# Request for an Amendment to a §1915(c) Home and Community-Based Services Waiver

## I. Request Information

**A.** The **State** of Maryland requests approval for an amendment to the following Medicaid home and community-based services waiver approved under authority of §1915(c) of the Social Security Act.

**B. Waiver Title** (*optional*): Family Supports Waiver

**C. CMS Waiver Number**: MD.1433.R02.00

**D. Amendment Number (***Assigned by CMS***):**

**E.1 Proposed Effective Date:** July 1, 2023

**E.2 Approved Effective Date** *(CMS Use):*

## II. Purpose(s) of Amendment

**Purpose(s) of the Amendment.** Describe the purpose(s) of the amendment:

The purpose of this Amendment is to provide an option to exempt live-in caregivers who provide Personal Support and Respite Care Services from Electronic Visit Verification (EVV) requirements. This applies to both the traditional and self-directed services delivery model. The exemption is that live-in caregiver staff do not have to clock in and out in real time.

## III. Nature of the Amendment

**A. Component(s) of the Approved Waiver Affected by the Amendment.** This amendment affects the following component(s) of the approved waiver. Revisions to the affected subsection(s) of these component(s) are being submitted concurrently *(check each that applies):*

| | Component of the Approved Waiver | Subsection(s) |
|---|---|---|
| ☐ | Waiver Application | |
| ☐ | Appendix A – Waiver Administration and Operation | |
| ☐ | Appendix B – Participant Access and Eligibility | |
| ☐ | Appendix C – Participant Services | |
| ☐ | Appendix D – Participant Centered Service Planning and Delivery | |
| ☐ | Appendix E – Participant Direction of Services | |
| ☐ | Appendix F – Participant Rights | |
| ☐ | Appendix G – Participant Safeguards | |
| X | Appendix I – Financial Accountability | I-2-b |
| ☐ | Appendix J – Cost-Neutrality Demonstration | |

**B. Nature of the Amendment.** Indicate the nature of the changes to the waiver that are proposed in the amendment *(check each that applies):*

| | |
|---|---|
| ☐ | Modify target group(s) |
| ☐ | Modify Medicaid eligibility |
| ☐ | Add/delete services |
| ☐ | Revise service specifications |
| ☐ | Revise provider qualifications |
| ☐ | Increase/decrease number of participants |
| ☐ | Revise cost neutrality demonstration |
| ☐ | Add participant-direction of services |
| X | Other (specify): |
| | The nature of this Amendment is to provide an option to exempt live-in caregivers who provide Personal Support and Respite Care Services from Electronic Visit Verification (EVV) requirements. This applies to both the traditional and self-directed services delivery model. The exemption is that live-in caregiver staff do not have to clock in and out in real time. |

## IV. Contact Person(s)

**A.** The Medicaid agency representative with whom CMS should communicate regarding this amendment is:

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|---|---|
| **First Name:** | Marlana R. |
| **Last Name** | Hutchinson |
| **Title:** | Director, Office of Long Term Services and Supports |
| **Agency:** | Maryland Department of Health |
| **Address 1:** | 201 West Preston Street |
| **Address 2:** | |
| **City** | |
| **State** | Baltimore |
| **Zip Code** | 21201 |
| **Telephone:** | 410-7671443 |
| **E-mail** | marlana.hutchinson@maryland.gov |
| **Fax Number** | |

**B.** If applicable, the operating agency representative with whom CMS should communicate regarding this amendment is:

| | |
|---|---|
| **First Name:** | Rhonda |
| **Last Name** | Workman |
| **Title:** | Director of Federal Programs |
| **Agency:** | Maryland Department of Health – Developmental Disabilities Administration |
| **Address 1:** | 201 West Preston Street |
| **Address 2:** | |
| **City** | Baltimore |
| **State** | Maryland |
| **Zip Code** | 21201 |
| **Telephone:** | 443-226-1539 |
| **E-mail** | Rhonda.workman@maryland.gov |
| **Fax Number** | |

## V. Authorizing Signature

This document, together with the attached revisions to the affected components of the waiver, constitutes the State's request to amend its approved waiver under §1915(c) of the Social Security Act. The State affirms that it will abide by all provisions of the waiver, including the provisions of this amendment when approved by CMS. The State further attests that it will continuously operate the waiver in accordance with the assurances specified in Section V and the additional requirements specified in Section VI of the approved waiver. The State certifies that additional proposed revisions to the waiver request will be submitted by the Medicaid agency in the form of additional waiver amendments.

**Signature:**

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State Medicaid Director or Designee

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|---|---|
| **Date:** | |

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|---|---|
| **First Name:** | |
| **Last Name** | |
| **Title:** | |
| **Agency:** | |
| **Address 1:** | |
| **Address 2:** | |
| **City** | |
| **State** | |
| **Zip Code** | |
| **Telephone:** | |
| **E-mail** | |
| **Fax Number** | |