RHODE ISLAND GOVERNMENT REGISTER
PUBLIC NOTICE OF PROPOSED RULEMAKING

AGENCY: Executive Office of Health and Human Services

DIVISION: Medicaid Policy Unit

RULE IDENTIFIER: 210-RICR-10-05-2 ERLID # TBD (Will be superseding ERLID # 8200)

REGULATION TITLE: Appeals Process and Procedures for EOHHS Agencies and Programs

RULEMAKING ACTION: Regular promulgation process

Direct Final: N/A

TYPE OF FILING: Repeal current rule and replace with this new rule adoption

TIMETABLE FOR ACTION ON THE PROPOSED RULE: Public comment will end on Monday, October 16, 2017.

SUMMARY OF PROPOSED RULE: These rules are being promulgated to replace the existing regulation, Medicaid Code of Administrative Rules, Section #0110 “Complaints and Appeals.”

The newly adopted regulation sets forth the respective roles and responsibilities of the EOHHS and beneficiaries pertaining to the exercise and protection of the right to dispute certain state agency actions by filing an appeal to request an administrative fair hearing. The EOHHS is authorized and designated by state law to be the entity responsible for appeals and hearings related to the publicly funded health and human services programs identified in subsection 210-RICR-10-05-2.1.3 of the rule. EOHHS has also been authorized by HealthSource RI (HSRI), Rhode Island’s health benefits exchange, to be the entity responsible for its appeals and hearings for applicants and customers (see also HSRI regulations R23-1-1-ACA §§ 1.12, 11.1).

COMMENTS INVITED: All interested parties are invited to submit written or oral comments concerning the proposed regulations by Monday, October 16, 2017 to the address listed below.

ADDRESSES FOR PUBLIC COMMENT SUBMISSIONS: All written comments or objections should be sent to the Secretary of EOHHS, Eric J. Beane, c/o Elizabeth Shelov, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services Mailing Address: Hazard Building, 2nd Floor, 74 West Road, Cranston, RI 02920 Email Address: Elizabeth.Shelov@ohhs.ri.gov

WHERE COMMENTS MAY BE INSPECTED: Mailing Address: Executive Office of Health & Human Services, Hazard Building, 2nd Floor, 74 West Road, Cranston, RI 02920

PUBLIC HEARING INFORMATION: If a public hearing is requested, the place of the public hearing is accessible to individuals who are handicapped. If communication assistance (readers/interpreters/captioners) is needed, or any other accommodation to ensure equal participation, please call (401) 462-6266 or RI Relay 711 at least three
(3) business days prior to the meeting so arrangements can be made to provide such assistance at no cost to the person requesting.

**ALTERNATIVE PUBLIC HEARING TEXT:**
In accordance with R.I. Gen. Laws § 42-35-2.8, an oral hearing will be granted if requested by twenty-five (25) persons, by an agency or by an association having at least twenty-five (25) members. A request for an oral hearing must be made within ten (10) days of this notice.

**FOR FURTHER INFORMATION CONTACT:**
Elizabeth Shelov, Interdepartmental Project Manager, Medicaid Policy Office, Rhode Island Executive Office of Health & Human Services, Hazard Building, 2nd Floor, 74 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov

**SUPPLEMENTARY INFORMATION:**
**Regulatory Analysis Summary and Supporting Documentation:**
Societal costs and benefits have not been calculated in this instance. To be in conformity with federal guidance, the state has little discretion in promulgating this rule.

For full regulatory analysis or supporting documentation see agency contact person above.

**Authority for This Rulemaking:** R.I. Gen. Laws Chapters 40-6 and 40-8; Title XIX of the Social Security Act; 45 CFR §155.505 related to the HSRI; 42 CFR §438.400 related to Medicaid managed care organizations; and 42 CFR §431, Subpart E, related to Medicaid Fair Hearings for applicants and beneficiaries

**Regulatory Findings:**
In the development of the proposed regulation, consideration was given to: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small business. No alternative approach, duplication, or overlap was identified based upon available information.

**The Proposed Amendment:**
The Executive Office of Health and Human Services proposes to adopt 210-RICR-10-05-02 as follows in the concise explanatory statement of proposed non-technical amendments below.

The proposed regulations would repeal and supersede ERLID 8200 (Proposed to be effective on or about November 20, 2017).
STATE OF RHODE ISLAND

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES

PUBLIC NOTICE OF PROPOSED RULE-MAKING

Section 210-RICR-10-05-2

“Appeals Process and Procedures for EOHHS Agencies and Programs”

The Secretary of the Executive Office of Health and Human Services (EOHHS) has under consideration the repeal of Section #0110 of the Medicaid Code of Administrative Rules entitled, “Complaints and Appeals.” It is proposed that Section 210-RICR-10-05-2, “Appeals Process and Procedures for EOHHS Agencies and Programs” will replace #0110. This proposed-to-be-newly-adopted regulation (i.e., Section 210-RICR-10-05-2) will be codified in accordance with Rhode Island General Laws (R.I. Gen. Laws) Section 42-35-2.3(a)(2) and the Rhode Island Department of State’s requirements.

The newly adopted regulation sets forth the respective roles and responsibilities of the EOHHS and beneficiaries pertaining to the exercise and protection of the right to dispute certain state agency actions by filing an appeal to request an administrative fair hearing. The EOHHS is authorized and designated by state law to be the entity responsible for appeals and hearings related to the publicly funded health and human services programs identified in subsection 210-RICR-10-05-2.1.3 of the rule. EOHHS has also been authorized by HealthSource RI (HSRI), Rhode Island’s health benefits exchange, to be the entity responsible for its appeals and hearings for applicants and customers (see also HSRI regulations R23-1-1-ACA §§ 1.12, 11.1).

Additionally, the new rule seeks to accomplish the following:

- Reorganize the rule to make it more concise and easier for the reader to navigate;
- Summarize “aid pending”, hearing decisions, and hearing deadlines in table format;
- Define new key terms and appeal processes and procedures;
- Set forth agency/program-specific provisions in section 210-RICR-10-05-2.4 of the rule;
- Incorporate applicable federal and/or state statutory/regulatory requirements, including the provisions of 45 CFR §155.505 related to the HSRI; 42 CFR §438.400 related to Medicaid managed care organizations; and 42 CFR §431, Subpart E, related to Medicaid Fair Hearings for applicants and beneficiaries;
- Include a more detailed section (210-RICR-10-05-2.4.4) on the federal review option for HSRI customers; and
- Include a new section (210-RICR-10-05-2.4.8) on institutional and community-based long-term care involuntary discharges and transfers.

These regulations are being promulgated pursuant to the authority contained above and in Rhode Island General Laws Chapter 40-8 (Medical Assistance) as amended; Rhode Island General Laws Chapter 40-6 (“Public Assistance”); Title XIX of the Social Security Act; Chapter 42-7.2 of the Rhode Island General Laws, as amended; and Chapter 42-35 of the Rhode Island General Laws, as amended.

In accordance with R.I. Gen. Laws 42-35-2.8(c), an opportunity for a hearing must be granted if a request is received by twenty-five (25) persons, or by a governmental agency, or by an association having not less than twenty-five (25) members, within ten (10) days of this notice that is posted in accordance with R.I. Gen. Laws 42-35-2.8(a). A hearing must be open to the public, recorded, and held at least five (5) days before the end of the public-comment period.
In the development of these proposed regulations, consideration was given to the following: (1) alternative approaches; (2) overlap or duplication with other statutory and regulatory provisions; and (3) significant economic impact on small businesses in Rhode Island. No alternative approach, duplication or overlap, or impact upon small businesses was identified based upon available information.

These proposed rules are accessible on the R.I. Secretary of State’s website: http://www.sos.ri.gov/ProposedRules/, the EOHHS website: www.eohhs.ri.gov, or available in hard copy upon request (401 462-1575 or RI Relay, dial 711). Interested persons should submit data, views, written comments, or a request for a public hearing by Monday, October 16, 2017 to: Elizabeth Shelov, Office of Policy and Innovation, RI Executive Office of Health & Human Services, Hazard Building, 74 West Road, Cranston, RI 02920 or Elizabeth.Shelov@ohhs.ri.gov.

The Executive Office of Health and Human Services does not discriminate against individuals based on race, color, national origin, sex, gender identity or expression, sexual orientation, religious belief, political belief or handicap in acceptance for or provision of services or employment in its programs or activities.

The EOHHS in the Hazard Building is accessible to persons with disabilities. If communication assistance (readers /interpreters /captioners) is needed, or any other accommodation to ensure equal participation, please notify the EOHHS at (401) 462-6266 (hearing/speech impaired, dial 711) at least three (3) business days prior to the event so arrangements can be made to provide such assistance at no cost to the person requesting.

Original signed by:

________________________________________
Eric J. Beane, Secretary
Signed this 8th day of September 2017
2.1 Purpose, Scope and Applicability

2.1.1 AUTHORITY

A. The Rhode Island Executive Office of Health and Human Services (EOHHS) was established in 2006 within the executive branch of state government and serves as the principal agency of the executive branch for the purposes of managing the Departments of Children, Youth, and Families (DCYF); Health (DOH); Human Services (DHS); and Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH). The EOHHS is designated as the “single state agency,” authorized under Title XIX of the U.S. Social Security Act (42 U.S.C. §1396a et. seq.) and, as such, is legally responsible for the program / fiscal management and administration of the Medicaid Program.

B. Although the four (4) state agencies under EOHHS (DCYF, DOH, DHS, and BHDDH) maintain the authority to execute their respective administrative powers and duties in accordance with state law, R.I. Gen. Laws §42-7.2-6.1(2) transferred to the EOHHS the principal responsibility for “legal services including applying and interpreting the law, oversight of the rule making process, and administrative duties and any related functions and duties deemed necessary by the secretary” for all publicly funded health and human services. It is in this capacity that the EOHHS is authorized and designated by state law to be the entity responsible for appeals and hearings related to the publicly-funded health and human services programs identified in §2.1.3 of this Part below. EOHHS has been authorized as the designated exchange appeals entity pursuant to the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange.

2.1.2 PURPOSE

The purpose of this rule is to set forth the respective roles and responsibilities of the EOHHS and beneficiaries pertaining to the exercise and protection of the right to dispute certain agency actions by filing an appeal to request an administrative fair hearing.
2.1.3 SCOPE AND APPLICABILITY

A. In accordance with R. I. Gen. Laws §42-7.2-6.1, the provisions of this rule apply to both applicants for and beneficiaries of publicly funded health and human services programs administered by the agencies operating under the EOHHS umbrella as well as to providers and other interested parties who may be affected by any actions they take.

1. Scope. The EOHHS is authorized by law, regulation, or directive of the Secretary to manage the appeals and hearing process for the agencies under its jurisdiction and such agencies as delegated to EOHHS. The EOHHS is also authorized to act as the appeal entity for transfers and discharges from licensed nursing facilities and assisted living residences for all payers. The rule covers both the appeal and hearing processes. The rule is organized as follows:

   a. Section 2.1 – Purpose, Scope, and Applicability. In addition to establishing the legal basis for the rule and its purpose, scope, and application, this part also sets forth the definitions for key terms and processes used throughout the rule.

   b. Section 2.2 – Appeals Process. General provisions for the appeals process, including appeal filing requirements and procedures, appellant and agency responsibilities, and informal options for resolving an appeal.

   c. Section 2.3 – Administrative Fair Hearings and Appeal Decisions. This section sets forth the provisions governing the administrative fair hearing process and the disposition of appeals.

   d. Section 2.4 – Agency/Program Special Provisions. The rule sets forth any agency/program-specific provisions required under applicable federal and/or state laws and regulations. These agency/program specific requirements are noted within the general provisions where applicable unless of such significant scope and effect that it was necessary and appropriate to include them in a separate section of this Part.

2. Applicability. The provisions set forth in this rule apply on a statewide basis to the following agencies and programs:

   a. Rhode Island Works (RIWorks) (See Rhode Island Department of Human Services (DHS) Rules and Regulations)

   b. Child Care Assistance Program (CCAP) (See DHS Rules and Regulations)
c. Supplemental Nutrition Assistance Program (SNAP), formerly “Food Stamps” (See DHS Rules and Regulations)

d. Supplemental Security Income and State Supplemental Payment Program, 288-RICR-20-00-03

e. Office of Child Support Services (OCSS) (See Rhode DHS Rules and Regulations, Section 0700). To the extent the OCSS administers a case in Family court, those matters are not governed by or otherwise subject to this rule.

f. General Public Assistance Program (GPA) (See DHS Rules and Regulations, 288-RICR-20-00-03)

g. Long-term Ombudsman, Community-Based Services, and Security Housing for the Elderly, Rhode Island Division of Elderly Affairs (DEA) of the DHS, programs and services (R. I. Gen. Laws Chapter 42-66 and DEA Rules, Regulations, and Standards Governing the Home and Community Care Services to the Elderly Program; Rules Regulations and Standards for Certification of Case Management Agencies; Rules and Regulations Governing the Long Term Care Ombudsperson Program; Rules and Regulations Governing the Prescription Drug Discount Program for the Uninsured; Rules, Regulations, and Standards Governing the Pharmaceutical Assistance to the Elderly Program; and Rules, Regulations and Standards Governing Security for Housing for the Elderly)

h. Vocational Rehabilitation (VR) Program and Services for the Blind and Visually Impaired Program (SBVI), Office of Rehabilitation Services’ (ORS) of the Department of Human Services, (See DHS Office of Rehabilitation Services’ Policies and Procedures Manual)

i. The RI Veteran’s Home, RI Veterans Cemetery, and State Veterans Office of Veterans’ Affairs (VA) (See R. I. Gen. Laws Chapter 30-17.1 and 180-RICR-10-01-02, the Administrative Procedures for the Billing and Collection of Maintenance Fees; DHS Rules and Regulations for the RI Veterans Memorial Cemetery; and Rhode Island Veterans Home General Rules and Regulations)

j. Medicaid, including eligibility for and the scope, amount, and duration of any Medicaid-funded health coverage, services, and/or supports authorized by the state’s Medicaid State Plan or Title XIX, Section 1115 research and demonstration waiver (See the Executive Office of Health and Human Services (EOHHS), R. I.
k. HealthSource RI is the state’s health benefits exchange pursuant to 45 CFR 155.505 (2012) and has designated EOHHS to serve as the Appeals entity. As defined by and contained in the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange. EOHHS is not designated as the Exchange Entity for large employer appeals.

l. Programs and services offered through the Department of Behavioral Healthcare, Development Disabilities, and Hospitals to include individuals with behavioral health care needs and persons with developmental disabilities and any related institutional and home and community-based services as contained in R.I. Gen. Laws Title 40.1, Rules and Regulations and Licensing Procedures for Facilities and Programs and Behavioral Healthcare Organizations; Rules and Regulations Relating to the Definition of Developmentally Disabled Adults; Rules and Regulations for Licensing of Developmental Disability Organizations.

m. Child protective and behavioral health services, child care, and foster care licensure and any related residential and community-based services. Department of Children, Youth, and Families (DCYF) programs and services as contained in R.I. Gen. Laws Chapter 42-72 and DCYF Rules, Standards, Program Policy and Procedures. Family and juvenile court matters are not governed by this rule.

n. Assisted living residences and nursing facility transfers or discharges for all residents, both Medicaid and non-Medicaid.

2.1.4 DEFINITIONS

A. For the purposes of this rule, the following terms are defined as follows:

1. "Administrative hearing officer" means an impartial official authorized to preside over and decide a hearing involving a contested case, without regard to whether the official is an administrative law judge, a hearing officer or examiner, or other person designated by the Secretary to serve in this capacity.

2. "Administrative fair hearing" means a formal adjudication of a contested case in which an appellant can assert the right to a benefit, service, form of assistance, or good and to secure, in an administrative proceeding
before an impartial hearing officer, equity of treatment under federal and state laws, rules, regulations, policies and procedures.

3. "Advance notice" means the formal notice sent by an agency to a person providing: a statement of an intended agency action that affects eligibility, the scope, amount, and/or duration of assistance; reasons and a legal citation for the action; the date the action will take effect, and an explanation of appeal rights and the process for requesting a hearing and, for some programs, obtaining legal representation. The notice must also identify the advance notice period and the circumstances in which benefits/services/assistance may continue if a hearing is requested.

4. "Advance notice period" means the period of time prior to the effective date of an adverse agency action in which a person may request the continuation or reinstatement of assistance – sometimes referred to as “aid pending” -- until the appeal is resolved.

5. "Adverse action" means a final agency action subject to appeal, including but not limited to: any decision resulting in a change, limitation, termination, or denial of eligibility, the scope, amount, duration or delivery of assistance, the ability to practice or to provide a service, an adverse decision by a managed care entity (after exhausting internal appeals), a decision related to the Pre-Admission Screening Resident Review ("PASRR") Program as contained in 42 C.F.R §431.201 (2016) or a decision that affects service planning or placement, or any other provision as set forth in §2.1.3(A)(2) of this Part.

6. "Affected party" means the person or entity who is applying for or receiving benefits/services/assistance whether referred to as a beneficiary, recipient, enrollee, client, consumer, small employer, employer or member, as well as any person acting as the designated representative or "agent" (navigator, broker, etc.) of such a person or entity.

7. "Affordable Care Act" or “ACA" means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) and the rules and regulations issued pursuant thereto and as may be amended from time to time.

8. "Agency action" means the administrative practices, procedures, or decisions of a state agency, or an entity authorized to act on behalf of a state agency, related to the application of a state or federal law or regulation or an agency rule, policy, or procedure.
9. "Agency representative" is a person authorized by the state to take agency actions and, therefore, to be designated or assigned to represent the agency’s rules, policies, and positions in the appeal process.

10. "Aid pending appeal" is the continuation or reinstatement of assistance while an appeal is pending. For most programs, the agency must grant aid pending upon request if made by an affected party during the advance notice period.

11. "Appeals entity" means a unit of state government designated to hear appeals of agency actions. The designated appeals entity responsible for hearing appeals in accordance with the provisions set forth in this rule is the EOHHS Hearing Office (EHO).

12. "Appeal process" means a proceeding that includes various forms of informal and formal dispute resolution. The intent of the appeal process is to ensure that agency actions are consistent with established federal and state laws, rules, regulations, policies, and procedures.

13. "Appeal record" means the appeal decision, all papers, documents, exhibits, and requests filed in the proceeding and, if a hearing was held, the transcript or recording of hearing testimony or an official report containing the substance of what happened at the hearing.

14. "Appeal response" means the explanation and rationale for the agency action subject to dispute. The appeal response is prepared by an agency representative and cites the rule, policy, and/or statute that provides the legal justification for the action in dispute.

15. "Appeal request" means a request by a person affected by an agency action to review and resolve a dispute of a final agency action in an administrative fair hearing; a desire to challenge agency delay or failure to act. The appeal request must be made in writing, preferably on agency forms designated for such purposes, unless federal law or regulation governing a program permits oral appeal requests. The appeal request may also be made electronically through the state’s web-based integrated eligibility system. An appeal request may include an affected party/parties or an individual/entity acting on behalf of the affected party/parties. An appeal request may also be filed to request a hearing to dispute one or more general issues related but not limited to, agency policies, standards, practices, notice requirements, and/or performance.

16. "Appellant" means the affected party who is requesting an appeal. An appellant may be a person or provider or a representative thereof, or a person or entity making an appeal on the behalf of an individual or class of individuals affected by an agency action.
17. "Assistance" means any cash payments, benefit, service or support, or benefit card, plan or package of services provided directly or by an authorized agent or contractor of a program administered by the health and human services agencies operating under the umbrella of the EOHHS. For the purpose of this rule, assistance has the same meaning as benefit(s), service(s), and support(s) irrespective of how provided or delivered.

18. "Complaint" has the same meaning as “grievance.”

19. "Complex Medicaid" means the Medicaid-funded health care programs for members of the Medicaid Integrated Health Care Coverage (IHCC) groups.

20. "Contested case" means a final agency action on appeal in which an affected party and an agency representative are prepared to provide testimony and evidence to support their respective positions in the formal dispute resolution process.

21. "De novo review" means a review of an appeal without deference to prior decisions in the matter.

22. "Dispute" means the subject of disagreement or dissatisfaction with a final agency action that serves as the basis for an appeal.

23. "EHO" means the Executive Office of Health and Human Services Hearing Office which has been designated by law and the Secretary to serve as the appeals entity for programs administered by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, the Department of Children, Youth and Families, the Department of Human Services, the EOHHS and which may also have been designated under Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange as the appeals entity for programs administered by HealthSource RI.

24. "Ex parte communication" means a written or oral communication about a matter on appeal that occurs between the administrative hearing officer and a party to a contested case, or a non-party who has an interest in the outcome of the case, outside the presence of all parties involved. Ex parte communications are prohibited except that communications with the hearing officer for the purpose of scheduling and other administrative functions are not considered to be ex parte.

25. "Formal dispute resolution" means a contested case proceeding, such as an administrative fair hearing, before a qualified hearing officer, or a pre-
hearing settlement conference in which both parties make a final effort to resolve the matter in dispute prior to the formal hearing.

26. "Grievance" means any complaint or dispute (other than a final agency decision or action) expressing dissatisfaction with any aspect of the operations, activities, or behavior of a provider, regardless of whether remedial action is requested. A grievance is not an appeal request.

27. "HealthSource RI" or "HSRI" means the state’s benefit exchange (also referred to as an “Exchange”) established under R.I. Gen. Laws Chapter 42-157 and which meets the applicable standards of 45 C.F.R Part 155 (2012) and, as such, is authorized to make qualified health plans (QHPs) available to individuals and employers/employees who meet certain eligibility requirements. Unless otherwise identified, “HSRI” includes the individual market for qualified individuals and the Small Business Health Options Program (SHOP) serving the state’s small group market for qualified employers /employees. The “Exchange” and “HSRI” have the same meaning for the purposes of this Part.

28. "Informal dispute resolution" means a discussion about the matter in dispute between an appellant and an agency representative. The informal dispute resolution process occurs while a contested case hearing is pending and excludes any involvement by the administrative hearing officer assigned to the case.

29. "Integrated Health Care Coverage Groups" or "IHCC" means a classification of persons eligible for Medicaid-funded health care on the basis of age (sixty-five (65) years or older), disability, blindness or receipt of Supplemental Security Income (SSI) or services and supports provided through the RI Department of Children, Youth and Services. IHCC includes Medicaid programs providing long-term services and supports or health care to anyone in a Medicaid coverage group that does not use the Modified Adjusted Gross Income standard to determine eligibility.

30. "Integrated Care Initiative" or “ICI” means a Medicaid initiative that delivers integrated and coordinated services to certain Medicaid and Medicare dual eligible beneficiaries through a managed care arrangement. Includes services from across the care continuum including primary, subacute, and long-term care.

31. “Modified Adjusted Gross Income” or "MAGI" means income used to determine eligibility for premium tax credits and other savings for Marketplace health insurance plans and for Medicaid and the Children’s Health Insurance Program (CHIP). MAGI is adjusted gross income (AGI) plus these, if any: untaxed foreign income, non-taxable Social Security
benefits, and tax-exempt interest. The MAGI is the standard for determining income eligibility for all Medicaid eligibility and enrollment.

32. "Medicare-Medicaid Plan" or "MMP" is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS) and EOHHS to provide fully integrated Medicare and Medicaid benefits to MME beneficiaries eligible for the ICI Phase II.

33. "Rhody Health Options" means the capitated managed care delivery system operating under contract with EOHHS to manage and coordinate the Medicaid covered services and supports for MNM and MME beneficiaries eligible for the ICI Phase I.

34. "Involuntary discharges and transfers" means the relocation of a resident initiated by a licensed nursing facility or assisted living residence to another health care facility, residence, or non-institutional setting. The EHO is the designated appeal entity for such discharges and transfers without respect to payer.

35. "Medicaid Affordable Care Coverage Group" or "MACC" means a classification of persons eligible to receive Medicaid who are subject to the MAGI, the same income standard to determine eligibility for a qualified health plan by the state’s health benefit exchanges, HSRI. This includes families with children, pregnant women and infants, and adults age nineteen (19) to sixty-four (64) who are not otherwise eligible for Medicaid.

36. "Pre-hearing settlement conference" means the formal dispute resolution option that takes the form of meeting, held prior to an administrative fair hearing, in which the affected party and a representative of the agency make a final effort to settle the appeal matters without having a formal adjudication. Not all agencies offer the option for a pre-hearing settlement conference in all situations.

37. "Qualified health plan" or "QHP" means a health plan certified and offered for purchase through HSRI that covers all essential health benefits as defined in the ACA, 42 U.S.C. 18022 §1302, and which meets all other related ACA and HSRI certification requirements to be offered through the state’s health benefits exchange.

38. "Recoupment" means the process in which an agency seeks to recover the cost for assistance provided to an affected party either in error or
during the aid pending period if an adverse action is upheld in the disposition of an appeal.

39. "Small Business Health Options Program" or "SHOP" means a program operated by an Exchange pursuant to the ACA, 42 U.S. C. § 1311 and 45 C.F.R § 155.700 et. seq. (2012). 45 C.F.R § 155.700 et. seq provides that a qualified employer may provide its employees and their dependents with access to one (1) or more QHP.

40. "Vacate" means to set aside a previous action.

41. "Valid appeal" means an appeal that has been filed in accordance with applicable program rules and regulations and that concerns agency actions subject to dispute either as a matter of law or EHO rule or policy or as may be determined such as at the discretion of the agency or the EHO in its capacity as the designated appeal entity.

2.2 Appeals: General Provisions

2.2.1 APPEAL PROCESS

A. The filing of an appeal initiates the hearing process. There are multiple opportunities to resolve an appeal while a hearing is pending.

1. Notification of Appeal Rights. An agency must include on all application forms – paper and electronic - a statement of the applicant’s right to appeal and request a hearing related to any agency action related to eligibility as well as on any notice of an adverse action. Such notices must also state the:

   a. Nature of the agency action, the legal basis for the action, the date the action takes effect, the right to representation, the process for review of agency documents if appealing and requesting a hearing, as well as the timelines and locations for doing so; and

   b. Except for HSRI notices, information about continuation or reinstatement of assistance while an appeal is pending, as indicated in the Aid Pending provisions contained in § 2.2.2 of this Part.

2. Notices may contain an appeal request form, indicate the ways to obtain such a form, or provide information on the acceptable format for submitting an appeal if a form is not required or available. Individuals participating in publicly funded health and human services programs with eligibility administered through the state’s web-based integrated eligibility system may have the option of obtaining all formal notices of agency
action and other official communications through the user’s private, secure online account created through the web portal.

3. The state agency must not limit or interfere with an Appellant’s freedom to make a request for a hearing.

4. Procedures for Filing an Appeal. An appeal must be filed in accordance with the following:

   a. Appeal Request Format – An affected party shall file an appeal in the format designated for such purposes, or in any other format allowed by the EHO. The EHO will accept appeals via the state’s web-based integrated eligibility system. An affected party may also download the EHO Appeal Form and file an appeal by traditional means (by postal mail, fax, or personal or commercial delivery). A complete and up-to-date Appeal Request form will be on the EOHHS website at: www.eohhs.ri.gov. The Appeal Request form may also be obtained through the state’s web-based integrated eligibility system, for those programs accessible via the state’s web-based integrated eligibility system, or from the agency taking the action, or the EHO.

      (1) An affected party may request assistance in filing an appeal by contacting the agency, the HSRI Contact Center (for enrollees in Medicaid or QHP via the state’s web-based integrated eligibility system), or the EHO.

      (2) The appellant must provide a valid Appeal Request that includes a clear statement of the matter in dispute – that is, the reason(s) for the appeal.

5. Appeal Date – The appeal date determines whether a request for aid pending and/or the appeal was submitted in accordance with applicable requirements. If mailed, the appeal date is the date the form or letter is first received by either the Appeals Office or the agency. If the appeal is filed via telephone or fax, the appeal date is the date the contact is made with the agency or EHO. If the appeal is filed online through the appellant’s account with the state’s web-based integrated eligibility system, the appeal date is the date the appeal appears in the appellant’s account.

6. Appeal response. The EHO is responsible for ensuring that all appeals are documented properly upon receipt in the electronic appeal database and referred, as applicable, for responses to the appropriate unit of the agency that took the action.
a. Components of the Response – The appeal response is prepared by a representative of the agency and cites the rule, policy, procedure, and/or statute providing the legal justification for the agency action in dispute.

b. Completeness – The agency representative with responsibility for preparing the response must complete all sections of the appeals form, including any related to the details of the action not provided by the appellant.

c. Confidentiality – The agency and/or the EHO must take whatever appropriate measures are necessary to ensure any private or confidential information contained in the appeal response is protected properly to the full extent required by applicable federal and/or state laws, rules or regulations.

d. Agency/Program Specific Provisions – HSRI -- The EHO must inform HSRI as soon as possible of any appeals related to HSRI programs that are filed solely through the EHO. HSRI must be provided with the opportunity to respond to any such appeals and appear at the hearing even in circumstances in which another agency bears principal responsibility for preparing the appeal response. Additional provisions on agency/program specific requirements located in §2.4 of this Part.

7. Valid appeal. The EHO determines whether the appeal is valid and an opportunity for hearing must be granted. An appeal is determined valid if submitted in accordance with the applicable procedures and filing requirements and the EHO finds, in its discretion, that the appeal is required or founded by applicable federal and state laws, regulations, and/or rules.

a. Types of valid appeals -- For most health and human services programs, an appeal filed properly concerning any of the following is valid and must provide an opportunity for a hearing:

   (1) Affected party’s claim for assistance is denied or not acted upon within the required timeframe;

   (2) Affected party believes that an agency has acted erroneously in terminating, suspending, or reducing eligibility; or delaying the delivery of and/or terminating, suspending, or reducing the scope, amount, or duration of assistance or the manner in which it is delivered;
(3) Affected party believes that agency’s determination related to initial screening, placement, periodic review, or intermittent or regular evaluation of a plan that initiates or affects access to assistance is erroneous or contrary to prevailing standards of practice.

(4) Affected party believes that the agency has limited the freedom to choose among providers without the appropriate federal and/or state authority;

(5) Affected party believes the agency erroneously calculated: the amount of assistance; a payment, or a contribution to the cost of assistance; or the required payment or reimbursement relative to prevailing agency rules, contract obligations, or other binding agreement;

(6) Affected party believes the agency’s decision about placement, care planning, or case management, or choice of services is inappropriate, erroneous, or contrary to prevailing standards of practice;

(7) Affected party believes the agency’s action with respect to licensure, certification, sanction, or scope of practice was made in error or inappropriately limits or restrains the ability to participate in a program or practice;

(8) Affected party claims discrimination based on age, disability, gender, sexual preference, race, religion, national origin, or color (additional specialized forms may need to be filed);

(9) Affected party believes agency indication of abuse or neglect unjustified or in error;

(10) Affected party believes a nursing facility or assisted living residence decision to transfer or discharge is erroneous;

(11) Affected party wishes to challenge the denial of coverage of, or payment for, health care/services based on an interpretation of medical necessity criteria, prior-authorization rules, managed care rules; and/or

(12) Any program specific matters that the agency has identified publicly by rule or notice that qualifies as an agency action subject to appeal.
(13) Acknowledgement of valid appeal – The EHO must send a timely acknowledgment to the appellant upon receipt of the appeal request. The acknowledgement must contain information about the formal and informal options for resolving the appeal including the administrative fair hearing process.

b. Duration – An appeal remains valid until:

(1) An affected party voluntarily withdraws it and the withdrawal is confirmed without undue delay by the EHO in writing; or

(2) An affected party or an affected party’s representative fails to appear at a scheduled hearing, without good cause (as below); or

(3) A hearing has been held and a decision made.

8. Invalid appeals. Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section and/or other applicable federal or state laws, regulations, and/or rules, the EHO or agency must, promptly and without undue delay, send written notice informing the affected party:

a. The appeal request has not been accepted;

b. The reasons for determining the appeal request invalid;

c. If there is any cure for the defects in the invalid request and the timeline in which the appellant may submit an amended appeal.

9. Agency/program Specific Requirements. For both HSRI and Medicaid, appeals must be filed pursuant to § 2.2.1(A)(4) of this Part within thirty-five (35) days of the date on the notice of adverse action being appealed. See §2.4 of this Part for special provisions related to the Office of Child Support Services and long-term care facility/resident actions.

2.2.2 CONTINUATION OR REINSTATEMENT OF AID PENDING RESOLUTION OF AN APPEAL

A. An appellant may request the continuation or reinstatement of eligibility or assistance in certain types of cases pending the resolution of an appeal during the advance notice period. This is also known as “aid pending appeal.” Such a request is considered valid if it is made in conjunction with an appeal accepted by the agency or the EHO in the advance notice period, as specified below:
1. Advance Notice Period. For the purposes of this section, the advance notice period is the length of time prior to the date an agency takes an adverse action in which a person may request the continuation or reinstatement of assistance until the appeal is resolved. The point in which the advance notice period begins varies by program as indicated the table in §2.2.2(C) of this Part.

B. Agency Responsibilities. Upon determining a request for aid pending is valid, except for HSRI, a representative of the agency or EHO must provide information about the following:

1. Consequences – The person requesting aid pending must be advised of the consequences of reinstating/continuing assistance during the appeal. See table in §2.2.2(C) of this Part for an overview of possible consequences if an adverse action is upheld on appeal.

2. Scope and duration – At the time aid pending is approved, the agency or EHO representative must inform the person that assistance will be continued until a hearing decision is rendered, unless:

   a. A determination is made at the hearing that the sole issue is one of a change in state or federal law, regulation/rule or policy; or

   b. Another agency change affecting the appellant’s assistance occurs while the hearing decision is pending and the appellant fails to request a hearing on the second issue after notice of that change.

3. Agency/Program-specific provisions – The appellant must be provided with notification of any special provisions related to aid pending that may affect in any way the delivery of the assistance while the appeal is pending. Agencies shall also abide by the provisions set forth in § 2.4 of this Part.

C. Summary of Aid Pending – The following table summarizes aid pending requirements, responsibilities, and possible consequences by agency/program:

<table>
<thead>
<tr>
<th>State Agency Administering Program</th>
<th>Name of Program</th>
<th>Advance Notice Period</th>
<th>Potential Consequence – Adverse Action Upheld</th>
</tr>
</thead>
<tbody>
<tr>
<td>(a) Department of Human Services</td>
<td>General Public Assistance (GPA)</td>
<td>10 days from the mail date. Appeal request must be accompanied by or include a written statement asking specifically for continuation of GPA to stay the reduction, suspension, or discontinuance until the fair hearing decision is issued.</td>
<td>Repayment may be required.</td>
</tr>
<tr>
<td>State Agency Administering Program</td>
<td>Name of Program</td>
<td>Advance Notice Period</td>
<td>Potential Consequence – Adverse Action Upheld</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------</td>
<td>-----------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>(b) Department of Human Services</td>
<td>Supplemental Nutrition Assistance Program (SNAP)</td>
<td>10 days beginning on the fifth day after the date on the notice of intended action. If the advance notice period ends on a holiday or weekend, beneficiary is entitled to aid pending if request is received on the day after the holiday or weekend.</td>
<td>SNAP benefits discontinued at the end of the certification period. Recoupment initiated.</td>
</tr>
<tr>
<td>(c) Department of Human Services</td>
<td>RI Works, +3</td>
<td>10 days from the mail date</td>
<td>Repayment required and recoupment is initiated. For RI Works participants, appeal period may count toward time-limits</td>
</tr>
<tr>
<td>(d) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals</td>
<td>All programs and services</td>
<td>10 days beginning on the fifth day after the date on the notice of intended action</td>
<td></td>
</tr>
<tr>
<td>(e) Health Source RI – health benefit exchange</td>
<td>Qualified Health Plans, Advance Premium Tax Credits and Cost Sharing Reductions, the Small Business Health Options Program</td>
<td>Within 30 days of the eligibility redetermination occurring</td>
<td>Reconciliation of advance receipt of premium tax credits which may require the repayment of advanced premium tax credits or otherwise impact a federal tax return. Payment of premium to carrier.</td>
</tr>
<tr>
<td>(f) Executive Office of Health &amp; Human Services</td>
<td>All Medicaid</td>
<td>10 days beginning on the fifth day after the date on the notice of intended action</td>
<td>Repayment for Medicaid-funded services required. Recoupment or estate recovery initiated.</td>
</tr>
<tr>
<td>(g) Executive Office of Health and Human Services</td>
<td>Nursing facility and assisted living transfers/discharges</td>
<td>10 days beginning on the fifth day after the date on the notice of intended action</td>
<td></td>
</tr>
</tbody>
</table>
2.2.3 APPELLANT RIGHTS AND RESPONSIBILITIES

A. The agency or the EHO acting on the agency’s behalf must ensure that appellants are aware of their rights and responsibilities once an appeal is filed and the hearing process is initiated.

B. Appellant Rights. Upon determining an appeal is valid, it is the responsibility of the agency, or the EHO acting on the agency’s behalf, to inform the appellant of the following:

1. Review of Evidence – The appellant has the right to examine all documents and records to be used at the hearing, at a reasonable time before the date of the hearing, as well as during the hearing.

2. Representation – The appellant has the right to self-representation and/or representation by a third party such as a friend, relative, or legal counsel.

3. Case Presentation – The appellant may present the case without undue interference and bring any witnesses and submit any evidence he or she deems necessary to support the case. The appellant also has the right to question or refute any testimony or evidence at the hearing including, but not limited to, the opportunity to cross-examine witnesses.

4. Voluntary Withdrawal Procedure – An appeal may be withdrawn voluntarily in writing or by telephone by the appellant at any time. Appeals also may be withdrawn by telephone or on-line for certain programs as follows:

   a. HSRI QHP/SHOP, Medicaid - Appeals may be withdrawn by calling the Contact Center or through a person’s online account.

   b. SNAP Appeals - SNAP appellants may make a verbal request to withdraw a hearing. In such SNAP cases, the administrative hearing officer assigned to the appeal must send written notice within ten (10) days confirming the withdrawal and providing the household with an opportunity to request or reinstate the appeal and request for a hearing within ten (10) days from date of the confirmation notice.

C. Appellant Responsibilities. Once the appeal has been initiated, the appellant is responsible for the following:

1. Hearing Appearance – The appellant or the authorized representative acting on the appellant’s behalf must appear at the scheduled hearing. Failure to appear without good cause is considered “abandonment of hearing,” as described in § 2.3 of this Part, and results in the closure of
the contested case (except in SNAP cases), and dismissal of the request for a hearing.

2. Withdrawal of Appeal – In cases where the appellant no longer wishes to proceed with the appeal or where the informal resolution process is successful, the appeal may be withdrawn at the appellant’s request.

3. Truthful and Accurate Information – The appellant must attest to the truthfulness and accuracy of information and materials presented during the appeal process and during the administrative fair hearing. Deliberate misrepresentations or omissions for the purposes of influencing the outcome of a contested case are treated as fraud and, as such, are subject to any applicable penalties established in state and federal laws, rules and regulations.

4. An appellant is responsible for notifying and keeping the EHO and the agency apprised of any changes in address and contact information.

2.2.4 EHO/APPEAL ENTITY ROLE AND RESPONSIBILITIES

A. The agency subject to the appeal or the EHO must fulfill certain responsibilities as the appeal entity.

1. Appeal Tracking – Notwithstanding the manner in which an appeal is submitted the EHO creates a record of the appeal. Hearing requests are tracked, scheduled, and managed while the appeal is pending and until a final decision is issued, or the appeal is withdrawn or resolved.

2. Hearing and Alternative Dispute Resolution Opportunities – An opportunity for an administrative fair hearing shall be granted to an affected party who submits a valid appeal.

3. Notice of Hearing – When a hearing is scheduled, EOHHS shall send a written notice to the appellant of the date, time, and location or format of the hearing, no later than fifteen (15) days prior to the hearing date unless specifically stated otherwise in this Part.

4. Dismissal of an Appeal – The EHO shall dismiss an appeal when the appellant:

   a. withdraws the appeal request orally or in writing, as is required by applicable law;

   b. fails to appear at a scheduled hearing without good cause;

   c. fails to submit a valid appeal request as defined herein;
d. the appeal is resolved in the informal dispute resolution process; or

e. dies while the appeal is pending (For HSRI only).

2.2.5 ALTERNATIVE DISPUTE RESOLUTION OPTIONS

A. State and federal laws require that public agencies make alternative informal and formal dispute resolution options available to an appellant during a contested case while awaiting hearing.

B. An alternative dispute resolution option occurs prior to a hearing by the administrative hearing officer and is considered to be informal because it involves only the appellant and agency. The administrative hearing officer does not participate.

C. Agencies may also offer appellants the opportunity to participate in one or more alternative formal dispute resolution options prior to the hearing in which the EHO assigns the administrative hearing officer or a designee to act as a mediator. The mix of informal and formal options is generally as follows with the exceptions noted:

1. Informal Dispute Resolution Options. Each agency provides appellants with one or more informal options for resolving an appeal while the hearing process goes forward. The informal dispute resolution process involves a discussion between the appellant and one or more representatives of the agency that took the action. Participation in informal resolution is entirely voluntary on the part of the appellant. If the informal resolution process is successful and the contested case does not advance to a hearing, the informal resolution decision is final and binding.

2. Disposition Related to Agency Errors – When it is determined through the informal resolution process that an agency error was the basis for an action under appeal, the contested case is disposed as follows:

   a. Agency Response Amended. Supporting documentation from the affected party may be entered into the agency response and retained as part of the record.

   b. Notice of Corrected Action. The agency reverses or withdraws the original action on appeal and provides the appellant with an updated notice indicating the corrected action.

   c. Appeal Withdrawal. Except in SNAP cases, the appellant must not be required to withdraw the appeal when disposition of the appeal identifies an error as the cause of an agency action. The agency or the EHO closes the contested case without further action by the
appellant. In SNAP appeals, the appellant is required to withdraw the appeal in writing even if it is determined during the informal resolution process that the original eligibility decision was incorrect.

D. Formal Dispute Resolution Option – Pre-Hearing Settlement Conference. An appellant may opt to by-pass the informal process entirely or proceed in incremental steps to the formal resolution options. The administrative fair hearing process is initiated when an appeal is filed and, as such, is the principal formal option.

E. While the contested case is proceeding, an appellant may choose to pursue a pre-hearing settlement conference as a formal dispute resolution option when an agency and circumstances allow. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH), HSRI (qualified health plan) customers, and the EOHHS often make this option available upon request to beneficiaries and providers. The pre-hearing settlement conference functions as follows:

1. Presiding Settlement Conference Officer – A pre-hearing settlement conference is presided over by an impartial hearing officer designated by the EHO. The presiding officer acts as a mediator between the appellant and agency and, in this capacity, endeavors to establish a settlement agreement, satisfactory to both parties, to serve as a disposition to the contested case.

2. Review of Case and Proposed Settlement – The presiding officer reviews the appeal and the agency’s response and the terms of any proposals that may be offered to resolve the dispute with the agency and the appellant and/or their legal representatives.

3. Components of Settlement Agreement – The settlement agreement must contain the terms for resolving the appeal, implementing any corrective actions required, withdrawing the appeal and closing the contested case as outlined in §2.3.3 of this Part.

4. Disposition of the Case – If accepted by all parties, the settlement agreement is final and binding and must be implemented in the terms established without due delay. If no agreement is reached, the contested case proceeds to a formal adjudication in an administrative fair hearing, as outlined Section 2.3 of these rules.

2.3 Administrative Fair Hearing Process

2.3.1 GENERAL PROVISIONS
A. The administrative hearing process is initiated when an agency or the EHO receives a valid appeal request.

B. The EHO is responsible for scheduling the date for the appeal hearing. Upon scheduling a hearing, the EHO must send a written notice to the appellant of the date, time, and location or format of the hearing, no later than fifteen (15) days prior to the hearing date. The EHO must also notify all other affected parties including any authorized representatives of the hearing date.

C. The EHO must assure that the appellant is sent an evidentiary packet, upon request, at least one (1) to three (3) days in advance of the hearing date. The evidence packet shall, at a minimum, include:

1. Except for HSRI, in eligibility cases, the appellant's original application, the eligibility decision, and, if available, verification results from third party data sources used to make the eligibility determination;

2. In all other cases, any documents provided to the agency by or on behalf of the appellant that were material to the action taken by the agency;

3. Any documents and explanations provided by the appellant;

4. The agency response where applicable;

5. All associated notices.

D. The evidence packet is available to all parties in attendance at the hearing. All parties may request an opportunity to view the evidence packet prior to the hearing, with sufficient advance notice prior to the scheduled hearing. Requests to review the evidence packet should be made to the EHO.

E. The appellant and/or an authorized representative of the appellant must appear for the hearing at the scheduled time, date, and location. Hearings are held typically on the EHO or agency premises or may be conducted by telephone.

1. Request for continuance – If the appellant or an authorized representative is unable to appear for the hearing, the appellant must contact the EHO prior to the hearing date to report that he or she will not be able to appear, explain the reason, and request a continuance/postponement of the hearing.

   a. No more than two (2) requests for continuances are permitted, unless the EHO allows, in its discretion, to permit an additional continuance subsequent to a valid claim of good cause as indicated below in §2.3.1(E)(3) of this Part.
b. A SNAP household may request and receive a postponement in accordance with the Department of Human Services’ Food Stamp Manual.

2. Dismissal for Failure to Appear – If the appellant or an authorized representative does not provide prior notification to the agency or the EHO of an inability to appear, the appeal is dismissed unless there is an approved claim of good cause. If good cause is found, the dismissal is vacated and the hearing is rescheduled as below.

3. Good Cause for Failure to Appear – Good cause for failure to attend a hearing shall be liberally interpreted in the appellant's favor. EHO staff may assist the appellant in the establishment of good cause, and when necessary, forward determining information to the hearing officer. If the hearing officer determines that good cause exists, the hearing is rescheduled within thirty (30) days of the request and benefits/assistance/services must be reinstated without undue delay if terminated due to dismissal of the appeal. Good cause claims include, but are not limited to:

   a. Sudden and unexpected event (such as loss or breakdown of transportation, illness or injury, or other events beyond the individual’s control) which prevents the appellant’s appearance at the hearing at the designated time and place; or appearance at the wrong office;

   b. Disabilities, such as linguistic and behavioral health limitations, that may affect the appellant’s ability to attend;

   c. Injury or illness of appellant or household member that reasonably prohibits the individual from attending the hearing; and

   d. Death in family.

4. Vacating a Dismissal – Upon determining that good cause exists, the dismissal is vacated, the hearing is rescheduled, and the EHO provides appropriate notification to the affected parties and agency. If the EHO finds that good cause does not exist, timely written notice of the denial of a request to vacate a dismissal is sent to the appellant. In HSRI appeal cases, the appellant must be advised in the notice in either case – denial or approval of request to vacate a dismissal – of the right to pursue the appeal at the federal level. An appellant choosing to exercise this right must make a request to the federal DHHS appeal entity in no more than thirty (30) days from the date of the EHO notice indicating whether the dismissal is vacated.
F. The appellant may designate anyone, including someone who is not licensed to practice law, to serve as an authorized representative during the appeal process. The appellant may make this designation to the EHO or the agency in-person or in writing by fax, email or U.S. mail or, as appropriate, the state’s web-based integrated eligibility system.

1. Role of the Authorized Representative – Once the designation has been recognized by the EHO, the authorized representative is copied on all correspondence pertaining to the appeal that is provided to the appellant. Although the authorized representative may act on behalf of the appellant in all matters leading up to, and including, formal adjudication in a fair hearing, the appellant may opt to participate on his or her own in any dispute resolution proceeding.

2. Legal representation – In situations in which the appellant chooses to engage a licensed attorney to serve as an authorized representative, the EHO must be notified in advance that the attorney intends to make an appearance on the appellant’s behalf. Such notification must be provided directly to the EHO by the attorney.

3. Authorized representatives who are out-of-state attorneys must file a pro hac vice motion in Rhode Island Supreme Court to request to be temporarily admitted to practice prior to providing legal representation in the administrative appeal process. In addition, all out-of-state attorneys must meet the requirements of the Rhode Island Supreme Court’s Article II, Rule 9 (requirements for non-resident attorneys).

4. If an appellant chooses to have legal representation at the hearing, the representative shall file a written “Entry of Appearance” with the EHO at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the appeal record. The Entry of Appearance is also needed for the EHO to confirm the representation for purposes of follow-up, review, requests for continuances, etc.

G. Persons attending the hearing typically include the appellant, the appellant’s authorized representative, the EOHHS Hearing Officer, state attorneys, and one or more representatives from the agency that took the action on appeal. In instances in which the subject on appeal is a change in agency policy, other affected parties may also have representatives in attendance.

1. Agency representatives attending the hearing must be prepared to answer questions related to the action on appeal.

2. It is the responsibility of the hearing officer to record the attendance of all persons who were involved in the relevant action under appeal.
H. All parties, authorized representatives, witnesses, and other persons present at a hearing must conduct themselves with the same decorum commonly observed in any Rhode Island court. Where such decorum is not observed, the hearing officer may take any appropriate actions to restore order, including ejection of parties or adjournment, as appropriate.

I. No person who is a party to or a participant in any proceeding before the agency or EHO or the party's counsel, employee, agent, or any other individual, acting on the party's or their own or another's behalf, is permitted to communicate *ex parte* with the hearing officer about or in any way related to the proceeding. The hearing officer must not request or entertain any such *ex parte* communications. These prohibitions do not apply to those communications that relate solely to general matters of procedure and scheduling.

J. Hearing officers hear the case *de novo* (or with no prior knowledge of the specific issue) and base decisions on applicable laws, regulations, rules and procedures.

K. Persons with disabilities shall have access to services and processes necessary to ensure their full participation in the hearing process.

L. In compliance with state and federal statutes and regulations, EHO must have interpreters available for persons with limited English proficiency and other persons needing such services, such as a telephonic interpreter service or a language line.

M. The EHO Administrative Hearing Officer shall be an impartial designee of the Secretary of EOHHS. Accordingly, a person who has participated in any way in the matter on appeal – either in an official or unofficial capacity – is prohibited from serving as a hearing officer. The hearing officer is responsible for eliciting all relevant facts bearing on the appellant’s claim and agency rules, regulations, policies, and/or procedures pertinent to the matter in dispute.

N. The EHO shall maintain an official transcript of oral presentations made in the hearing. If not transcribed, any tape recording and any memorandum prepared by a presiding official summarizing the contents of those presentations shall be maintained on file. Any person who testifies at the hearing shall be sworn in by the hearing officer. An orderly procedure must be followed that includes but is not limited to the following:

1. A statement by the hearing officer reviewing the agency’s purpose relative to the hearing; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made, and the manner in which the individual is informed of the decision.

2. A statement by the appellant and/or authorized representative outlining the appellant’s understanding of the matter in dispute.
3. A statement by an agency representative, setting forth the legal basis for the agency’s action that specifies applicable rules, regulations, policies, and/or procedures.

4. A full and open discussion of all facts and policies at issue by participants under the active leadership of the hearing officer.

O. The hearing may be adjourned from day to day or, within reason, held open to a later date at the discretion of the hearing officer if the appellant has reason to believe that he or she will obtain further relevant information to present at the hearing.

2.3.2 RULES OF EVIDENCE IN ADMINISTRATIVE FAIR HEARINGS

A. The appellant may submit supporting documents into evidence in-person at the time of the hearing, by mail, or by fax.

B. The EHO shall provide the appellant with the opportunity to:

1. Review the appeal record, including all documents and records to be used by agency at a reasonable time before the date of the hearing, as well as during the hearing;

2. Bring witnesses to testify;

3. Establish all relevant facts and circumstances;

4. Be informed of the right to judicial review, if dissatisfied with the hearing decision;

5. Present an argument without undue interference;

6. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses;

7. For HSRI actions, an appellant shall be informed of the right to appeal further to the federal HHS, if dissatisfied with the hearing decision; and

8. For appeals related to HSRI and Medicaid Affordable Care Coverage, an appellant must be informed that a hearing decision affecting one household member may require eligibility re-determinations for other household members.

C. The EOHHS Hearing Officer shall consider all relevant evidence presented during the course of the appeals process, including any evidence introduced at the formal hearing. Only information bearing directly on the issue under review and the policy, regulation or law put forth as supporting the agency action may be
presented by the agency. The hearing officer is prohibited from reviewing any information that is not made available to all parties to the appeal. Further, the hearing officer is prohibited from reviewing any records or evidence that have not been introduced at the hearing.

D. When a hearing involves medical documentation required by federal or state law, such as a diagnosis, a physician’s report, or a medical review team’s decision, a medical assessment from a qualified person (other than the person(s) involved in the original decision) may be obtained at the expense of the agency and integrated into the appeal record if the hearing officer deems it necessary.

E. No evidence is admitted after completion of a hearing or after a case is submitted on the record, unless the hearing officer allows the record to remain open for such limited purpose, or the hearing officer reopens the hearing, or the parties agree to the submission, and all the parties have been notified of allowing the record to remain open or said reopening.

2.3.3 APPEAL HEARING DECISIONS

A. The full responsibility of the agency and/or the EHO in the hearing process is discharged when a definite decision has been made, in writing, by the EOHHS hearing officer.

B. The hearing decision must be based on the applicable provisions stipulated in federal and/or state policies, rules, regulations, and/or procedures and any additional relevant evidence presented during the course of the appeals process, including at the hearing.

C. The statement must include a plain language description of the effect of the decision on the appellant and, when applicable, members of the appellant’s household; summarize the facts relevant to the appeal; identify the legal basis, including the regulations that support the decision; and state the effective date of the decision.

1. Scope and Applicability – In addition to the elements specified in §2.3.3(C) of this Part, the EHO must indicate in writing that the appeals decision is final, unless the appellant chooses to exercise the right to pursue legal action through the RI court system or, in HSRI cases, appeal to the federal DHHS as indicated in § 2.4.4 of this Part.

D. The EHO must issue written notice of the decision to the appellant within ninety (90) days of the date the appeal request is received, unless otherwise indicated in the program-specific special provisions indicated in §2.4 of this Part. The EHO must provide notice of the appeal decision and implementation instructions to the agency pertaining to the continuation, reinstatement, or termination of
benefits/assistance/services or any required changes in the scope, amount, and/or duration of benefits/assistance/services.

E. The table below provides an overview of special hearing requirements by agency and program:

<table>
<thead>
<tr>
<th>State Agency Administering Program</th>
<th>Name of Program</th>
<th>Deadline for Hearing (From Date Appeal is Received)</th>
<th>Hearing Decision Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>(01) Department of Human Services</td>
<td>General Public Assistance (GPA)</td>
<td>Unspecified</td>
<td>90 days from date the appeal request is received</td>
</tr>
<tr>
<td>(02) Department of Human Services</td>
<td>Child Support Services</td>
<td>Unspecified</td>
<td>30 days from date of close of hearing</td>
</tr>
<tr>
<td>(03) Department of Human Services</td>
<td>Supplemental Nutrition Assistance Program (SNAP)</td>
<td>60 days from date appeal request is received</td>
<td>60 days from date appeal request is received</td>
</tr>
<tr>
<td>(04) Department of Human Services</td>
<td>Office of Rehabilitative Services</td>
<td>45 days from the date appeal request is filed</td>
<td>30 days from the date of the close of the hearing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: Requests for Mediation must take place within 15 days of the appeal request and within 30 days of hearing date</td>
<td></td>
</tr>
<tr>
<td>(05) Department of Human Services</td>
<td>Division of Elderly Affairs, Home and Community-based Services</td>
<td>14 days from date the appeal request is received</td>
<td>90 days from the date the appeal is received</td>
</tr>
<tr>
<td>(06) Department of Human Services</td>
<td>All Other DHS Programs including Child Care Assistance, and the State-funded Supplemental Security Program</td>
<td>90 days from the date the appeal is received</td>
<td>90 days from the date the appeal is received</td>
</tr>
<tr>
<td>(07) Department of Children, Youth, &amp; Families</td>
<td>Findings of Abuse and Neglect</td>
<td>120 days from date appeal request is received</td>
<td>120 days from date appeal request is received</td>
</tr>
</tbody>
</table>
## Special Hearing Requirements

<table>
<thead>
<tr>
<th>State Agency Administering Program</th>
<th>Name of Program</th>
<th>Deadline for Hearing (From Date Appeal is Received)</th>
<th>Hearing Decision Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other programs</td>
<td></td>
<td>180 days from date appeal request is received</td>
<td>120 days from date appeal request is received</td>
</tr>
<tr>
<td>(08) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals</td>
<td>Non-Medicaid Programs</td>
<td>15 days from the date the appeal is received</td>
<td>25 days from date of close of hearing</td>
</tr>
<tr>
<td>(09) Health Source RI – health insurance benefit exchange</td>
<td>Qualified Health Plan, Advanced Premium Tax Credits and Cost Sharing Reductions</td>
<td>Varies – See §2.4.3 of this Part</td>
<td>Varies – See §2.4.3 of this Part</td>
</tr>
<tr>
<td>(10) Executive Office of Health &amp; Human Services</td>
<td>Medicaid</td>
<td>90 days from date appeal is received unless expedited</td>
<td>90 days from date appeal is received unless expedited. See §2.4.3 of this Part for expedited appeal requirements</td>
</tr>
<tr>
<td>(11) Executive Office of Health and Human Services</td>
<td>Nursing Facility/Assisted Living Transfers and Discharged</td>
<td>Varies – see §2.4.7 of this Part</td>
<td>10 days from the date of close of a hearing unless expedited. If expedited, see §2.4.2 of this Part</td>
</tr>
</tbody>
</table>

### 2.3.4 OPPORTUNITIES FOR FURTHER RECOURESE

A. An appeal decision is final and is the last step in the state’s administrative adjudication process for resolving a contested case. Not all available remedies are exhausted once the appeal decision is final, however. Therefore, an appellant also must be informed by the EHO of the opportunity to pursue recourse through other legal channels if dissatisfied or aggrieved by the appeal decision as follows:
1. The appellant may file a complaint requesting judicial review of the appeal decision by the appropriate state court with jurisdiction pursuant to R.I. Gen. Laws §42-35-15, as amended. The filing of such a complaint does not automatically stay the decision or order unless so ordered by the Superior Court.

2. Agency/program Specific Reviews as set forth in Section 2.4 of this Part.

2.3.5 IMPLEMENTATION OF APPEAL DECISIONS

A. After the appeal hearing is held and a decision is reached, the Administrative Hearing Office prepares a written document containing the elements identified above in section § 2.3.3(C) of this Part. The EHO is responsible for the appropriate dissemination of the decision and providing any additional instructions to the agency that may be necessary to ensure the decision’s timely and proper effectuation.

B. The EHO is responsible for assuring that the written decision is disseminated to the following:

1. Appellant/Authorized representative;

2. Agency representatives, including caseworker if there is one, and the associate director and administrator of the agency unit/division responsible for implementation of the action in dispute;

3. Chief legal counsel assigned to the agency, if applicable;

4. Agency Administrative Rules Coordinator, if applicable; and

5. Any other such interested persons or parties that may be involved directly in the decision’s implementation.

C. The EHO provides public access to all appeals decisions, subject to all applicable federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information, including the redaction of personally identifiable information.

1. Redacted EOHHS hearing decisions, rendered in accordance with its record retention schedule, are available for examination upon request at the EHO.

2. EOHHS may, at its discretion, make redacted hearing decisions available on a publicly accessible website in lieu of, or in addition to, making them available at the central office.
2.3.6 APPEAL RECORD

A. The EHO is responsible for developing and maintaining the appeal record.

B. The appeal record consists of:
   1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;
   2. All papers and requests filed in the proceeding; and
   3. The recommendation or decision of the hearing officer.

C. The EHO must make the appeal record accessible to the appellant within a reasonable time, at a convenient place, in accordance with all applicable requirements of federal and state laws regarding privacy, confidentiality, disclosure, and personally identifiable information.

2.3.7 DISCHARGE OF THE HEARING RESPONSIBILITY

A. The hearing responsibility of the state agency is considered discharged when the following steps have been completed:
   1. The hearing officer renders a written decision, based exclusively on evidence and other material introduced at the hearing, on behalf of the state agency.
   2. Copies of the decision are distributed to the appellant, the agency representatives including specific case managers, program administrators, and department senior staff as appropriate, and other interested parties. The decision must set forth the issue, the relevant facts brought out at the hearing, the pertinent provisions in the law and state agency policy, and the reasoning which led to the decision; and
   3. Action required by the decision, if any, has been completed by the agency, and confirmed in writing to the EHO.

2.3.8 MOTIONS

A. General – Any party may request of the EHO any order or action not inconsistent with law, these Rules and/or the Rhode Island Superior Court Rules of Civil Procedure.
   1. Motions may be made in writing at any time before or after the commencement of a pre-hearing conference or hearing, and/or may be made orally during a pre-hearing conference or hearing. Each motion shall
set forth the grounds for the desired order or action and state whether oral argument is requested.

2. Within ten (10) business days of a written motion being filed with the EHO, a party opposing said motion must file a written objection to the granting of the motion, and shall, if decided, request oral argument.

3. A hearing officer shall be assigned to determine whether oral argument on the motion is warranted and, if oral argument shall be heard, assign a date, time and place for such an argument. The hearing officer may decide a motion without argument if the motion involves a matter as to which the presentation of testimony or oral argument would not advance his or her understanding of the issue involved, or if disposition without argument would best serve the public interest. The hearing officer may act on a motion when all parties have responded thereto, or the deadline for responses has passed, whichever comes first, but no later than thirty (30) days following the filing of the motion.

B. At any time after the issuance of an appeal decision any party may, for good cause shown, by motion petition for a reconsideration of the final order. The petitioner shall file his/her motion within ten (10) days of the issuance of an appeal decision and shall set forth the grounds upon which he/she relies.

2.4 Agency/Program Specific Appeal and Hearing Provisions

The EOHHS Hearing Office is bound by federal and/or state law and regulations to recognize the unique appeal provisions applicable to persons participating in the following programs and/or delivery systems.

2.4.1 AID PENDING

A. See § 2.2.2 of this Part for additional information related to the continuation or reinstatement of Aid Pending the resolution of an appeal.

B. HSRI – Commercial Health Insurance through HSRI Renewals.

1. HSRI. Aid Pending is available to customers who appeal an eligibility redetermination. Eligibility redetermination shall be defined in accordance with 45 C.F.R. §155.330(e)(1)(ii) (December 22, 2016) and 45 C.F.R. §155.335(h)(1)(ii) (March 8, 2016) not to include later amendments thereto. Aid Pending is available to customers who appeal eligibility redetermination.

C. For appeals pertaining to General Public Assistance (GPA), a written request for hearing made within the ten (10) day advance notice period and must be accompanied by or include a written request for continuation of GPA to stay the
reduction, suspension, or discontinuance until the administrative fair hearing decision is issued. Only at the applicant/recipient’s specific written request must the agency continue GPA benefits.

D. If an appeal of resident discharge or transfer is filed within ten (10) days from the date of the notice of intended action, a resident may continue residing in the facility until the EHO administrative hearing decision is issued.

2.4.2 MEDICAID MANAGED CARE PLAN APPEALS – EOHHS

A. Medicaid beneficiaries enrolled in certain managed care delivery systems must attempt to resolve disputes unrelated to eligibility (disenrollment, prior authorization denial, change in the amount of a covered service, access to a particular provider, etc.) through the managed care plan’s grievance and appeal process before requesting a hearing through the EHO.

B. The timelines for filing an appeal listed in the table in Section §2.3.3(E) of this Part are suspended while the matter is on review with the managed care plan. However, a Medicaid beneficiary retains the right to request an Administrative Fair Hearing through the EHO, in accordance with the provisions set forth in §2.3.1 of this Part if the matter remains unresolved after exhausting all remedies available through the managed care plan’s grievance and appeals process.

C. The rules governing grievances and appeals may vary by type of managed care plan and population served and are specified accordingly in the applicable sections of the MCAR as follows:

<table>
<thead>
<tr>
<th>Medicaid Managed Care Delivery System</th>
<th>Managed Care Plan Grievance and Appeal Process</th>
<th>Applicable MCAR Section(s)</th>
</tr>
</thead>
</table>
| a) Rite Care Plans – Neighborhood Health Plan and United | Medicaid beneficiary once enrolled as a plan “member” must exhaust plan grievance and appeal process before requesting hearing through EHO. | Section 1309 – Scope of Services  
Section 1311.16 to 1311-22 – Plan Appeal Process  
Section 1311.24 – Member Rights |
| b) Rhody Health Partners – Medicaid Affordable Care Coverage Group Adults Age 19-64 | Medicaid beneficiary once enrolled as a plan “member” must exhaust plan grievance and appeal process before requesting hearing through EHO. | Section 1310 –Scope of Services  
Section 1311.16 to 1311-22 – Plan Appeal Process  
Section 1311.24 – Member Rights |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| c) Communities of Care – Rlte Care or Rhody Health Partners | Medicaid beneficiary may appeal assignment to Communities of Care directly to the EHO. Enrollment and service access/level must be appealed through plan process first. | Section 1314 – Scope of Services  
Section 1311.16 to 1311.22 – Plan Appeals Process  
Section 1314.06 (2) – Appeal of Assignment to Restricted Network |
| d) Rlte Share Premium Assistance Program | Medicaid beneficiary must appeal issues in accordance with commercial plan appeals and grievance process. Appeals on all other matters, including cost-sharing and failure to enroll, and any coverage issues that remain unresolved must be made to EHO. | Section 1312.07 – Scope of Program  
Section 1312.19 to 1312.23 – Program and cooperation requirements. |
| e) Rhody Health Partners – Persons who are aged, blind or with disabilities | Medicaid beneficiary must exhaust levels I and II of managed care plan’s grievance and appeals process before requesting a hearing through EHO.  
For MCO contracts starting on July 1, 2017, Medicaid beneficiary must exhaust one level of managed care plan’s grievance and appeals process before requesting a hearing through EHO. | § 40-10-1 of this Title, RHP Benefit Package  
§ 40-10-1.2.6 of this Title, Grievances, Appeals and Hearings |
| f) Community Health Team – RI. | Medicaid beneficiary must appeal directly to the EHO. | § 40-10-1.26.3 of this Title, Service Delivery Options  
§ 40-10-1.41.7 of this Title, Grievances, Appeals and Hearings |
<table>
<thead>
<tr>
<th>Medicaid Managed Care Delivery System</th>
<th>Managed Care Plan Grievance and Appeal Process</th>
<th>Applicable MCAR Section(s)</th>
</tr>
</thead>
</table>
| g) Rhody Health Options –            | Medicaid beneficiary must exhaust level II of managed care plan’s appeals process before requesting a hearing through EHO. | § 40-10-1.28 of this Title, RHO Benefit Package  
§ 40-10-1.27.5 of this Title, Grievances, Appeals and Hearings |
| h) Community Health Team – RI.      | Medicaid beneficiary must file appeals related to medical services directly to the EHO. If contracted entity, overseeing delivery option, fails to resolve non-medical formal appeals within set timelines, Medicaid beneficiary may request hearing through EHO. | § 40-10-1.26.3 of this Title, Service Delivery Options  
§ 40-10-1.41.7 of this Title, Grievances, Appeals and Hearings |
| i) Medicare Medicaid Plan (MMP)     | Medicaid/Medicare beneficiary must exhaust level II of managed care plan’s appeals process before requesting a hearing through EHO for Medicaid services or overlap services covered by both Medicare and Medicaid. | § 40-10-1.41.8 of this Title, MMP Benefit Package  
§ 40-10-1.41.7 of this Title, Grievances, Appeals, and Hearings |

### 2.4.3 EXPEDITED APPEAL – MEDICAID, HSRI, LTSS, SNAP

**A.** A Medicaid appellant may request an expedited appeal in circumstances when the matter in dispute cannot reasonably be resolved during the standard appeals process without jeopardizing the appellant’s life, health, or ability to obtain the services required to attain, maintain, or regain maximum function.

B. A long-term services and supports (LTSS) expedited appeal may also be granted in instances in which a state licensed nursing facility or assisted living residence initiates a transfer or discharge of a resident due to either: the planned closure of the facility/residence; or (2) the resident has failed, after reasonable and appropriate notice, to pay for a stay in the facility/residence.

C. An HSRI customer may request an expedited appeal when there is “any immediate need for health services because a standard appeal could jeopardize the appellant’s life, health, or ability to attain, maintain, or regain maximum function.”
D. When applicable, the appellant making an expedited appeal request must provide evidence that all required levels of the managed care grievance and appeals process have been exhausted in accordance with the provisions identified above. In all other instances, the appellant must indicate what, if any other, avenues of recourse have been pursued. In addition, the request must include information documenting that an expedited resolution of the health care matter or pending action is necessary to sustain the appellant’s health, safety, and/or welfare.

E. The EOHHS Hearing Office shall review all expedited appeal requests upon receipt and, as appropriate, require the agency or LTSS provider that initiated the action to prepare and return a response to the EHO in three (3) business days or less in instances involving dual-eligible beneficiaries enrolled in Medicaid managed care. (See § 2.4.3(H) of this Part).

F. If the EHO exercises its reasonable discretion and grants an expedited appeal, hearings are scheduled as follows:

1. Health Coverage Appeals – In instances in which the appellant is enrolled in affordable care coverage (QHP through HSRI or Medicaid) or is being involuntarily discharged/transferred from a long-term care facility in the circumstances indicated in §§ 2.4.8(C) and (D), the hearing must be scheduled expeditiously and the decision must be issued without undue delay, taking into account the appellant’s condition, the immediacy of the need for the health care access or coverage in dispute, and the extent to which any delays in the adjudication process may jeopardize the well-being or pose risks to the appellant or affect the efficacy of the health care access or coverage in dispute.

2. Dually Eligible Beneficiaries – If the appellant is a dually eligible Medicare-Medicaid beneficiary, a hearing must be scheduled immediately and appeal must be resolved in no more than three (3) business days from the date the EHO received the expedited appeal request.

G. If the request for an expedited appeal is denied, the EHO shall notify the appellant of this decision without undue delay by either telephone or other commonly available electronic media; a letter shall also be sent to the appellant explaining the reasons for the denial. Denial of a request for an expedited appeal does not delay or otherwise disrupt the timeline for resolving the dispute through the standard appeal process.

H. EHO shall expedite hearing requests from households, such as migrant farmworkers, that plan to move from Rhode Island before the administrative hearing decision would normally be reached. Hearing requests from these households shall be processed faster than others if necessary to enable them to
receive an administrative hearing decision and restoration of benefits if the administrative hearing decision so indicates before they leave Rhode Island.

2.4.4 HSRI FEDERAL REVIEW OPTION

A. As the state entity recognized by the U.S. Department of Health and Human Services (DHHS) for implementing the federal components of the ACA, HSRI, and the EHO acting as the appeal entity on the agency’s behalf, shall afford appellants certain specific rights prior to and after an administrative hearing decision is rendered.

B. If related to an HSRI action, the EHO shall provide an explanation of the appellant’s right to pursue the appeal before the federal DHHS appeals entity within thirty (30) days of the date of the notice of the administrative hearing decision. The federal DHHS appeals process provides the appellant with an additional opportunity for informal resolution and a formal administrative hearing.

C. As applicable, EHO shall transmit, via secure electronic interface, the appellant’s appeal record, including the appellant’s records from HSRI, to the DHHS appeals entity. The appellant shall also be informed that seeking federal review is not a prerequisite for seeking judicial review unless or until a court with appropriate jurisdiction finds otherwise.

1. Upon receiving notice from the EHO of an administrative hearing decision overturning an agency action, the HSRI shall promptly implement the administrative hearing decision. Specifically, such an administrative hearing decision shall be effective:

   a. Prospectively, on the first day of the month following the date of the notice of appeal decision, or consistent with 45 C.F.R. 155.330(f)(2) (or (3) (2012) (not including later amendments) and in accordance with R.I. Gen. Laws § 42-35-3.2(a)(1) and (d); or
   
   b. Retroactively, to the date the incorrect agency action became effective, at the option of the appellant.

2. HSRI must, pursuant to 45 C.F.R. 155.545(c)(2) (2012)(not including later amendments) and in accordance with R.I. Gen. Laws §42-35-3.2(a)(1) and (d)) redetermine the eligibility of household members who have not appealed the agency action, but whose eligibility for coverage and/or advanced premium tax credits or reductions in cost sharing may be affected by the appeal decision, in accordance with the standards specified in 45 C.F.R.155.305 (2012) not including later amendments.

3. IRS Role – Decisions related to an award or level of advance premium tax credits must include a plain-language statement that the final calculation
of tax credits is conducted by the federal Internal Revenue Service (IRS) through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue Code, and that decisions or interpretations of the EHO are not binding against the IRS during that process.

2.4.5 HSRI SMALL BUSINESS HEALTH OPTIONS PROGRAM ("SHOP")

A. HSRI operates the SHOP to provide small employers with the opportunity to offer their employees with the option to obtain affordable health coverage through one or a choice of qualified health plans. The EHO has been designated as the entity responsible for handling appeals of SHOP actions initiated by SHOP employers and employees.

B. All SHOP employer and employee valid appeal hearings shall be conducted in accordance with 45 CFR §155.740, 45 CFR §§ 155.505(e) through (g) (2012) not including later amendments, and 45 CFR §§ 155.510(a)(1), (a)(2), and (c) (2012) not including later amendments.

1. An employer or employee wishing to appeal denial of eligibility by HSRI shall do so within ninety (90) days of the date on the notice of the action being taken by the agency. Such appeals may be filed through the EHO or the HSRI Contact Center by mail or telephone.

C. SHOP appellants, whether an employer or employee, have the right to request an alternative form of dispute resolution known as a “desk review” in lieu of an in-person hearing. In this option, the administrative hearing officer reviews written submissions and evidence provided by the appellant and agency representative(s) and any applicable statutes, rules and regulations used as the basis for the agency action. The hearing officer then issues an appeal decision based on the findings of this review.

1. To request a desk review, the appellant shall notify the EHO or HSRI Contact Center in advance and as follows:

   a. If the hearing has already been scheduled, the request for the desk review shall be provided to the EHO or HSRI in no less than five (5) business days before the hearing date. In such cases, the written submissions from both parties – agency and appellant – shall be provided to the EHO on the day the hearing is scheduled to occur.

   b. If the hearing has not yet been scheduled, the appellant may request the desk review at any time. Written submissions in such instances are due to the EHO within ten (10) days of the date the request is made or at such other time as may be agreed to by the affected party, the agency, and the EHO.
2. Upon requesting a desk review, the appellant forfeits the opportunity for an in-person hearing. The agency and the EHO are responsible for ensuring that the appellant is aware that the in-person hearing option has been forfeited and provide information related to any US DHHS and judicial review opportunities.

2.4.6 DHS OFFICE OF REHABILITATIVE SERVICES – APPEAL DECISION REVIEW AND IMPLEMENTATION

A. The Office of Rehabilitative Services, of the Rhode Island Department of Human Services, sets forth the due process procedures and process for handling contested cases, including opportunities for mediation and hearings as provided for in the ORS Policy and Procedure Manual. Either party in an ORS contested case may request a review of the appeal decision of the hearing officer within twenty (20) days after the date the decision is rendered. If neither party requests this review, the decision of the hearing officer becomes the final decision of the agency on the 21st day after the decision is issued.

B. Director’s Review – The impartial review of the hearing officer’s decision when requested is conducted by the Director of the Department of Human Services.

1. Review Standards — The following standards of review apply when conducting a review of the appeal decision and the agency action in dispute:

   a. Evidence. Each party is given an opportunity for the submission of additional evidence and information relevant to the issue;

   b. Basis for Decision. The reviewing official is prohibited from overturning or modifying the decision of the hearing officer, or part of the decision that supports the position of the applicant or eligible individual, unless the Director concludes, based on clear and convincing evidence, that the decision of the hearing officer is clearly erroneous and contrary to:

      (1) The approved ORS State Plan;

      (2) The Rehabilitation Act of 1973, 29 U.S.C. section 701 et seq. as amended, including regulations implementing the Act; or,

      (3) Any applicable state regulation, rule, policy, or procedure that is consistent with the Federal Rehabilitation Act of 1973, 29 U.S.C. section 701 et. seq.
2. The DHS Director shall render a final decision within thirty (30) days of the initial request to review.

3. The reviewing official shall provide a written decision to both parties.

C. If a party brings a civil action to challenge a final decision of an impartial hearing officer or to challenge a final decision of the Director’s review, said decision shall be implemented pending review by the court.

D. Any individual aggrieved by the final agency decision may:

1. Bring a civil action for review of such decision in a United States district court of competent jurisdiction without regard to the amount in controversy, or

2. File for judicial review in accordance with R. I. Gen. Laws §42-35-15 as amended by filing a complaint in the Superior Court of Rhode Island.

2.4.7 DHS CHILD SUPPORT SERVICES APPEALS

A. The DHS Office of Child Support Services (OCSS) is the state agency charged with establishing and enforcing child support obligations. In this capacity, the OCSS is responsible for determining the paternity of children, issuing court orders for financial and medical support, modifying or changing orders when appropriate, and enforcing child support obligations on the behalf of persons participating in the state’s Medicaid, RIWorks, and Child Care Assistance programs. Accordingly, program participants have the right to dispute OCSS actions that affect their child support through the appeal and hearing process set forth in §§2.3 - 2.4 of this Part, with the exceptions provided as follows:

1. As the state’s principal child support agency, OCSS appeal and hearing requests must concern matters that are within the agency’s jurisdiction. Disputes related to eligibility or the scope, amount, and/or the duration of benefits/assistance/services must be directed at the agency with the statutory responsibility for administering and thus taking such actions. Therefore, for an OCSS appeal to be considered valid, it must meet the filing requirements established in §2.2.1(A) of this Part and address agency actions related to:

   a. Amount of support paid;
   
   b. Date such payment was made;
   
   c. Date such payment was received by the applicable state agency or RI Family Court;
   
   d. Date and amount of pass-through and/or child support paid; and
e. Pass-through payments that were not made and the reason for non-payment.

B. The OCSS sends a quarterly notice to program participants with child support obligations that shall include, at a minimum, information about any such actions and a participant’s right to appeal and request a hearing for any that may be in dispute and when a pass-through payment was not sent in a particular month an explanation as to why the payment was not made.

C. In instances in which a contested case proceeds to a formal administrative hearing, the appellant is advised that the EHO shall send a written decision via US Mail that includes any remedies required on the part of the agency or the appellant in no more than (30) days following the close of the hearing. In the event that an OCSS action was found to be in error, the agency shall make any corrections required and issue a new quarterly notice containing information that reflects any changes that have been made as a result of the appeal.

2.4.8 INSTITUTIONAL AND COMMUNITY-BASED LONG-TERM CARE RESIDENT INVOLUNTARY DISCHARGES AND TRANSFERS

A. The Executive Office of Health and Human Services is the single state agency for Medicaid under Title XIX of federal law. In this capacity, the EOHHS has been designated as the appeal entity for resident discharges and transfers initiated by state licensed and federally certified nursing facilities and state licensed assisted living residences, without regard to payer. As such transfer/discharges that are taken by a provider without the written agreement or consent of the resident or the resident’s legal guardian or authorized representative are considered to be involuntary and referred to hereinafter as such.

B. The provisions of this subpart apply only to involuntary resident discharges and transfers and irrespective of whether Medicare, Medicaid or private parties pay all or some of the costs for the resident’s stay. State agency actions affecting Medicaid eligibility or Medicaid-funded long-term services and supports (LTSS) must be appealed through the process set forth in §§2.2 and 2.3 of this Part and/or, where applicable, the Medicaid managed care or expedited appeal provisions set forth in §2.4.2 of this Part.

C. In accordance with applicable federal and state laws, regulations and rules, an involuntary transfer or discharge may only be initiated by a licensed entity as follows:

1. A resident transfer/discharge is permitted under applicable federal regulations when it is necessary for medical reasons resident’s health and/or safety or the health and safety of other residents or staff is endangered if the resident remains; or a resident – or the party
responsible for the resident – has failed, after reasonable and appropriate notice, to pay for their stay at the facility.

2. A resident transfer/discharge may be initiated in accordance with the regulations set forth in the RI Department of Health (DOH).

D. Both licensed nursing facilities and assisted living residences must provide a formal notice of the intent to transfer/discharge to the resident and/or resident’s authorized representative.

1. If the resident has been in the facility or residence for more than thirty (30) days, at least thirty (30) days advance notice is required. If the resident’s stay is less than (30) days, the notice of the intent to discharge/transfer must be sent as soon as feasible prior to the relocation date. The advance notice period begins on the fifth day from the date notice is mailed.

2. For the notice to be valid, it must be sent within the time limits indicated above and include the following written in plain language:

   a. The reason for the transfer;
   
   b. The effective date of the transfer;
   
   c. Where the resident will be re-located;
   
   d. Notice to the resident of the right to appeal and request a hearing through the EHO, designate someone, including legal counsel, to act as an authorized representative during the appeals process, and to review medical and other pertinent evidence.

   e. Indicate that if the transfer/discharge is related to facility/licensure closure or non-payment or may pose imminent risk to a resident’s health, a request for an expedited appeal should be filed within ten (10) days of the notice. The ten (10) day period begins on the fifth day from the date the notice is mailed.

   f. Contact information for both the state’s Long-term Care Ombudsman and the DOH Center for Health Facility Regulations for the aged. Persons with behavioral health care conditions must be provided with information about the state’s Mental Health Advocate and contact information for the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals and persons with developmental disabilities must be provided with contact information for the Rhode Island Disability Law Center.
E. For an appeal of an involuntary discharge to be valid, it must be filed in writing to the EHO during the thirty (30) day appeal period. An expedited appeal request may be filed and determined to be valid in instances involving non-payment by a third party (Medicaid or Medicare) and/or imminent risk to the resident, at the discretion of the EHO, if received within ten (10) days of the notice of the intent to transfer/discharge sent by the provider. To ensure timely resolution of such cases, the EHO must notify the provider upon the appeal's receipt that a written response must be prepared within the timelines specified in §2.4.8(D)(1) of this Part.

F. The EHO must provide the nursing facility or assisted living residence with a copy of the appeal. The provider must prepare and return a response to the EHO in no more than seven (7) days. In instances in which the EHO has approved a request for an expedited appeals process, the response must be prepared in accordance with the requirements of §2.4.8(D)(1) of this Part.

G. If a resident’s appeal request is submitted within ten (10) days of the date of the notice of intent to discharge/transfer, the resident is prohibited from being relocated pending the decision of the hearing officer, including in instances in which a continuation is granted beyond the date of the intended action. If the appeal decision is rendered prior to the date of the intended action, but upholds the nursing facility’s decision to discharge/transfer, the resident may remain in the facility until the date of the intended action.

H. Prior to issuing a notice, the provider and the resident may have attempted and exhausted all available informal dispute resolution options. Appeals to the EHO may only occur subsequent to the sending of the notice of intended action by the facility/residence.

I. The administrative hearing generally will be conducted at the appellant’s facility/residence, unless otherwise requested by the appellant.

J. If not an expedited appeal, official notice of the hearing must be sent by the EHO to all parties involved at least ten (10) days prior to the scheduled hearing date. Expedited appeals proceed in accordance with the provisions in section §2.4.3 of this Part.

K. The administrative hearing process proceeds in accordance with the provisions established in §2.3 of this Part except as indicated herein and as follows:

1. An appellant may request a continuance of the appeal hearing by contacting the EHO prior to the date of the scheduled hearing. To the extent feasible, continued hearings must be rescheduled by the EHO for a date that is within forty (40) days from the date of the notice of intended action. Although state and federal laws and/or regulations do not limit the number of continuations that may be granted, the EHO may require an
appellant seeking more than one rescheduling of the same hearing to provide good cause, as defined in §2.3.1(E)(3) of this Part. Notice of the rescheduled hearing must be provided to the affected parties must be provided in a minimum of two (2) business days prior to the date of the rescheduled hearing.

2. The EHO administrative hearing office must issue a decision in no more than ten (10) days from the date of the hearing.

L. In instances in which an appellant does not remain in a facility or residence during an appeal, a hearing must be conducted as soon as feasible but not more than ninety (90) days from the date the EHO receives the appeal. An appellant may request in writing a continuance that extends beyond this date for the purposes of case preparation.

2.4.9 DCYF CHILD ABUSE AND NEGLECT APPEALS

A. Persons contesting an action of the Department of Children, Youth, and Families (DCYF) may file a complaint with the agency though the Central Office or Child Protective Services, in accordance with §2.2 of this Part, or by-pass the complaint process and request an administrative hearing with the agency or the EHO.

B. In the case of a complaint related to an indicated finding of child abuse or neglect, a complaint sent to either the DCYF or the EHO initiates the appeal and hearing process. The affected party must send the original complaint explaining the manner in dispute along with the request for hearing directly to the EHO. Upon receipt, the appeal is handled in accordance with the provisions established in Part II related to preparation of agency response and the respective responsibilities of the appellant, the EHO and the agency.

C. At an Administrative Hearing on such a complaint, the EOHHS Hearing Officer determines whether the:

1. Department proved that abuse or neglect occurred by a preponderance of evidence; and/or

2. Agency representative that made the determination complied with all policy and procedures relating to the conduct of such investigation(s).

D. An appeal decision must be rendered and sent to the affected parties in no more than 120 days from the date the appeal was filed in cases in which a finding of an abuse or neglect offense disqualifies the appellant from employment in a child care position. For appeals on all other issues, the decision and notice must be rendered in no more than 180 days from the date the appeal was filed with the EHO.
2.4.10 EQUAL ACCESS TO JUSTICE ACT (EAJA) REQUIREMENTS

A. This section implements the statutory requirements contained in R.I. Gen. Laws Chapter 42-92, as amended, in order to provide equal access to justice for small businesses and individuals. This section governs the application and award of reasonable litigation expenses to qualified parties in adjudicatory proceedings conducted by, or under the auspices of, EOHHS.

B. It is EOHHS's policy that individuals and small businesses are encouraged to contest unjust administrative actions in order to further the public interest, and toward that end, such parties are entitled to state reimbursement of reasonable litigation expenses when they prevail in contesting an agency action which is, in fact, without substantial justification, as defined herein.

C. As used in this subsection, the following terms shall be construed as follows:

1. “Party” means any individual whose net worth is less than five hundred thousand dollars ($500,000) at the time the adversary adjudication was initiated; and any individual, partnership, corporation, association, or private organization doing business and located in the state, which is independently owned and operated, not dominant in its field, and which employs one hundred (100) or fewer persons at the time the adversary adjudication was initiated.

2. “Reasonable litigation expenses” means those expenses which were reasonably incurred by a party in adjudicatory proceedings, including, but not limited to, attorney’s fees, witness fees of all necessary witnesses, and other costs and expenses as were reasonably incurred, except that:

   a. The award of attorney's fees may not exceed one hundred and fifty dollars ($150) per hour, unless the court determines that special factors justify a higher fee;

   b. No expert witness may be compensated at a rate in excess of the highest rate of compensation for experts paid by this state.

3. “Substantial justification” means that the initial position of the agency, as well as the agency's position in the proceedings, has a reasonable basis in law and fact.

D. Whenever a party prevails in contesting an agency action and has provided the state agency with timely notice of the intention to seek an award of litigation expenses as provided by law, the administrative hearing officer may request testimony, supporting documentation and evidence, briefs or other legal memoranda from the parties prior to making a decision.
E. The decision of the administrative hearing officer to make an award of reasonable attorney’s fees shall be made part of the appeal record, shall include written findings and conclusions with respect to the award, and shall be sent to the claimant, unless the same is represented by an attorney, in which case the decision shall be sent to the attorney of record.

F. No other agency official may review the award.

G. The administrative hearing officer will not award attorney’s fees or expenses if he/she finds that the agency was substantially justified in actions leading to the proceedings and in the proceeding itself.

H. The administrative hearing officer may, at his or her discretion, deny fees or expenses if special circumstances make an award unjust.

I. There shall be disallowance of attorney’s fees or expenses, if the party is not the prevailing party.

J. Whenever substantially justified, the administrative hearing officer may recalculate the amount to be awarded to the prevailing party, without regard to the amount claimed to be due on the application, for an award.

K. Notice of the decision disallowing an application for an award of fees and expenses shall be sent to the party by the EHO via regular mail provided however, that if the party is represented by an attorney, said notice shall be sent by regular mail to the attorney of record.

L. All claims for an award of reasonable litigation expenses shall be made by letter application supplied by the agency and shall be filed with the hearing office within thirty (30) days of the date of the conclusion of the adjudicatory proceeding which gives rise to the right to recover such an award. The proceeding shall be deemed to be concluded when the agency or administrative hearing officer renders a ruling or decision, there is an informal disposition, or termination of the proceeding by the agency.

M. The administrative hearing officer may, at his or her discretion, permit a party to file a claim not in keeping with the timeframe stated above upon a showing of proof and finding by such administrative officer that good and sufficient cause exists for allowing a claim to be so filed.

N. All claims must be postmarked or received by the hearing office if filed electronically, no later than thirty (30) days from the date of the conclusion of the adjudicatory proceeding. These claims must contain:

1. A summary of the legal and factual basis for filing the claim;
2. A detailed breakdown of the reasonable litigation expenses incurred by the party in the adjudicatory proceedings, including copies of invoices, bills, affidavits, or other documents, all of which may be supplemented or modified at any time prior to the issuance of a final decision on the claim by the administrative hearing officer;

3. A notarized statement swearing to the accuracy and truthfulness of the statements and information contained in the claim, and/or filed in support thereof. In this statement, the claimant must also certify that legal fee time amounts were contemporaneously kept.

O. Any party aggrieved by the decision to award reasonable litigation expenses pursuant to the EAJA may bring an appeal to the Superior Court in the manner provided by the Administrative Procedures Act, R.I. Gen. Laws §42-35-1 et seq.

2.4.11 SEVERABILITY

A. If any provisions of these regulations or the application thereof to any person or circumstance shall be held invalid, such invalidity shall not affect the provisions or application of these regulations which can be given effect, and to this end the provisions of these regulations are declared to be severable.
IT IS PROPOSED THAT THIS RULE WILL BE REPEALED IN ITS ENTIRETY.

0102—Confidentiality of Information

0102.05—Criteria for Use of Confidential Information
REV: 08/2013

The use and disclosure of information concerning applicants and recipients will be limited to purposes directly connected with the following:

- The administration of the program. Such purpose includes establishing eligibility, determining the amount of assistance, and providing services for applicants and recipients.

- Any investigation, prosecution, or criminal or civil proceeding conducted in connection with the administration of the programs.

- The administration of any other federal or state assisted program which provides assistance, in cash or in kind, or services, directly to individuals on the basis of need. The disclosure to any committee or legislative body (federal, state or local) of any information that identifies, by name and address, any applicant or recipient is prohibited.

- All information, such as federal tax information, shall remain confidential.

0108—Equal Access to Justice

0108.05—Purpose Scope and Authority
REV: 08/2013

The purpose of 42-92-1 of the General Laws of Rhode Island, 1993, is to provide equal access to justice for small businesses and individuals.

The rules and regulations of this law govern the application and award of reasonable litigation expenses to qualified parties in adjudicatory proceedings conducted by the state agency.

The rules and regulations herein contained are promulgated pursuant to Chapters 35 and 92 of Title 42 of the Rhode Island General Laws. They are applicable to all agencies currently administered under the auspices of the EOHHS.

It is hereby declared to be the official policy of the EOHHS that individuals and small businesses should be encouraged to contest unjust administrative actions in order to further the public interest, and toward that end, such parties should be entitled to state reimbursement of reasonable litigation expenses when they prevail in contesting an agency action which is, in fact, without substantial justification.

Application/Awards of Litigation Expenses
All claims for an award of reasonable litigation expenses shall be made on an application form to be supplied by the agency and shall be filed with the hearing office within thirty (30) to forty-five (45) days of the date of the conclusion of the adjudicatory proceeding which gives rise to the right to recover such an award. The proceeding shall be deemed to be concluded when the agency or adjudicative officer renders a ruling or decision.

The adjudicative officer may, at his or her discretion, permit a party to file a claim out of time upon a showing of proof and finding by such administrative officer that good and sufficient cause exists for allowing a claim to be so filed.

All claims shall be filed on a state agency form which is obtained from the hearing office. All claims must be postmarked or delivered to the hearing office no later than thirty (30) days from the date of the conclusion of the adjudicatory proceeding. These claims must contain:

- A summary of the legal and factual basis for filing the claim;

- A detailed breakdown of the reasonable litigation expenses incurred by the party in the adjudicatory proceedings, including copies of invoices, bills, affidavits, or other documents, all of which may be supplemented or modified at any time prior to the issuance of a final decision on the claim by the adjudicative officer;

- A notarized statement swearing to the accuracy and truthfulness of the statements and information contained in the claim, and/or filed in support thereof. In this statement the claimant must also certify that legal fee time amounts were contemporaneously kept.

**0108.15.05 Allowance of Awards**

Whenever a party which has provided the state agency with timely notice of the intention to seek an award of litigation expenses as provided in these rules, prevails in contesting an agency action, and the adjudicative officer finds that the state agency was not substantially justified in: (1) the actions leading to the proceeding; or (2) in the proceeding itself, an award shall be made of reasonable litigation expenses actually incurred.

In accordance with section 42-92-2 of the Rhode Island General Laws, as amended, "reasonable litigation expenses" means those expenses which were reasonably incurred by a party in adjudicatory proceedings, including, but not limited to, attorney's fees, witness fees of all necessary witnesses, and other costs and expenses as were reasonably incurred, except that: (i) The award of attorney's fees may not exceed one hundred and twenty-five dollars ($125) per hour, unless the court determines that special factors justify a higher fee; (ii) No expert witness may be compensated at a rate in excess of the highest rate of compensation for experts paid by this state.

The decision of the adjudicative officer to make an award shall be made a part of the record, shall include written findings and conclusions with respect to the award, and shall be sent to the claimant, unless the same is represented by an attorney, in which case the decision shall be sent to the attorney of record.
0108.15.10—Disallowance of Awards

REV: 08/2013
No award of fees or expenses may be made if the adjudicative officer finds that the state agency was substantially justified in the actions leading to the proceeding and in the proceeding itself.

There should be disallowance of fees or expenses if the party is not actually the prevailing party.

The adjudicative officer may, at his/her discretion, deny fees or expenses if special circumstances make an award unjust.

The adjudicative officer may deny, in whole or in part, any application for award of fees and expenses where justice so requires or which is considered to be excessive.

Whenever substantially justified, the adjudicative officer may recalculate the amount to be awarded to the prevailing party, without regard to the amount claimed to be due on the application, for an award.

Notice of the decision disallowing an application for an award of fees and expenses shall be sent to the party by the agency via regular mail provided however, that if the party is represented by an attorney, said notice shall be sent by regular mail to the attorney of record.

0108.20—Appeals and Severability
REV: 08/2013
Any party aggrieved by the decision to award reasonable litigation expenses may bring an appeal to the Superior Court in the manner provided by the Administrative Procedures Act, Rhode Island General Laws, Section 42-35-1, et seq.

If any provision of these rules and regulations, or the application thereof, to any person or circumstances are held invalid, such invalidity shall not affect the provisions of application of the rules and regulations which can be given effect, and to this end the provisions of these rules and regulations are declared to be severable.

0110—Complaints and Hearings  0110.05—Administrative Authorization  REV: 08/2013

The Executive Office of Health and Human Services (EOHHS), through federal/state programs established by the Social Security Act of 1935, as amended, the Rehabilitation Act of 1973, as amended, and through state/local programs established by Chapter 42-7.2, of the General Laws of Rhode Island, as amended, is the Department in the Rhode Island State Government authorized by law and designation to hold hearings on a statewide basis, the following public financial, medical, vocational and social services programs:

- **RIW**: Rhode Island Works
- **CCAP**: Child Care Assistance Program
- **SNAP**: Supplemental Nutrition Assistance Program
- **SSI-SSP**: Supplemental Security Income and State Supplemental Payment Program
The Rhode Island Health Benefits Exchange (“RIHBE” or “Exchange”) has designated EOHHS to serve as the Exchange appeals entity for all Exchange appeals other than large employer appeals (hereinafter "Exchange Appeals"). EOHHS accepts that designation and thus is the Department authorized and designated hereinafter to hear and decide such Exchange Appeals.

Exchange Appeals include the following categories of appeals: Basic QHP Eligibility; APTC/CSR Eligibility or Calculation; Exemption; SHOP—Employer; SHOP—Employee; and Large Employer.

These specific policies and procedures are set forth under the law to provide equitable treatment for all applicants and recipients.

0110.10 Expressions of Dissatisfaction

REV: 08/2013

Expressions of dissatisfaction may arise in the administration of DHS, RIHBE, or OHHS programs for a variety of reasons. The state agency provides a method for receiving expressions of dissatisfaction that include but are not limited to: Complaints from certain applicants/recipients or their designated representatives questioning the application of policy with respect to such applicants/recipients;

Appeals by an applicant/recipient or his/her designated representatives concerning:

- A particular decision or delay in a decision rendered by an agency representative;
- The manner in which agency services have been delivered; and/or
- Some aspect of the financial, medical, social services, or food assistance programs;

Requests for a hearing by an individual claimant or a group, relating to more general issues of agency policy and/or the adequacy of agency standards.

In compliance with state and federal statutes and regulations, the agency shall have interpreters
available for individuals needing such services, such as a telephonic interpreter service/language line.

**Definition of a Complaint**

**REV: 08/2013**

A “complaint” means any verbal or written expression of dissatisfaction made to state agency personnel responsible for receiving such complaints that includes: staff workers either in the field or office; and Central Office personnel by an applicant/recipient or his/her authorized representative questioning the administration of agency policies and programs with respect to the treatment and/or eligibility of said claimant to receive an assistance payment, medical assistance, social services, child support services and/or food assistance.

Complaints related to RIHBE-administered programs shall be referred to the RIHBE directly or to the RIHBE contact center for appropriate follow-up and resolution.

**The Complaint Process**

**REV: 08/2013**

Complaints received from an applicant/recipient or his/her designated representative, either in any DHS field office or at the EOHHS Central Office, are referred to the appropriate supervisor for follow-up as below.

If the complaint involves a question of eligibility or need:

- The complaint is referred to the appropriate state agency representative;
- The state agency representative has the responsibility to contact the individual to discuss with him/her the details of the complaint.

If the complaint relates to social services:

- The complaint is referred by the service supervisor to the appropriate state agency social worker;
- The state agency social worker then contacts the individual in order to discuss the complaint. When the issue cannot be resolved by the state agency representative, the claimant is informed of his/her right to the following three options while the appeals process is proceeding:
  - Discuss the issue with the assigned state agency supervisor;
  - Have an adjustment conference, as described in section 0110.20.05;
  - Proceed with a hearing.

If the complaint relates to Child Support:

- The complaint is referred by the state agency supervisor to the appropriate child support agent;
- The child support agent then contacts the individual to discuss the complaint.

If the complaint relates to a program administered by the RIHBE:
• The complaint is referred to the contact center administered by the RIHBE for appropriate follow-up.

If further information/documentation is required concerning the situation from alternate sources, the claimant may obtain the necessary information or may request the state agency representative to obtain this information.

**Definition of an Appeal**

**REV: 08/2013**

An “appeal” means a request by a claimant (or his/her authorized representative) for an opportunity to present his/her case to the appropriate state agency authority for resolution of the pertinent matter. The appeal must be filed within:

- Ten (10) days from the mail date if it pertains to General Public Assistance;
- Ninety (90) days from the mail date related to SNAP benefits;
- Forty-five (45) days from the mail date related to Office of Rehabilitation Services matters;
- Thirty (30) days from the mail date related to child support services;
- Thirty (30) days from the mail date related to the State Medical Assistance (Medicaid) Program;
- DCYF: Thirty (30) days from the mail date for any DCYF-related matter;
- BHDDH: Thirty (30) days from the mail date for any BHDDH-related matter;
- Thirty (30) days from the mail date for any other DHS program;
- Thirty (30) days from the mail date for any RIHBE-administered program.

Appeal requests for any of the programs listed above may be submitted:

- In person to any DHS/DCYF/BHDDH field office/appeals office, as appropriate; and
- By U.S. Mail to any DHS/DCYF/BHDDH field office/appeals office, as appropriate. Appeal requests related to the MAGI Medicaid Program or related to any program administered by the RIHBE may, in addition to the submission methods listed above, be submitted:
  - by telephone to the RIHBE contact center;
  - by fax to the RIHBE contact center/appeals office;
  - by U.S. Mail to the address indicated on the appeals request form; or
  - online by accessing the user’s account through the website made available by the RIHBE allowing for the electronic submission of appeals.

**0110.20.05—The Appeal Process**

**REV: 08/2013**
The intent of the appeal process is to protect a person or family’s right to assistance, social services, child support services, health insurance benefits, or food assistance.

While the appeals process is proceeding, an appeal generally can be resolved through a discussion with the staff member who made the decision or, for MAGI Medicaid or programs administered by the RIHBE, through a discussion with a representative of the contact center administered by the RIHBE. If a claimant determines it is necessary to go beyond that staff member or representative to be assured that s/he is receiving equitable treatment, s/he must be informed of the following alternative provisions for expressing his/her complaint:

- A discussion of the disputed issue(s) can be arranged for the individual with the appropriate agency representative and his/her supervisor in the district or regional office ("supervisory conference"); or

- If the individual prefers, and the issue relates to programs other than those administered by the RIHBE, then instead of the supervisory conference, or following it, an ‘Adjustment Conference’ can be arranged with the regional manager while the appeals process is proceeding. This is an informal hearing in which an individual has an opportunity to state his/her dissatisfaction with agency action. The state agency representative presents the facts upon which action was based. The regional manager determines whether or not the staff decision was made in accordance with state agency policy; or

- Since the individual has a right to request and receive a hearing unconditionally, s/he can proceed directly to a full hearing review of his/her complaint.

If the complaint or appeal relates to the MAGI Medicaid or any program administered by the RIHBE, then, in addition to the informal channels discussed above, an appellant shall have the opportunity to request informal resolution of the appeal prior to a hearing by contacting the contact center administered by the RIHBE, or a representative of the contact center administered by the RIHBE may contact the appellant and offer to discuss the issue if the appellant agrees.

- The appellant’s right to a hearing shall be preserved if the appellant is dissatisfied with the outcome of the informal resolution process. The informal resolution process is voluntary and neither an appellant’s participation nor nonparticipation in the informal resolution process shall affect the right to a hearing.

- The informal resolution process shall not delay the timeline for a hearing.

- During the informal resolution process, the representative shall try to resolve the issue through a review of case documents, allowing the appellant to submit further documentation, and submitting updated information or providing further explanation of previously submitted documents.

If an appellant is dissatisfied with the informal resolution, all additional submitted documentation shall be included in the documentation sent to hearing.
For programs administered by BHDDH, the informal resolution process shall be as contained in the Rules and Regulations Governing the Practices and Procedures before the Rhode Island Department of Mental Health, Retardation, and Hospitals last amended in February 2002.

For programs administered by DCYF, the informal resolution process shall be as contained in Complaints and Hearings last amended in January 2000.

0110.25 Legal Basis for Appeals and/or Hearings
REV: 08/2013

Procedures are available for applicants and/or recipients who are aggrieved because of a state agency decision or delay in making such a decision. Entitlements to appeals, reasonable notice and opportunity for a fair hearing, are provided by:

- Title 40 of the General Laws of Rhode Island, as amended;
- Rhode Island Works Program (RIW, as authorized under Title IV-A of the Social Security Act;
- Medicaid Program, as authorized under Title XIX of the Social Security Act and 42 C.F.R. 431.200 et seq.;
- Supplemental Security Income (SSI) Program, as authorized under Title XVI of the Social Security Act;
- Social Services Program, as authorized under Title XX of the Social Security Act;
- The Vocational Rehabilitation Act of 1972, as amended; and
- The Food Stamp Act of 1977, as amended.
- Title 15 of the R.I. General Laws;
- Chapter 42-7.2 of the Rhode Island General Laws
- Section 1411 of the ACA and 45 C.F.R. Part 155 Subpart F and section 155.740 of Subpart H;
- Chapter 42-35 of the Rhode Island General Laws, as amended.

Definition of a Hearing
REV: 08/1987

A hearing is an opportunity provided by the agency for responding to an appeal. It is an instrument by which a dissatisfied individual may assert his/her right to financial assistance, medical assistance, health insurance, social services, and/or food assistance; and, to secure in an administrative proceeding before an impartial appeals officer, equity of treatment under state law and policy and the agency’s standards and procedures.

An opportunity for a hearing is granted to an applicant/recipient or his/her designated representative, when:

- His/Her claim for assistance, social services, or access to a program administered by the RIHBE is denied,
- Is not acted upon with reasonable promptness, or
• S/He is aggrieved by any other agency action resulting in suspension, reduction, discontinuance, or termination of assistance, social services, or access to a program administered by the RIHBE.

A hearing need not be granted:

• If a change in benefits is due to an automatic adjustment required by either state or federal law for classes of recipients, unless the reason for an individual appeal is a challenge of the correctness of the computation of his/her assistance payment or another aspect of the application of the automatic adjustment.

**The Right to Request a Hearing**

REV: 08/2013

Assistance, social services, child support services and food assistance application forms shall include a statement regarding the right to request a hearing.

An individual shall be fully informed of the opportunity for a hearing. At the time of application, and at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing, of:

• His/Her right to request and receive a hearing;

• The method of obtaining it; and

• His/Her right to be represented by others or to represent himself/herself.

Where applicable, at the time of any action affecting his/her claim for assistance, social services, or health insurance, the individual shall be informed, in writing:

• Of the circumstances under which the applicant’s or enrollee’s eligibility may be maintained while the appeal is pending; and

• That advance payments of the premium tax credit paid while awaiting a hearing are subject to reconciliation under 26 C.F.R. § 1.36B-4.

A hearing request remains valid until:

• The claimant voluntarily withdraws it and such withdrawal is confirmed without undue delay by the EOHHS Central Appeals Office in writing (For SNAP benefit hearing requests, upon receipt of a verbal request to withdraw a hearing, the appeals officer shall send written notice within ten (10) days confirming such withdrawal and providing the household with an opportunity to request or reinstate the hearing within ten (10) days of the confirmation notice.); or

• The claimant or his/her representative fails to appear at a scheduled hearing, without good cause (abandonment) as described in section 0110.40 (“Abandonment of the Hearing Request”); or
A hearing has been held and a decision made.

0110.30.10 Method of Processing Hearing Requests
REV: 08/2013

The hearing process begins when a request is received through any of the methods described in section 0110.20 above. When a request is received, it shall be referred to the appropriate state agency representative. The following requirements shall be met by said agency:

- The decision at issue shall be reviewed with the individual to help him/her understand the provisions in state law and/or agency policy on which the decision was based.

- The individual shall be informed of the complete complaint procedure, including informal “adjustment conference” opportunities available with the appropriate supervisor while the appeals process is proceeding.

- If the individual decides to continue the appeal, the hearing process shall be reviewed with him/her to help the individual understand what s/he might expect and what is to be expected of him/her.

None of the forgoing prevents any State agency or department from employing other supplementary procedures (e.g., mediation) to attempt to explain decisions to appellants and/or seek informal resolutions of disputes.

0110.30.15 The Request for Hearing Form and Agency Response
REV: 08/2013

The individual is requested to submit his/her appeal to the appropriate office through any of the methods described in section 0110.20 above. If the appeal is submitted in writing, the OHHS-121 (Request for Hearing), the DHS-121 (Request for Hearing) or DHS-121F (Request for Hearing-Child Support) forms may be used, and the appellant shall be provided any needed assistance to complete this form.

When the individual appeals to any office other than the DHS field office, a copy or description of the appeal shall also be sent, electronically or manually, to the hearing office at EOHHS Central Appeals Office. A copy or a description of the appeal shall also be sent, electronically or manually, to the appropriate office for that office to supply the state agency's response to the
appeal (e.g., through completion of section III of DHS-121, or through some other method of
documenting the agency response).

The state agency’s response shall be returned, electronically or manually, to the EOHHS Central
Appeals Office within seven (7) days. If the field office determines during this period that the
individual does not wish to proceed with the hearing, the hearing office shall be notified. An
appellant’s decision not to proceed with a hearing shall be documented, either in writing from the
appellant, or recorded through other available recording means (e.g., voice recording of a phone
call).

For Exchange Appeals or appeals related to MAGI Medicaid, all appeals submitted on paper, in
person, or over the phone (to the contact centered administered by the RIHBE) shall be
documented within the available electronic appeals database.

For appeals other than Exchange appeals or appeals related to MAGI Medicaid, when an individual
who has submitted a written request for a hearing does not submit the required information on a
form provided by the state within a seven (7) day period, the state agency representative shall
complete, all applicable sections of the appeal form, attach the written request to the form and
submit it to the appeals officer, electronically or manually. All applicable sections of the state
agency form shall be prepared by the state agency representative and shall be transmitted to the
EOHHS Central Appeals Office, setting forth clearly and concisely the policy on which the
decision at issue was based.

The Appeals office, in consultation with DHS, EOHHS and the RIHBE, will determine the
appropriate office responsible for responding to the appeal.

For all Exchange Appeals, an appropriate representative of the Exchange shall be informed of the
appeal and given the opportunity to respond and appear at the hearing, even for appeals for which
DHS is the primary agency responsible for responding to the appeal.

0110.30.20—Advance Notice Period
REV: 08/2013

If a request for a fair hearing is made within the 10-day advance notice period the appropriate state
agency shall assist the individual understanding the implications of continuing to receive the
current amount of cash assistance, Medical Assistance, and/or food assistance until a hearing
decision is made. Only at the applicant/recipient’s specific request shall the agency representative
discontinue such assistance.

The date on which the notice is received is considered to be five (5) days after the date on the
notice, unless the beneficiary shows that he or she did not receive the notice within the 5-day
period.

The applicant/recipient may indicate the request for discontinuance of RIW, Medicaid, and/or
SNAP, or continuance of GPA, as appropriate, in either Section II of the DHS-121 or Section I of
the INRHODES Request for Hearing together with the recipient’s statement of complaint. This
section must be signed by the recipient. When an individual requests a hearing via the DHS-121F to
contest an administrative lien, the lien on the bank account, insurance settlement or real property
shall remain in full force and effect until the hearing decision is rendered.

When a hearing is requested after the advance notice period, the agency action being challenged is completed and remains in force until the decision is altered or reversed at the hearing, or is changed by another change in circumstances relating to the individual’s assistance or services.

Unless the recipient requests the discontinuance of his/her assistance, such assistance shall be continued until a hearing decision is rendered, unless:

- A determination is made at the hearing that the sole issue is one of state or federal law or policy or change in state or federal law and not one of incorrect computation of the assistance payment; or

- Another change affecting the individual’s assistance or services occurs while the hearing decision is pending and the individual fails to request a hearing on the second issue after notice of that change;

- The individual withdraws his or her appeal; or

- The assistance affected by the aggrieved action is Supportive Services and/or Child Care Services.

**Hearing Requests Related to General Public Assistance**

For fair hearing requests pertaining to General Public Assistance, a written request for hearing shall be made within the 10 day advance notice period and shall be accompanied by or include a written request for continuation of GPA to stay the reduction, suspension, or discontinuance until the fair hearing decision is issued. Only at the applicant/recipient’s specific written request shall the state agency representative continue GPA benefits.

If the recipient requests the continuance of his/her GPA, such assistance may be continued, except in the following instances:

- A determination is made at the hearing that the sole issue is one of state law or policy or change in state law and not one of incorrect computation of the assistance payment; or

- Another change affecting the individual’s assistance occurs while the hearing decision is pending and the individual fails to request a hearing on the second issue after notice of that change.

**Rights of the Individual**

**REV: 08/2013**

The individual shall be informed of his/her right to be represented by legal counsel and/or such witnesses as s/he may deem necessary to support the appeal. The state agency representative shall assist the individual to obtain legal services, if desired, by helping him/her to arrange an appointment with available community resources, such as Rhode Island Legal Services.
The individual shall be informed that s/he is given opportunity and time to examine documents and records used at the hearing, at a reasonable time before the hearing, and during the hearing.

The individual shall be informed of his/her right to: present his/her own case or enlist the aid of an authorized representative to present a case on his or her behalf; to bring witnesses; to establish pertinent facts and circumstances; to advance arguments without undue interference; and, during the hearing, to question or refute any testimony or evidence including opportunity to confront and cross-examine adverse witnesses.

The individual shall be informed of his/her right to judicial review if dissatisfied with the hearing decision.

For appeals related to programs administered by the RIHBE, the individual shall be informed of his/her right to appeal to the federal Department of Health and Human Services, if dissatisfied with the hearing decision.

For appeals related to MAGI Medicaid and to programs administered by the RIHBE, the individual shall be informed that an appeal decision for one household member may result in eligibility re-determination for other household members.

0110.30.30 Expedited Appeals

REV: 08/2013

For appeals relating to Medicaid benefits or benefits for RIHBE-administered programs relating to health insurance coverage, the appellant may request an expedited appeals process in circumstances where there is immediate need for health services such that a routine appeal could seriously jeopardize the appellant’s life, health, or ability to attain, maintain, or regain maximum function.

If an expedited appeal is granted by the EOHHS appeals office in its reasonable discretion, the hearing shall be expeditiously scheduled and the decision shall be issued without undue delay, taking into account the circumstances of appellant's medical condition and the extent to which a favorable hearing outcome may impact treatment and/or the favorable outcome such treatment.

If an expedited appeal is denied, the EOHHS appeals office shall notify the appellant without undue delay by telephone or other commonly available electronic media as provided by the applicant/recipient, to be followed in writing, of the denial of the request to expedite the appeal. If a request to expedite an appeal is denied, such an outcome shall not delay the timeline for a hearing and the appeal shall be handled through the standard appeal process.

0110.30.35 Special Procedures for SHOP Appeals

08/2013

For appeals related to the SHOP Exchange in accordance with 45 C.F.R. 155.740, whether filed by an employer or employee, the appellant shall have the right to request a "desk review" by the hearing officer in lieu of an in person hearing. A “desk review” means the hearing officer reviews
written submissions and evidence from the appellant and any appropriate state agency representative(s) and issues a decision based on same.

In order to request a desk review, the appellant shall notify the EOHHS appeals office or the RIHBE call center in advance and as follows:

- If the hearing has already been scheduled, this advance notice shall be given no less than five business days before the scheduled hearing. In such cases, the written submissions shall be due on the day the hearing would have occurred.

- If the hearing has not yet been scheduled, the appellant may request the desk review at any time, and the written submissions shall be due within ten (10) days of such request or at such other deadline to be agreed between the appellant and the EOHHS Central Appeals Office.

Upon requesting a desk review, the appellant forfeits his/her opportunity for an in-person hearing.

0110.35 Hearing Office Action

When an appeal is submitted through any of the methods described in 0110.20 above, the EOHHS Central Appeals Office schedules the date, time, and place of the hearing. A hearing is generally held at the central, regional or field office, in an individual’s home, or telephonically when circumstances require. Hearings related to programs administered by the RIHBE shall be held at either the central EOHHS office or the offices of the Rhode Island Department of Administration.

Official notice of the hearing shall be sent to all parties involved at least ten (10) days before the scheduled hearing date.

The individual shall be notified in writing at their last known address of the hearing date, time, and location, and the written notice shall include basic information about the hearing process.

If an individual chooses to have legal representation at the hearing (e.g., be represented by an attorney, paralegal, or legal assistant) the representative shall file a written Entry of Appearance with the EOHHS Central Appeals Office at or before the hearing. The Entry of Appearance shall act as a release of confidential information, allowing the legal representative access to the agency case record. (See DHS Manual Section 0102 regarding confidentiality of information.) The Entry of Appearance is also needed for the EOHHS Appeals Office to confirm the representation for purposes of follow-up, review, requests for continuances, etc.

The state agency representative whose decision is being appealed shall receive information about the appeal in advance, including a copy of the Form DHS-121B, Form OHHS-121, and/or the completed Form DHS-121 if available.

Evidence submitted at hearings shall be made available to all parties, including agency representatives. Final hearing decisions, with confidential contents redacted, shall be made available to the public. All participants shall be promptly notified if the demands of the state agency and/or the convenience of the individual make a postponement or other adjustment in the date,
0110.40—Continuances and/or Abandonment of the Hearing Request

REV: 08/2013

If an individual wishes to continue the request for a hearing and reschedule, s/he must call the EOHHS Central Appeals Office or, for appeals related to MAGI Medicaid or programs administered by the RIHBE, call the RIHBE contact center before the time of the hearing. No more than three (3) requests for continuances shall be permitted, unless the EOHHS Appeals Office exercises its discretion to allow more than three continuances after a demonstration of good cause. A SNAP household may request and receive a postponement in accordance with the Department of Human Services’ Food Stamp Manual, Section 1032.10.05, “Household Request for Postponement.”

A hearing request may be denied or dismissed when it is determined that it has been abandoned. Abandonment may occur when, without good cause, an individual or her/his authorized representative fails to appear at a hearing.

If the individual (or authorized representative) does not appear and has not notified the EOHHS Central Appeals Office (or the contact center administered by the RIHBE, for Exchange Appeals or appeals related to MAGI Medicaid) prior to the hearing to request a continuance or report that s/he is unable to appear, the individual shall be notified, in writing, that the hearing request is considered abandoned.

The written notice shall advise the claimant/legal representative to contact the EOHHS Central Appeals Office within ten (10) days if s/he wishes to reschedule the hearing and can demonstrate good cause (as described in Section 0110.40.05 as below) for failing to keep the appointment.

0110.40.05—Good Cause for Failure to Appear at Hearing

REV: 08/2013

A hearing shall not be considered abandoned as long as the individual has either: 1) requested a postponement or continuance before the time of the hearing, or 2) notified the EOHHS Central Appeals Office (or the contact center administered by the RIHBE, for Exchange Appeals or appeals related to MAGI Medicaid) prior to the hearing that s/he is unable to keep the appointment and still wishes a hearing.

Staff should assist the claimant in the establishment of good cause, and when necessary, forward determining information to the hearing officer.

Good cause for failure to attend a hearing shall be liberally interpreted in the claimant’s favor and shall include, but shall not be limited to:

- Sudden and unexpected event (such as loss or breakdown of transportation, illness or injury, or other events beyond the individual’s control) which prevents the individual’s appearance at the hearing at the designated time and place; or appearance at the wrong office.
Disabilities, such as linguistic and behavioral health limitations, that may impact the claimant’s ability to attend.

Injury or illness of claimant or household member that reasonably prohibits the individual from attending the hearing.

Death in family.

If the hearing officer determines that good cause exists, the hearing shall be rescheduled. The benefit shall be reinstated without undue delay in the event it was terminated because of the abandonment.

**0110.45 Time Limits in the Hearing Process**

REV: 08/2013

It is the intention of the state agency to meet requests for hearings promptly. The hearing process, therefore, is subject to the following time schedule:

- A hearing regarding Long Term Care Medicaid, requested pursuant to section 0380.40.35, shall be scheduled within thirty (30) days of receipt by the agency of a written request for a hearing.

- The claimant and all interested parties shall be given at least ten days notice, in writing, of the date, time, and place of the hearing (e.g., through the DHS-121B or other scheduling notice).

- The entire hearing process, including the reporting of an action required to make the decision effective, shall be completed, whenever possible, within thirty (30) days of the receipt of a request, but in no case shall exceed a maximum of ninety (90) days, unless the individual requests in writing a delay to prepare his/her case.

- In food assistance hearings, final administrative action shall not be any later than sixty (60) days from the date of the hearing request.

**0110.50 The Appeals Officer**

REV: 08/2013

The hearing shall be convened by an impartial designee of the Secretary of EOHHS. No person who has participated in the pertinent matter under review shall be eligible to serve as an appeals officer.

The appeals officer shall endeavor to bring out all relevant facts bearing on the individual’s
situation at the time of the questioned state agency action or inaction and on state agency policies pertinent to the issue. The hearing shall not be closed until the appeals officer is satisfied that all interested parties have had the opportunity to present the facts needed for a decision.

0110.55 The Hearing Procedure

REV: 08/2013

The hearing shall be recorded. Any person who testifies at the hearing shall be sworn in by the appeals officer. An orderly procedure shall be followed that includes no less than the following:

- A statement by the appeals officer reviewing the state agency’s purpose relative to the hearing; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made, and the manner in which the individual is informed of the decision.

- A statement by the claimant (or his/her authorized representative) outlining his/her understanding of the problem at issue.

- A statement by the state agency representative, setting forth the state agency’s policies under which action was taken or denied.

- A full and open discussion of all facts and policies at issue by participants under the active leadership of the appeals officer.

The hearing may be adjourned from day to day or to a designated day when either the appeals officer and/or the individual needs time to obtain further information.

0110.55.05 Admissible Information

REV: 08/2013

Only information bearing directly on the issue under review and the supporting policy may be introduced from agency records. The appeals officer shall not review any information that is not made available to all interested parties.

Ex Parte Communications

"Ex Parte" communications means a discussion, correspondence or contact regarding a contested case between the administrative hearing officer and a party to a contested case, or a non-party who has an interest in the outcome of the case, without all parties being present to such communication. Communications for the purpose of scheduling and other administrative functions shall not be considered ex parte.

No person who is a party to or a participant in any proceeding before the state agency, or the party's counsel, employee, agent, or any other individual, acting on the party's or their
own or another's behalf, shall communicate *ex parte* with the administrative hearing officer about or in any way related to the proceeding; and the administrative hearing officer shall not request or entertain any such *ex parte* communications. The prohibitions contained above do not apply to those communications which relate solely to general matters of procedure and scheduling.

**Evidence after Completion.** No evidence shall be admitted after completion of a hearing or after a case submitted on the record, unless the administrative hearing officer reopens the hearing or the parties agree to the submission, and all the parties have been notified of said reopening.

The administrative hearing officer shall not review any records or evidence that has not been introduced at the hearing.

### 0110.55.10 — Hearing Attendance

**REV: 08/2013**

Attendance at hearings shall be restricted to individuals directly concerned with the issue(s), including the appellant's chosen representative, if any, and the appeals officer. If, at any time, the appeals officer finds that the number or the conduct of persons in attendance limits or prevents an orderly process to the hearing of the complaint, s/he may adjourn the hearing and reschedule it at a later date and time.

A representative of DHS or the RIHBE, or one from each agency, as appropriate in accordance with Section 0110.30.15 above, shall attend the hearing prepared to answer questions pertinent to the appropriate agency’s decision. With respect to DHS representatives, an appropriate supervisory person shall endorse the findings. The state agency representative(s) shall have the obligation to secure, if possible, the attendance of all persons who were involved in the relevant action under appeal.

### 0110.55.15 — Right to Legal Counsel

**REV: 08/2013**

The individual shall be informed at all times of his/her right to legal counsel in the preparation and/or presentation of his/her complaint, and the accessibility of such counsel through Rhode Island Legal Services and other community resources, as applicable.

If the individual chooses to have legal representation, e.g., be represented by an attorney, paralegal, or legal assistant, the representative must file a written Entry of Appearance with the Hearing Office at or before the hearing. The Entry of Appearance acts as a release of confidential information, allowing the legal representative access to the agency case record. (See DHS Manual Section 0102 General Provisions and all applicable federal and state statutes and regulations regarding confidentiality of information.) The Entry of Appearance is also needed for the Appeals Office for purposes of follow-up, review, requests for continuances,
0110.55.20—Medical Assessment
REV: 08/2013

When the hearing involves medical issues such as those concerning a diagnosis, an examining physician’s report, or a medical review team’s decision, a medical assessment from someone other than the person or persons involved in the original decision, shall be obtained, at state agency expense, and made part of the hearing record, if the appeals officer considers it necessary.

0110.55.25—The Hearing Record
REV: 08/2013

The recording, together with all papers and documents introduced, shall constitute the complete and exclusive record for the decision. This record shall be available to the individual or his/her representative(s), within a reasonable time.

0110.60—The Hearing Decision
REV: 08/2013

The full responsibility of the state agency in the hearing process shall be discharged only when a definite decision has been made, in writing, by the EOHHS appeals officer and the required action, if any, is carried out. No adjournment for further information limits the EOHHS appeals officer’s responsibility to make such a final decision.

Any decision in favor of the individual shall apply retroactively to the date of the incorrect action, except as provided below. All decisions made in the hearing process shall be binding upon all state agency personnel who have responsibility for carrying them out.

In the case of appeals decisions where retroactive application could lead to financial liability for the appellant, for example if the appellant would owe premiums for the retroactive months of health insurance, the appeals office shall allow the appellant to elect whether the decision shall be effective retroactively or prospectively.

0110.60.05—Discharge of the Hearing Responsibility
REV: 08/2013

The hearing responsibility shall not be considered discharged until the following steps have been taken:

- A written decision, based exclusively on evidence and other material introduced at the
hearing, has been rendered, on behalf of the state agency, by the person who conducted the hearing.

- Copies of the decision, setting forth the issue, the relevant facts brought out at the hearing, the pertinent provisions in the law and state agency policy, and the reasoning which led to the decision, have been sent to the individual, the staff member involved, and the appropriate supervisor, and other agencies as appropriate (for Exchange Appeals, a copy of the decision must be sent to a representative of the Exchange); and

- Action required by the decision, if any, has been completed by the state agency representative and confirmed in writing to the EOHHS Central Appeals Office.

For appeals relating to programs administered by the RIHBE, the individual shall be notified of his or her right to make an appeal request to the federal Department of Health and Human Services within thirty (30) days of the notice of decision.

The individual shall also be notified of the right to seek judicial review. Appeal to the federal Department of Health and Human Services shall not be a prerequisite for seeking judicial review unless or until a court with appropriate jurisdiction finds otherwise.

Decisions related to an award or level of advance premium tax credits shall include a plain-language statement that the final calculation of tax credits is conducted by the federal Internal Revenue Service (IRS) through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue Code, and that decisions or interpretations of the EOHHS appeals office are not binding against the IRS during that process.

0110.70—Public Access to Hearing Decisions

REV: 08/2013

EOHHS hearing decisions rendered in accordance with its record retention schedule are available for examination at the Hearing Office, Hazard Building, 74 West Road, Cranston, Rhode Island, between the hours of 9:00 A.M. to 11:00 A.M. and 1:00 P.M. to 3:00 P.M., Monday through Friday. An index of decisions is available to facilitate this examination. EOHHS may, at their discretion, make hearing decisions available on a publicly accessible website in lieu of or in addition to making them available at their offices.

0110.75—OCSS Quarterly Notice and Hearing Procedures

REV: 08/2013

The Office of Child Support Services (OCSS) shall provide a quarterly notice (computer generated) to RIW recipients and non-recipients for whom a child support obligation has been established and for whom a child support collection has been made.
The quarterly notice shall specify, at a minimum, the amount of support paid, the date such payment was made, the date such payment was received by DHS or R.I. Family Court, the date and amount of pass-through and/or child support paid to the applicant/recipient, and an explanation of the recipient’s rights to a hearing which shall be requested within 30 days of the date of the notice. When a pass-through payment is not sent to a recipient in a particular month, the quarterly notice shall include an explanation as to why it was not made. A hearing request form shall be enclosed with the quarterly notice.

The following shall constitute the OCSS hearing procedure:

1. The recipient of the quarterly notice will mail the request form to the OCSS Accounting office, 77 Dorrance Street, Providence, RI 02903. The form will be date stamped and logged in a central location by the business office. The Business Agent shall research the records to determine all pass-through payments made for the months the recipient was on RIW (if applicable). In most cases it will not be necessary to refer the matter to obtain the RIW payroll card because the recent RIW on/off dates are on the IV-A system to which the agents have access. The agent shall refer the hearing request form packet to the legal unit for scheduling of a hearing indicating in their log the date the matter was so referred.

2. Clerical staff shall date stamp the packet, log the case in a central log and schedule the matter for hearing. A notice shall be mailed to the applicant/recipient advising him/her of the hearing date. Notice of scheduled hearings shall be given to the business office on a weekly schedule.

The hearing shall be conducted in the same manner as the income tax intercept hearings. The business officer or other OCSS representative shall be present and shall be available to answer the applicant/recipient’s relevant questions relating to the information provided to the applicant/recipient in the quarterly notice. The applicant/recipient shall then have an opportunity to present why s/he believes s/he should have received a child support payment and/or pass-through in a given month. The business officer or other OCSS representative shall then be given an opportunity to respond by presenting testimony and/or evidence with respect to the child support and/or pass-through payments and periods contested by the applicant/recipient.

The hearing officer may, in his or her discretion, grant a continuance to any party for good cause shown, including, but not limited to, a party’s reasonable request to obtain, review, and present additional relevant evidence. The applicant/recipient shall be advised s/he will receive a written decision by mail within 30 days following the close of the hearing. The hearing officer shall prepare a decision letter. The original shall be sent to the applicant/recipient, with copies to his/her representative, masterfile, hearing file, and business office.

Any person who has exhausted all available administrative remedies and who is aggrieved by
a final order of the state agency shall be entitled to judicial review pursuant to Section 42-35-15 of the R.I. General Laws, as amended.

If an applicant/recipient appeals the decision of the hearing officer to the Family Court, the hearing officer shall be responsible to obtain a transcript of the hearing, assemble the evidence (Exhibits) and forward the material to the Chief Legal Counsel, OCSS.

September 10, 2015
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