVID-19 response efforts. These reports and activities include but are not limited to those specified in Attachment B.

4. Flexibility in Performance of Required Eligibility Activities

In addition to the request as described above, the Department further requests flexibility with respect to the timeliness requirements for processing applications for all new applications for Medicaid as required pursuant to 42 C.F.R. §435.912 and 42 C.F.R. §457.340. The Department intends to delay closure of new applications for which a consumer has not submitted all required documentation or which cannot be processed timely until after the requested 1135 waiver expires.

CMS has already granted the Department flexibility regarding delaying renewal processing pursuant to an email dated Friday, March 13, 2020. This waiver applies to processing of all renewals, both MAGI and non-MAGI participants, until three months after Maryland's State of Emergency expires.

5. Provider Enrollment-Related Waivers

a. Provider Enrollment: Site Visit

The Department requests to temporarily suspend site visits as required pursuant to 42 C.F.R § 455.432, which requires State Medicaid agencies to conduct pre-enrollment site visits to providers designated as "moderate" or "high" categorical risk. The Department requests this flexibility in order to prevent spread of COVID-19 as Department site visit staff go between offices; streamline provider enrollment activities; and mitigate strain on providers across the state, and out of state, to increase provider network to better respond to the COVID-19 pandemic. The Department intends to conduct post enrollment site visits for moderate and high risk providers after the requested 1135 waiver expires.

b. Provider Enrollment: Criminal Background Checks

The Department requests authority to temporarily suspend during the state of national emergency fingerprinting in criminal background checks as required pursuant to 42 C.F.R. § 455.434. The Department requests this temporary suspension in order to mitigate administrative strain on providers across the state and to stabilize provider network to better respond to COVID-19 pandemic; to ensure all provider resources allocated toward patient care and prevent providers from focusing limited resources on enrollment; and to prevent enrollment delay due to other entities delay in processing fingerprinting results. The Department intends to conduct fingerprinting post-enrollment after the requested 1135 waiver expires. Those who do not meet fingerprinting requirements will be immediately terminated.

c. Provider Enrollment: Revalidation Requirement

The Department requests to temporarily suspend the revalidation of provider enrollment as required pursuant to 42 C.F.R. § 455.414. Maryland requests to temporarily cease revalidation of providers due to revalidate on or after January 27, 2020, until the requested 1135 waiver expires. This temporary suspension request will mitigate administrative strain on providers across the state and help stabilize the provider network as it responds to COVID-19 pandemic. The temporary suspension will further prevent rerouting provider efforts toward administrative provider enrollment requirements to ensure provider resources are allocated toward patient care. The Department intends to revalidate all providers whose revalidation is postponed after the requested 1135 waiver expires.

d. Provider Enrollment: Provider License Verification

The Department requests to temporarily suspend provider license verification as required pursuant to 42 C.F.R. § 455.412, which requires State Medicaid Agencies to ensure the provider is licensed in accordance with State licensure and confirm the provider's license has not expired. The Department anticipates that Licensing Boards will be understaffed and behind on administrative license renewals in Maryland and throughout the region.

Maryland Medicaid will request that providers submit the licenses, but if expired, Maryland will proceed with enrollment as long as there is no apparent Board sanction. One example of this scenario would be a provider who recently retired, letting their license expire but returns to work to assist with providing emergency services during this time - a "moonlighting" scenario. Another example would be a provider whose license is set to expire at the end of March, the provider submits their renewal but the Board is unable to process by the March 31 expiration.

Additionally, the Department notes that pursuant to an Executive Order issued by Governor Larry J. Hogan on March 16, 2020, Licensing Boards will be required to permit any person who holds a valid, unexpired license as a health care practitioner that is issued in another state, to engage in activities authorized under such a license without first obtaining a license or practice letter from the applicable licensing agency or board in certain circumstances. The expiration date of all temporary health care licenses extended to out-of-state providers will also be extended through the State of Emergency.[1]

This waiver allows Maryland the flexibility to quickly scale up our network and maintain the active enrollment status of existing providers. Maryland will track these providers in one of two different ways: 1) for these "moonlighting" providers providing services only during the emergency, we will set an auto end-date to their enrollment effective 7/1/20; or 2) track license expiration waivers for providers who will be Medicaid providers beyond the crisis and obtain updated license information within two months of the end of the state of emergency. This will impact community-based and institutional providers. After the requested 1135 waiver expires, the Department will resume payment suspensions for providers with expired licenses.

e. Provider Enrollment: Disenrollment/Termination

The Department requests to temporarily suspend termination or denial of enrollment requirements pursuant to 42 CFR § 455.416(a)-(d), which requires state Medicaid agencies to terminate or deny enrollment to providers due to provider or owners' exclusion or failure to supply necessary documentation timely. The Department requests a temporary waiver from terminating providers for this reason while operating under a State of Emergency. Maryland requests temporarily suspending these requirements in order to mitigate strain on providers across the state to stabilize provider network to better equip/respond to COVID-19 pandemic and not decrease provider network; to ensure all provider resources allocated toward patient care and prevent providers from focusing limited resources on enrollment; enable provider and state efforts to focus on COVID-19 response and operating at maximum capacity; align other requests surrounding provider appeal processing. Maryland intends to disenroll according to requirements above after the requested 1135 waiver expires.

[1] March 16, 2020, Order Relating to Various Health Care Matters, https://governor.maryland.gov/wp-content/uploads/2020/03/Executive-Order-Health-Care-Matters.pdf

6. **State Fair Hearing Requests and Appeal Deadlines**

The Department requests a modification of timeframe under 42 CFR 438.408(f)(2) for managed care enrollees to exercise their State fair hearing rights. Specifically, any managed care enrollees for whom the 120 day deadline described in 42 CFR 328.408(f)(2) would have occurred between March 1, 2020 through the expiration of the approved 1135 waiver, up to an additional 120 days to request a State Fair Hearing.

The Department also requests the flexibility to delay scheduling State fair hearings and issuing final determinations. The waiver would extend federal time limits for final decisions in state fair hearing cases by 60 days plus the number of days that the state of emergency is in effect.

7. **Benefit Flexibilities**

The Department requests flexibility with respect to covered benefits, including but not necessarily limited to the following:

- Request flexibility with respect to provision of services telephonically where a participant does not have access to an appropriate device to facilitate delivery of the service through synchronous real-time audio and video connection and such service can be appropriately delivered by telephone.

- Request for recognition of any COVID-19 testing and related treatment of a Maryland Medicaid participant outside of an emergency room setting as constituting "emergency services" or services for an "emergency medical condition" for purposes of various Medicaid requirements including, but need not be limited to, 42 U.S.C. §1396u-2(b)(2) and 42 U.S.C. §1396b(v)(2)-(3).

- Allow for federal financial participation for expenditures related to temporary housing for the homeless as a result of the emergency, including but not limited to, commandeered hotels, other places of temporary residence, and other facilities that are suitable for use as places of temporary residence or medical facilities as necessary for quarantining, isolating or treating individuals who test positive for COVID-19 or who have had a high-risk exposure and are thought to be in the incubation period.

8. **Waiver of Premiums**

The Department requests to waive premiums for all Medicaid participants pursuant to 42 CFR 447.55(b)(4). This waiver would extend to all participants for whom premiums apply in Maryland, including Maryland Children's Health Program Premium (MCHP) and Employed Individuals with Disabilities (EID).

9. **Extension of Time to Pay Assessment Fee for Increased Community Services (ICS)**

The Department requests to extend the time available to ICS enrollees to remit assessment fees until 60 days after the end of the emergency. Under §1115 authority, ICS participants are required to pay the program the amount by which their monthly income exceeds 300% of the federal benefit rate (FBR).

10. Waiver of Certain Requirements Related to Eligibility Applications

CMS has already granted the Department flexibility regarding preparation of eligibility applications in-person by caseworkers employed by the State of Maryland and navigators pursuant to an email dated Thursday, March 19, 2020. Medicaid applications are being collected and processed by workers who are teleworking to promote social distancing during the emergency. These individuals typically do not have the ability to record calls. A process, which requires waiver of 42 C.F.R. 42 CFR §435.907(f), has been established to permit collection of consent verbally without an audio recording by following a written protocol. A similar written protocol will be established for collection of self-attested application affidavits that cannot be signed and submitted electronically or in hard copy by the consumer.[2] Applications received in this manner during the emergency will be subject to program integrity review and random audit.

11. Waiver of Public Notice Requirements

The Department requests waiver of public notice requirements under §1135(b)(1)(C) of the Act– to modify and waive preapproval requirements. Public notice for state plan amendments (SPAs) are required under 42 C.F.R §447.205 for changes in statewide methods and standards for setting Medicaid payment rates, 42 C.F.R. §447.57 for changes to premiums and cost sharing, and 42 C.F.R. 440.386 for changes to Alternative Benefit Plans (ABPs). In light of the public health emergency, Maryland must act expeditiously to protect and serve the general public. Therefore, the Department requests to waive public notice requirements for SPAs that only provide or increase beneficiary access to items and services related to COVID-19, which would not be a restriction or limitation on payment or services or otherwise burden beneficiaries and providers, and that are temporary, with a specified sunset date related to COVID-19. Similarly, the Department requests flexibility in modifying our tribal consultation timeframe, including shortening the number of days before submission or conducting consultation after submission of the SPA.

12. Waiver to Permit Certain Payments for Community First Choice Services

Permit payment for Community First Choice (CFC) State Plan services rendered by family caregivers or legally responsible individuals. CFC uses a residential services agency (RSA) model. The Program already enrolls family caregivers. The Department requests to expand that authority to include legally responsible individuals (spouses, and parents of minor children). These individuals would be permitted to be paid through the RSA through the emergency period and two months thereafter. Similar to the current family caregivers, the participant receiving services may waive the following background check, First AID training, and the purified protein derivative (PPD) skin test.

[2] Self-attestation affidavits include: No Income; Self-employment Income; Non-incarceration; Exemption from Obtaining a SSN; Fluctuating Income; Other Income; Residency; and Social Security Income.

Thank you for your consideration of these matters. If you have any questions, please contact Tricia Roddy (tricia.roddy@maryland.gov) or Alyssa Brown (alyssa.brown@maryland.gov).

Sincerely,

Tricia Roddy
Director, Office of Innovation, Research, and Development
Maryland Department of Health

cc: Robert R. Neall, MDH
Dennis Schrader, MDH
Webster Ye, MDH
David Lapp, MDH
Alyssa Brown, MDH

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Attachment A. Prior Authorization and Utilization Control Waivers

Service	Citation reference	Prior Authorization/Utilization Control Request
Remote Patient Monitoring	Attachment 3.1A, p. 9C-1	Request to waive preauthorization requirements surrounding amount and duration of remote patient monitoring.
Optometrists Services	Attachment 3.1A, p 17-D to p.19	Request to waive preauthorization for glasses, contact lenses, contacts, if covered by Medicare.
Prescriptions for Eyeglasses	3.1 A, p.29-A to 29-C	Request to waive requirement for preauthorization of eyeglasses, lenses, contacts, and that the prescription must be used within 6 months of service date.
Non-Emergency Admissions	Attachment 3.1 A, p. 10	Request to waive requirement for preauthorization for non-Emergency admissions.
Durable Medical Equipment, Durable Medical Supplies/	Attachment 3.1 A, p. 15-G	Request to waive requirement that DME/DMS gain preauthorization.
Audiology services	Attachment 3.1A, p.21A-C	Request to waive requirement that services authorized for Hearing Aids be used within six months of service date.
Podiatry services	Attachment 3.1A, p. 18 10.09.15.06	Request to waive requirement that for persons with peripheral vascular disease or diabetes, preauthorization be attained for more than one service in a 60-day period; as well as preauthorizations for certain services not listed on the Department's fee schedule.
Physician's Services	Attachment 3.1 A, p. 17-c	Request to waive requirement that: 1) all radiology and pathology services must be preauthorized; 2) physicians must attain preauthorization in order to perform vital organ transplants; and 3) physician attain preauthorization for inpatient surgical procedures.
Individualized Family Plan of Services (IFSP) and Individualized Education Plan (IEP)	Supplement 6 to Attachment 3.1A, p. 5; Supplement 10 to Attachment 3.1A, p.9.	Request to waive the requirement that IFSPs must be annually preauthorized for the duration of the emergency.
Home Health Services	Attachment 3.1A, p. 19-C	Request to waive preauthorization to continue Home Health Services if requiring more than one visit per day, four or more hours of care, and anytime an aide renders services without a skilled nursing services being provided. This also includes supplies needed for said services.

Service	Citation reference	Prior Authorization/Utilization Control Request
Private Duty Nursing	Attachment 3.1 A, p. 21-B-1	Request to waive requirement around 60 day preauthorization renewal, and physician order renewal every 60 days.
Hospice services	Attachment 3.1A, p. 29-K	Request to waive requirement that in order to renew the third election of hospice services duration, the provider must assess the participant 30 days prior to the third election period – or any subsequent election period. Request to waive any preauthorization requirement for face to face assessment. To the extent an assessment may be performed, request to permit it to be performed telephonically.
Personal Assistance Services	Attachment 3.1A, p. 31B	Request to waive preauthorization requirements for renewal time frames for personal assistance services.
Accessibility Adaptation and Environmental Assessments	Attachment 3.1-K, p. 8	Request to waive preauthorization requirements for adaptations including: goods, services and technologies. Also: Request to waive preauthorization requirements for the Department requiring Occupational Therapists to assess the individual's home and make recommendations before adaptations are approved.
Preadmission Screening and Resident Review	42 CFR 483.100 to .138	Request to waive requirement for PASSAR timeframe completions up to 30 days post admission for Level I (and Level II when necessary); prior to admission to nursing facility.
PACE	Attachment 3.1A, p.34,	Request to waive any preauthorization requirement for face to face assessment.
Drug Utilization Review Program	Attachment 4.26	Request to waive all prospective review requirements.
Care Coordination for Children	Attachment 4.19B, p.15A	Request to waive all requirements for face-to-face contact in order to bill for a “unit of service” for all three levels of service (Level I, Level II, Level II, and Level III).

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Attachment B: Flexibility in Required Activities

The Department requests flexibility with respect to deadlines and timetables for performance of required activities conducted by the Department, HealthChoice managed care organizations (MCOs), the Department's behavioral health administrative services organization (ASO), the Department's dental benefits administrator (DBA), Local Health Departments (LHDs), Local Departments of Social Services (LDSS), and other related entities to permit all Parties to prioritize COVID-19 response efforts. Proposed revised deadlines are included for reference.

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
PERM ELIGIBILITY difference resolutions and appeals	The Eligibility review contractor imposes tight deadlines on the responses needed for errors and deficiencies as well as appeals if our rebuttals are not successful.	25 days from error finding for DR; 15 days from DR finding for appeal	60 days
PERM ELIGIBILITY additional information to be provided	The Eligibility review contractor is requesting missing information needed in order to review sampled cases. the Department needs at least a one-month extension.	Varies according to the list they send us for missing information	6/15/2020 for current cases; may need 60 additional days for any future cases
CMS Performance Indicators Report	The CMS Performance Indicators report is a monthly submission that details enrollment and application data.	4/18/2020, 5/18/2020	6/18/2020
PERM Medical Record Documentation	The Review Contractor is requesting additional MR documentation from dozens of providers who have already responded, and this list may grow as they continue their reviews of over 100 more MRs.	4/15/2020	6/15/2020
PERM Data Processing Documentation	The Review Contractor is requesting additional data from source systems - Eligibility, Provider Enrollment, Claims, Pharmacy POS, etc - that may be more challenging to gather quickly.	N/A, These could become errors at anytime	60 days from end of PERM cycle
PERM Medical Review Difference Resolutions/Appeals	Medical review errors are cited on a rolling basis. The Department has 25 days to file a difference resolution for the RC to reconsider the claim. This may require obtaining	25 days from error finding for DR; 15 days from	60 days from end of PERM cycle

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
	additional documentation from the provider to support the Department's position.	DR finding for appeal	
PERM Data Processing Review Difference Resolutions/Appeals	Data processing review errors are cited on a rolling basis. The Department has 25 days to file a difference resolution for the RC to reconsider the claim. This may require obtaining additional documentation from the Department's systems, or an ASO or other vendor.	25 days from error finding for DR; 15 days from DR finding for appeal	60 days from end of PERM cycle
Group VIII Audit	CMS regional fiscal staff are requesting provider documentation for approximately 20 claims.	No hard deadline (CMS said we could take some more time), but did not specify how much.	90 days
CHIP HSI SPA Quarterly Report	Quarterly report on enrollment and outcomes for children enrolled, as well as local health department (LHD) performance indicators.	5/10/2020	6/10/2020
Maternal Opioid Misuse (MOM) Model Quarterly Progress Report (QPR)	A quarterly progress report to CMMI inclusive of a SPA/Waiver timeline.	5/1/2020	7/1/2020
Maternal Opioid Misuse (MOM) Model Federal Financial Report (FFR)	A semiannual Federal Financial Report to CMMI. This report captures grant expenditures for the MOM model.	8/1/2020	9/15/2020
Fee-for-Service Drug Utilization Annual Survey Report	Required by 1927 (g) (3) (D) of SSA, each State is responsible to submit an annual report on the operations of its Medicaid Drug Utilization Review (DUR) program.	7/1/2020	9/1/2020
Medicaid Managed Care Organization Drug Utilization Review Annual Report	42 CFR 438.3(s)(4) and (5) require that each Medicaid managed care organization (MCO) must operate a drug utilization review (DUR) program that complies with the requirements described in Sec. 1927 (g) of SSA and submit an annual report on the operations of its DUR program activities.	7/1/2020	9/1/2020
CMS-416 (EPSDT report)	Annual reporting of EPSDT rates.	4/1/2020	60 days after deadline until the end of state of emergency
HealthChoice Quarterly Reports	Quarterly demonstration monitoring report per HealthChoice STCs. Requires inputs from Finance and Eligibility.	5/1/2020	60 days after end of state of emergency

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
Meaningful Use Electronic Health Record Incentive Program Deadline	Pushing back attestation date for providers.	3/17/2020	3/31/2020
21-B Projection	Quarterly budget submission related to Children's Health Expenditures by Type of Service.	5/15/2020	6/15/2020
37 Admin Projection	Quarterly budget submission related to expenditures for State and Local Administration for the Medical Assistance Program.	5/15/2020	6/15/2020
37 Map Projection	Quarterly budget submission related to MAP including CHIP (Total Medicaid).	5/15/2020	6/15/2020
CMS 64	Quarterly submission of actual Medical Assistance Program Expenditures by Type Of Service.	4/30/2020	5/30/2020
CMS 21	Quarterly submission of actual Children's Health Expenditures by Type of Service.	4/30/2020	5/30/2020
Statistical Enrollment Data System (SEDS)	Quarterly statistical data and program expenditures.	4/30/2020	5/30/2020
MACFin INBRS	MACFin ensures that states and CMS execute the quarterly budgeting and expenditures processes that calculate and fund the federal match for the critical State-based Medicaid Programs. It provides functionality to support managing budget, accounting, and expenditure forecasts for Medicaid and Children's Health Insurance Program (CHIP).	3/30/2020	4/30/2020
Qualified Providers Serve Waiver Participants	The IMMT (Interagency Medicaid Monitoring Team) audits the service coordinators records annually, on a rolling basis, to ensure compliance with AW SC requirements.	Rolling	90 days after school closures end
Qualified Providers Serve Waiver Participants	The PIMMT (Provider Medicaid Monitoring Team) audits AW providers on a bi-annually basis on a rolling basis. Providers of services of TI, ITI, FC, EAA currently require face-to-face therapies or intervention or in-person provision of service and may have or will be required to shut-down.	Rolling	120 days after the end of the state of emergency.
Service Plans are Responsive to Waiver Participant Needs	Service Coordinators convene the multidisciplinary team for the purpose of holding initial, annual, and 'as-needed' change requests when services need	Varies	30 days after school closures end

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
	modification due to change in status. This team includes the school psychologist, parents, participant, and others. Due to closure of the LSS, the school psychologist is unavailable to participate in the MDT meeting for initials, annuals, and change requests.		
Annual SPA audits	The State or designee conducts at least an annual review of each case management agency.	6/30/2020	90 days past current date or 90 days post end of state of emergency
HITECH APD Quarterly Progress Report	Summary of activities and expenditures.	3/31/2020	60 days or defer to submit with next quarter's report
SUPPORT Act APD Quarterly Progress Report	Summary of activities and expenditures.	3/31/2020	60 days or defer to submit with next quarter's report
LTSS Development APD Quarterly Progress Report	Summary of activities and expenditures.	3/31/2020	Defer to next quarter; or 30 days
Brain Injury and DDA HCBS waivers follow the Policy on Reportable Incidents and Investigations currently reported via DDA's PCIS2 web-based portal	Quarterly BI and DDA meet with the Department to review performance measures to include appx. G. Health and Welfare where REs are reported for timeliness in reporting, ability to identify and prevent, and address. REs are reported via PCIS2 and is mined by DDA personnel in regard for Community Pathways only for the purpose of a formal report for review by the Department and subsequently submitted to CMS in compliance with an active CAP.	Quarterly via face-to-face	Quarterly via Zoom
Autism Waiver follows the Reportable Event policy (2014 version)	Quarterly MSDE meets with the Department to review all performance measures and sub-assurances to include appx. G. Health and Welfare where REs are reported for timeliness in reporting, ability to identify and prevent, and address. MSDE currently uses phone calls and emails in communicating RE activity as they are not in LTSSMaryland.	Quarterly via face-to-face	Quarterly via Zoom
Model Waiver	Quarterly MW Advisory Meeting with review of performance measures, etc.	Quarterly via face-to-face	Quarterly via Zoom

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
MW Plan of Care Meetings	Annual or bi-annual multidisciplinary meeting routinely held at a primary care physician's office.	Annual or bi-annual face to face meeting	Annual or bi-annual meeting via phone
Percentage of assisted living facilities providers receiving information and training on home and community based setting requirements during the 5 year waiver cycle	Educating CO ALF providers on community settings.	Quarterly	Annual reporting, activity being done via phone, email and videoconferencing currently
MW Level of Care Determinations	The State requires the Utilization Control Agent (UCA) to complete a level of care (LOC) determination within 3 business days.	3 business days	5 business days or TBD based on feedback from UCA
Annual interRAI assessment	The LOC of enrolled individuals is reevaluated at least annually.	Annual	Annual (interRAI assessments authorized telephonically)
CO Performance Measure	Number and percent of new assisted living providers that meet State training requirements for attending the provider orientation.	Quarterly	60 days after end of State of Emergency
MW Weekly Meetings	MW weekly meetings held face-to-face with the case management agency.	Weekly face to face	Weekly via phone
Number and percent of participants' plans of service that were updated annually.	Annual POS development occurs following the annual redetermination interRAI. This is conducted in person with the participant/representative.	Following annual redetermination interRAI	60 days after end of State of Emergency
CO Advisory Council Meetings	CO Advisory Council Meetings must happen per waiver requirements	Quarterly In Person/Webinar	Quarterly (Webinar only)
Number and percent of service plans that were revised based on a change in participants needs	Revised POS development occurs following a significant change interRAI.	Rolling, Following significant change interRAI	60 days after end of State of Emergency
Percentage of interviewed participants and/or representatives during the annual quality survey that are satisfied with the services they are receiving.	Quality of Life survey conducted in CPAS, CFC, CO, & ICS participants.	Quarterly	Evaluate annually rather than quarterly to account for temporary suspension of QoL surveys in Q3
Number and percent of participants who have signed a Freedom of Choice form indicating choice of	Obtained at time of CO application completion or denial of application assistance.	Quarterly	Annually

Title of Report/Performance Deadline/Required Activity	Brief Description of Report	Current Deadline	Proposed Revised Deadline
waiver services versus institutional care, choice of services and choice of providers.			
Number and percent of participants who receive information on how to report (A/N/E) at the time of assessment/reassessment	Performance measure on pertinent Information given during in-person Supports Planner visits.	Quarterly	Annually
Number and percent of participants who reported during annual interRAI assessment that their blood pressure was measured within the past year	Performance measure on blood pressure measurement during in-person interRAI assessment.	Quarterly	Annually
Quarterly EBR submission to CMS	CO waiver is on a technical assistance placement requiring the EBR (just report, no evidence) is submitted quarterly.	Quarterly	Annually OR if data can be continue to be gathered remotely, deadline will not need to change
HCBS - Extending deadlines for all programs (Except home modifications.)	HCBS - the Department is extending compliance deadlines for providers and reporting deadline to the Department.	Quarterly goals	Compliance deadlines already in place after the end of state of emergency.
All HCBS New ALF providers Initial Visit requirement for Community Settings and to receive a Medicaid number	All initial provider assessments will be conducted by video chat to fulfill requirements, with follow up with an in person visit after the state of emergency..	10 business days	Compliance deadlines will be amended during the state of emergency.
T-MSIS	The set of data produced in the daily operation of the Medicaid and CHIP programs. These are the data about enrollees, services, and costs, including: fee-for-service (FFS) claims, encounters performed under managed care arrangements, beneficiary eligibility and demographic information, and provider enrollment data.	Monthly	Additional 60 days