

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850



September 24, 2020

Stephen Groff
Director
Division of Medicaid and Medical Assistance
P.O. Box 906
New Castle, DE, 19720

Re: Delaware State Plan Amendment (SPA) 20-0006

Dear Mr. Groff:

We have reviewed the proposed amendment to add section 7.4 Medicaid Disaster Relief for the COVID-19 National Emergency to your Medicaid state plan, as submitted under transmittal number (TN) 20-0006. This amendment proposes to implement temporary policies, which are different from those policies and procedures otherwise applied under your Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 *et seq.*), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences of the COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and this state plan provision will no longer be in effect, upon termination of the public health emergency, including any extensions.

Pursuant to section 1135(b)(5) of the Act, for the period of the public health emergency, CMS is modifying the requirement at 42 C.F.R. 430.20 that the state submit SPAs related to the COVID-19 public health emergency by the final day of the quarter, to obtain a SPA effective date during the quarter, enabling SPAs submitted after the last day of the quarter to have an effective date in a previous quarter, but no earlier than the effective date of the public health emergency.

The State of Delaware requested a waiver of public notice requirements applicable to the SPA submission process. Pursuant to section 1135(b)(1)(C) of the Act, CMS is waiving public notice requirements applicable to the SPA submission process. Public notice for SPAs is 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). Pursuant to section 1135(b)(1)(C) of the Act, CMS is approving the state's request to waive these notice requirements otherwise applicable to SPA submissions.

These waivers or modifications of the requirements related to SPA submission timelines and public notice apply only with respect to SPAs that meet the following criteria: (1) the SPA provides or increases beneficiary access to items and services related to COVID-19 (such as by waiving or eliminating cost sharing, increasing payment rates or amending ABPs to add services or providers); (2) the SPA does not restrict or limit payment or services or otherwise burden beneficiaries and providers; and (3) the SPA is temporary, with a specified sunset date that is not later than the last day of the declared COVID-19 public health emergency (or any extension thereof). We nonetheless encourage states to make all relevant information about the SPA available to the public so they are aware of the changes.

We conducted our review of your submittal according to the statutory requirements at section 1902(a) of the Act and implementing regulations. This letter is to inform you that Delaware's Medicaid SPA Transmittal Number 20-0006 is approved effective March 18, 2020. This SPA is in addition to the Disaster Relief SPA approved on May 27, 2020 and does not supersede anything approved in that SPA.

Enclosed is a copy of the CMS-179 summary form and the approved state plan pages.

Please contact Talbatha Myatt at 215-861-4259 or by email at Talbatha.Myatt@cms.hhs.gov if you have any questions about this approval. We appreciate the efforts of you and your staff in responding to the needs of the residents of the State of Delaware and the health care community.

Sincerely,

Alissa M.
Deboy -S

Digitally signed by Alissa
M. Deboy -S
Date: 2020.09.24
07:27:08 -04'00'

Alissa Mooney DeBoy
Acting Deputy Director
Center for Medicaid & CHIP Services

Enclosures

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL
FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES**

1. TRANSMITTAL NUMBER

2 0 — 0 0 6

2. STATE

Delaware

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE

~~March, 19, 2020~~ March 18, 2020

5. TYPE OF PLAN MATERIAL (*Check One*)

NEW STATE PLAN

AMENDMENT TO BE CONSIDERED AS NEW PLAN

AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION

~~Title XIX Medicaid State Plan~~ Title 19 of the Social Security Act

7. FEDERAL BUDGET IMPACT

a. FFY 2020 \$ 82,123

b. FFY 2021 \$ 341,513

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT

Section 7.4

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (*If Applicable*)

10. SUBJECT OF AMENDMENT

Medicaid Disaster Relief

11. GOVERNOR'S REVIEW (*Check One*)

GOVERNOR'S OFFICE REPORTED NO COMMENT

OTHER, AS SPECIFIED:

COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

AGENCY OFFICIAL

Stephen M. Groff

16. RETURN TO

Stephen M. Groff, Director, DMMA, P.O. Box 906 New Castle, DE19720

14. TITLE

Director

15. DATE SUBMITTED 9/18/2020 | 7:03 AM EDT

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED

September 18, 2020

18. DATE APPROVED

September 24, 2020

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL

March 18, 2020

20. SIGNATURE OF REGIONAL OFFICIAL

S

Digitally signed by Alissa M. Deboy -S
Date: 2020.09.24 07:28:23 -04'00'

21. TYPED NAME

Alissa Mooney DeBoy

22. TITLE Acting Deputy Director

Center for Medicaid & CHIP Services

23. REMARKS

DE requested pen & ink changes to Box 4 (Proposed Effective Date), Box 6 (Federal Statute/Regulation Citation), Box 9 (Superseded Plan Section), and Box 7 (Federal Budget Impact).

Section 7 – General Provisions

7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A, except where sunset dates are noted in Section E.

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

- a. SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.
- b. Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

State/Territory: Delaware

- c. _____ Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [insert name of state] Medicaid state plan, as described below:

Please describe the modifications to the timeline.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

Include name of the optional eligibility group and applicable income and resource standard.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:

- a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)

Income standard: _____

-or-

- b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.

Less restrictive income methodologies:

State/Territory: Delaware

Less restrictive resource methodologies:

4. ____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. ____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. ____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. ____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. ____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

State/Territory: Delaware

3. ____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. ____ The agency adopts a total of ____ months (not to exceed 12 months) continuous eligibility for children under age enter age ____ (not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.
5. ____ The agency conducts redeterminations of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every ____ months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).
6. ____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).
- a. ____ The agency uses a simplified paper application.
 - b. ____ The agency uses a simplified online application.
 - c. ____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. ____ The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Please describe whether the state suspends all cost sharing or suspends only specified deductibles, copayments, coinsurance, or other cost sharing charges for specified items and services or for specified eligibility groups consistent with 42 CFR 447.52(d) or for specified income levels consistent with 42 CFR 447.52(g).

2. ____ The agency suspends enrollment fees, premiums and similar charges for:
- a. ____ All beneficiaries
 - b. ____ The following eligibility groups or categorical populations:

State/Territory: Delaware

Please list the applicable eligibility groups or populations.

3. ____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. ____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ____ The agency makes the following adjustments to benefits currently covered in the state plan:

3. ____ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. ____ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

- a. ____ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.
- b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

State/Territory: Delaware

Telehealth:

5. ____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. ____ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

Please describe the change in days or quantities that are allowed for the emergency period and for which drugs.

7. ____ Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. ____ The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

Please describe the manner in which professional dispensing fees are adjusted.

9. ____ The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. ____ Newly added benefits described in Section D are paid using the following methodology:

- a. ____ Published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

State/Territory: Delaware

b. Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. The agency increases payment rates for the following services:

State plan day services authorized by DDDS and 1915(i) Pathways to Employment supported employment services. This authority will sunset on the earlier of (1) the end of the PHE or (2) March 31, 2021.

a. Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. A supplemental payment or add-on within applicable upper payment limits:

ii. An increase to rates as described below.

Rates are increased:

Uniformly by the following percentage: _____

Through a modification to published fee schedules –

Effective date (enter date of change): _____

Location (list published location): _____

Up to the Medicare payments for equivalent services.

By the following factors:

To respond effectively to the COVID-19 outbreak, the State may temporarily increase payment rates to providers of day services and

1915(i) supported employment services by up to 5% above the regular payment rate using the CMS-approved methodology described in the state plan. The rate will only be increased when it is necessary to enable the provider to maintain the DSP workforce due to increased risk to the DSPs who are required to support COVID-19 positive members or to cover DSPs who must work higher than normal overtime that is not already factored into the provider rate or to recognize the additional costs of personal protective equipment.

This authority will sunset on the earlier of (1) the end of the PHE or (2) March 31, 2021.

Payment for services delivered via telehealth:

3. For the duration of the emergency, the state authorizes payments for telehealth services that:
- a. Are not otherwise paid under the Medicaid state plan;
 - b. Differ from payments for the same services when provided face to face;
 - c. Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

- d. Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:
- i. Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.
 - ii. Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. Other payment changes:

Temporarily Include Retainer Payments to Address Emergency-Related Issues

DDDS may make retainer payments to providers of 1915(i) Pathways to Employment supported employment services. DDDS may make retainer payments for supported employment services authorized by DDDS that include personal care as a component part in order to preserve provider networks. DDDS may make retainer payments for providers whose attendance and utilization for the service drops by at least 50% due to COVID-19 containment efforts. Retainer payments will be made at a percentage of the regular service rate using the CMS-approved methodology

described in the state plan, not to exceed 75% of the regular rate. Retainer payment units are limited to average prior utilization for each member. The resulting payment will not exceed the total amount that the provider would have received had services been provided as expected. DDDS will use prior authorization and billing procedures to ensure that there are no duplicative payments.

The state will allow the provider to receive retainer payments for services that include up to three episodes of up to 30 consecutive days per beneficiary for personal assistance. The state assures a retainer payment will not exceed the payment for the supported employment services. The state will collect an attestation from the provider acknowledging that retainer payments will be subject to recoupment if inappropriate billing or duplicate payments for services occurred or duplicate uses of available funding streams, as identified in a state or federal audit or any other authorized third-party review. The state will require an attestation from the provider that it will not lay off staff and will maintain wages at existing levels. For providers that had already laid off staff prior to June 30, 2020, in lieu of this attestation, the state will clarify via written policy that the provider may alternatively attest that the retainer payments it will bill to the state as a percentage of the regular payment take into account any staff layoffs that have already occurred and that the retainer payments reflect the provider's remaining fixed costs, including the cost of any staff that have not been laid off. The state will require an attestation from the provider that they had not received funding from any other sources, including but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE, or that the retainer payments at the level provided by the state would not result in their revenue exceeding that of the quarter prior to the PHE. If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped. If a provider had already received revenues in excess of the pre-PHE level, retainer payments are not available.

Retainer payments will occur on a case by case basis when the provider is directly affected by COVID-19.

Retainer payments will not be authorized for a participant for units of service for which a provider is authorized to be paid for actual service delivery.

This authority will sunset on the earlier of (1) the end of the PHE or (2) March 31, 2021.

Section F – Post-Eligibility Treatment of Income

1. ___ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:
 - a. ___ The individual's total income
 - b. ___ 300 percent of the SSI federal benefit rate
 - c. ___ Other reasonable amount: _____

State/Territory: Delaware

2. ____ The state elects a new variance to the basic personal needs allowance. (Note: Election of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Please describe the group or groups of individuals with greater needs and the amount(s) protected for each group or groups.

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

Temporarily expand setting(s) where services may be provided:

Section 1915(i) Pathways to Employment supported employment services may be delivered in a provider-managed residential setting, in a private home via the use of remote or virtual technology supports in accordance with HIPAA requirements such as: Zoom, Facetime, or Skype to deliver components of Supported Employment as authorized in the Pathways Employment Plan (i.e. person-centered plan specific to employment goals). Any alternate settings must be approved in advance by DDDS.

Temporarily modify provider qualifications:

Direct Support Professionals Employed in other states: Many DDDS providers operate in multiple states. If a Delaware DDDS authorized provider of supported employment services has staff from another state who are available to provide services in Delaware, DDDS will honor the background and training requirements from the other state. In those cases, the provider agency must notify DDDS if they are using staff from another state. Staff must receive training on any participant's ISP for whom they are providing support.

DDDS will allow provider staff to continue to provide services for the duration of the emergency when CPR, Limited Lay Administration of Medication (LLAM) and Mandt crisis response certification has lapsed. DDDS will require provider Direct Support Professional staff to continue to complete the instructional portions of the CPR & Mandt curricula that are available via an online training platform. Any element of the training that cannot be done via the virtual training platform will be made available at a later time once the emergency restrictions for group gatherings are eased.

During the period of the emergency, Direct Support Professionals may meet the requirement for initial LLAM certification by completing the "procedural" portion of LLAM via webinar that would normally be attended in person. New hires will not be required to attend the in-person demonstration of skills and will not be required to perform the 10 Supervised Field Medication Pass Observations. DDDS will allow "Unlicensed Assistive Personnel" (UAP) who have successfully passed the remote procedural portion of the initial LLAM training to assist with medications. When possible, given staffing shortages, the provider will endeavor to pair staff who have not been certified for field operations with staff that meet the full LLAM requirements. DDDS program evaluators will not cite providers for failing to comply with DDDS training requirements in these instances.

TN: 20-0006

Supersedes N/A

This SPA is in addition to the Disaster Relief SPA approved on May 27, 2020 and does not supersede anything approved in that SPA.

Approval Date: 09/24/2020

Effective Date: 03/18/2020

State/Territory: Delaware

DDDS will require all Direct Support Professionals to be fully re-certified within 90 days of the date that the in-person portions of each curriculum are available.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.