Medicaid Pathways to Healthcare Coverage

for

Working Adults with Developmental Disabilities

Web Site: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Sherlock%20Plan%20Guide.pdf

In an effort to provide information for working individuals with a Developmental Disability, the following guide can be utilized by professionals and advocacy groups to assist individuals and families regarding the impact of work and healthcare coverage. While this guide may not answer all questions, it does give an overview of the programs, eligibility requirements, and the covered services. Individuals and families involved with receiving Medicaid funded services through the Department of Disabilities can also contact their social worker to assist in answering questions about Medicaid pathways to healthcare coverage.

The guide is a collaborative effort among several state agencies and consumer advocacy groups committed to allaying fears and concerns associated with the impact of work on healthcare coverage; Medicaid benefits; keeping earned income; and high costs of care.

Participating Contributors:

The Community Provider Network of Rhode Island

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH)

The Executive Office of Health and Human Services

The Office of Rehabilitation Services/ Vocational Rehabilitation and Benefits Specialist

The Paul V. Sherlock Center on Disabilities

The Rhode Island Developmental Disability Council

This guide can be viewed on the Executive Office of Health and Humans Services web site of http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/Sherlock%20Plan%20Guide.pdf

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I-Medicaid Pathways

It is common for individuals with Developmental Disabilities, their family members and professionals, to have concerns about the impact of work on Medicaid coverage, cost of care and the individual's earned income. The following two **Medicaid Pathways** provides information that allows one to work; maintain coverage; and maintain earned income.

Medicaid Pathway #1:

SHERLOCK PLAN/ Medicaid for Working People with Disabilities Program, sometimes referred to as the Medicaid Buy-in Program.

Program Description:
The Sherlock Plan is a Medicaid Buy-In Program for working adults with disabilities that provides comprehensive health coverage. The program is intended to help individuals with disabilities maintain or obtain health coverage and other services and supports that will enable them to maintain employment. There may be a monthly premium.
If an individual is offered employer-based coverage that is cost-effective, the individual may be required to enroll in that plan.

*** The premiums and income information provided in this document are those that are current for the year 2014 and may change in following years.

Application Process/How to apply for the Sherlock Plan:

Option 1: You may call 401-462-2354 if you think you may be eligible. If it appears likely that you may qualify, staff will direct you to your local Department of Human Services Office. You may then call or visit this office to obtain an application. Once the application is completed, return it to this office in person or by mail.

Option 2: You may obtain an application online. Go to the DHS web site, which is www.dhs.ri.gov . First click on **Forms and Applications** and then on **Medical Assistance Application**, then click on the form labeled **DHS-2**. Please note that the words **Sherlock Plan** do not appear on the application. The application is labeled **DHS-2** and it is entitled **Statement of Need.** Print out the application, complete it, and mail or deliver it to your local DHS office. The DHS Office locations can also be found at www.dhs.ri.gov.

You may wish to include a note indicating that you are interested in applying for the Sherlock Plan.
For further information, please refer to the following web site:
http://www.sos.ri.gov/documents/archives/regdocs/released/pdf/EOHHS/7792.pdf

Important Questions:

1) **Who is Eligible?**
   - Persons age 18 years or older;
   - A person with a disability - per Medicaid or Social Security Administration (SSA) definition;
   - Must be employed; no minimum amount of hours is required;
   - Income: Single person's countable earned net income up to $**2,431**[1] per month. Spousal income is not counted for eligibility purposes;
   - Resources: limited to $10,000 for an individual and $20,000 for a couple; Medical savings accounts or retirement accounts are not counted as a resource; approved items that are necessary for an individual to remain employed are not counted as a resource (i.e., wheelchair accessible van).
2) **How long will it take to process an application?**
   - In general, eligibility determinations are made within one month. However, federal guidelines provide States with 90 days to determine if the individual is eligible for the Sherlock Plan.
   - A letter will be mailed to the identified responsible party with a notification of the eligibility determination.

3) **What is needed to apply?**
   - A comprehensive list is provided on page 3 of the form titled **Statement of Need.**
   - Most important items are photo identification or proof of identity; proof of last date worked and **most recent month's verification of earned income**, an earning statement; any information on assets; award letter(s) or proof of social security, SSI.
   - Specific to individuals with Developmental Disabilities: If you have a developmental disability, you may be able to work without a cost of care requirement and may not need the Sherlock Plan. This is because some of your income may be disregarded (not counted) due to a special therapeutic income rule. When you begin working, you should complete a form entitled *"The Department of Behavioral Healthcare, Disabilities and Hospitals' Integrated Community Employment Income Disregard Form."* **This form may be obtained from your provider or your Developmental Disabilities worker.**

4) **Why would I apply?**
   - The Sherlock Plan allows people to maintain comprehensive healthcare coverage that they may be at risk of losing as their income increase.
   - Eligibility is reviewed annually without submission of Medical bills.

5) **Do I have to pay a premium?**
   - There is a monthly premium if your total household income is over a certain amount. The premium amount is determined based on the applicant's earned income as well

[1] Calculation for counted earned net income is calculated on a case by case basis and an individual dollar amount is calculated for each case.

as a spouse's income. Additionally, any unearned income, such as Social Security payments is applied.

- Currently Premiums are based on Federal Poverty Limit (FPL) guidelines[2]:
  - $0 for a household of one whose total monthly income is less than 150% of the Federal Poverty Limit (FPL) or **$1,458.75 in year 2014.**
  - $61 a month for a household of one whose total monthly income is greater than 150% of the FPL, **$1,458.75**, but less than 185% of the FPL, or **$1,799.13** in year 2014.
  - $77 a month for a household of one whose total monthly income is greater than 185% of the FPL, **$1,799.13**, but less than 200% of the FPL, or $**1,945** in year 2014.
  - $92 a month for a household of one whose total monthly income is greater than 200% of FPL. **$1,945** and less than 250 **% $2,431.25 in year 2014.**

6) How much money can I save before my ability to be eligible for Medicaid is affected?

- When your financial resources or assets exceed $10,000 for an individual and $20,000 for a couple, your Medicaid coverage can be affected.
- Your Medicaid Coverage can also be affected if you exceed the monthly net earned income limit of $**2,431**[3]. It is the responsibility of the individual to **report any changes of income or resources** to the local Department of Human Services Office.

7) How will I know when there is a change to my benefit or I have to pay more of a premium?

- When you report a change in your income, the Department of Human Services will notify you of any change. (This is noted in the application).

8) How often does my application get reviewed?

- Eligibility is determined once a year or upon receipt of new information.

9) How long can I be on the Sherlock Plan?

- You may be on the Sherlock Plan as long as you remain employed, are considered a person with a qualifying disability and your income and assets do not exceed the limits for your individual living arrangement.
- **If employment is lost or terminated the individual remains on the Sherlock Plan for four months, as long as the premium is paid.**
- If you anticipate any change to your income, assets or living situation, you should contact **401-462-2354** and we will help you figure out how it will affect your eligibility.

[2] Please note that income information and dollar amounts provided in this document are those that are current for the year 2014 and may change in following years.

[3] Calculation for counted earned net income is calculated on a case by case basis and an individual dollar amount is calculated for each case.

Medicaid Pathway #2:

I- INTEGRATED COMMUNITY EMPLOYMENT INCOME DISREGARD FORM (ICE-ID)

The **form** and the **instructions** for completing the form can be found at:

Link to form and instructions for sending encrypted e-mail:
http://www.bhddh.ri.gov/ddd/providers.php or
http://www.riemploymentfirst.ri.gov/participants/iceemployment.php

Specific to individuals with Developmental Disabilities:

If you have a developmental disability you may be able to work without a cost of care requirement and may not need the Sherlock Plan. This is because some of your income may be disregarded (not counted) due to a special therapeutic income rule. When you begin working, you should complete a form entitled *"The Department of Behavioral Healthcare, Disabilities and Hospitals' Integrated Community Employment Income Disregard Form."* **This form may be obtained from your provider or your Developmental Disabilities worker.**

1) What does this mean for you?

When you become employed you should ask the agency that is providing you employment services or your fiscal intermediary to complete an Integrated Community Employment Income Disregard form. Submitting the ICE-ID form may allow DHS to disregard, most if not all of your earned income so that you will pay little or nothing for your cost of care.

2) What are the benefits:

- No impact on Medicaid; Medicaid coverage is maintained
- Money earned can be kept by the individual
- Money earned goes to the individual and not towards the portion of your cost of care

3) What is it?

Integrated Community Employment Income- Wages earned by an adult individual receiving Medicaid funded services through the Developmental Disabilities system in accordance with their Individual Service Plan.

Integrated Community Employment Income Deduction- Wages subtracted from the total gross income of the individual in the calculation of applied income (sometimes referred to as the "share").

4) How to get the deduction?

The DD provider or fiscal intermediary agency submits a completed ICE-ID form and a copy of the individual's paystubs for a one (1) month period to the following:

- Individual's BHDDH-DD social worker
- The DHS Long Term Care office.

DD provider(s) or fiscal intermediary will need to submit a **new form** when:

1. A person begins receiving supported employment services.
2. A person obtains or changes employment.

DD provider(s) or fiscal intermediary submits **updates to the form** in the following circumstances:

1. The person has a change in employment hours.
2. The person has an increase or decrease in pay.

5) When to submit the ICE-ID form?

DD provider(s) or fiscal intermediary who coordinates their care must submit the completed ICE-ID form for an individual when:

- The individual starts or stops working
- Significant change in wage
- When the person changes place of employment

6) Where to send your Integrated Community Employment Income Disregard Form (ICE-ID)?

CRANSTON FAX 462-3034

For the following areas: Charlestown, Coventry, Cranston, East Greenwich, Exeter, Foster, Hopkinton, Johnston, Narragansett, New Shoreham (Block Island), North Kingstown, Richmond, Scituate, South Kingstown, Warwick, West Greenwich, West Warwick, Westerly

EAST PROVIDENCE FAX 415-8421

For the following areas: Barrington, Central Falls, East Providence, Pawtucket, Warren

MIDDLETOWN FAX 851-2110

For the following areas: Bristol, Jamestown, Little Compton, Middletown, Newport, Portsmouth, Tiverton

PROVIDENCE FAX 415-8422

For the following areas: North Providence, Providence

WOONSOCKET FAX 235-6238

For the following areas: Burrillville, Cumberland, Glocester, Lincoln, North Smithfield, Smithfield, Woonsocket

*****This form must be faxed to the correct office noted above and a copy mailed to your BHDDH Social Worker*****

II-Cost of Care

The calculation of a cost-of-care and the collection of the payment apply to all individuals seeking Medicaid-funded long-term services and supports. Cost of care applies to people whether they are living in the community or in a setting that is not considered community-based, such as a nursing home. Having individuals pay a cost-of-care enables the State to provide Medicaid-funded long-term services and supports to individuals who might not otherwise meet the Medicaid income standards. When a person's income is higher than Medicaid long-term care income limits, an amount that the individual needs to pay every month is calculated and determined to be the cost-of-care.

As a result of this payment, the client is able to meet Medicaid eligibility requirements and Medicaid-funded long-term care services are available. The intent of the cost-of-care is to increase access to Medicaid-funded long-term services and supports.

Calculations on Cost of Care are done by the Department of Human Services Long Term Care Offices. Allowable deductions are the following[4]:

- $992.50, Maintenance Needs Allowance for Categorically Needy Individual (annually adjusted)
- $104.50, Medicare premium deduction
- Gross wage/therapeutic income (individual's earned income)
- Not eligible for therapeutic deduction. Client is medically needy eligible as income is over the Federal Cap ($2163.) Maintenance Needs Allowance is $878**.

Concerns or issues regarding calculations done by the Long Term Care Office can be addressed by contacting the Long Term Care Worker's office where the information was submitted.

[4] Please note that income information and dollar amounts provided in this document are those that are current for the year 2014 and may change in following years.

III-Guidelines to choose the Sherlock Plan or the Integrated Community Employment Income Disregard Form

- Those with combined unearned and earned income over $2163[5] do not qualify for the therapeutic deduction or submission of the Integrated Community Employment Disregard Form
- Initiate **review** for Sherlock Plan when combined earned and unearned income is over $2163[6] and/or recipient has a concern about **cost of care**.

If the individual or family member has other concerns, additional resources to help with choice are:

- Contact your DD social worker
- Contact your DD Provider(s) or Fiscal Intermediary
- Contact the Work Incentive Planning and Assistance Program (WIPA) at 462-7902
- Call the Recipient Resolution Unit of the Executive Office of Health and Human Services at 462-2354

[5] Please note that income information and dollar amounts provided in this document are those that are current for the year 2014 and may change in following years.
[6] Ibid.

IV-Frequently Asked Questions

Sherlock Plan

1) When applying for Sherlock or submitting the ICE-ID forms, should I continue to pay my cost of Care?

Answer: Yes. No retroactive changes will be made to the cost of care. After all necessary paperwork is submitted and reviewed; the change will be made to the cost of care and or premium in the next month.

2) If an individual having a cost of care due to income decides to go with the Sherlock Plan, what is the best way for the DD SCW to notify DHS?

Answer: After having an informed discussion with the individual about the option of being able to choose either program, the DD social worker (SCW) can send the Long Term Worker (LTC) a CP-30A or page 1 of the DHS *"Application for Assistance*", signed by the individual indicating the choice of Sherlock if he/she chooses this option. (The CP-30A form is an internal communication/interagency form between the DHS Long Term Care Worker and the DD social worker)

3) What are premiums for Sherlock based on?

Answer: Premiums for Sherlock are based on EARNED and unearned income of the individual. Also premiums can be based on spouse's income if applicable. They are also based on Federal Poverty Levels. Here are the current 2014 premiums[7]:

- $0 for a household of one whose total monthly income is less than 150% of the Federal Poverty Limit (FPL) or **$1,458.75 in year 2014.**
- $61 a month for a household of one whose total monthly income is greater than 150% of the FPL, **$1,458.75**, but less than 185% of the FPL, or **$1,799.13** in year 2014.
- $77 a month for a household of one whose total monthly income is greater than 185% of the FPL, **$1,799.13**, but less than 200% of the FPL, or **$1,945.00** in year 2014.
- $92 a month for a household of one whose total monthly income is greater than 200% of FPL. **$1,945.00** and less than 250 **% $2,431.25 in year 2014.**

[7] Please note that income information and dollar amounts provided in this document are those that are current for the year 2014 and may change in following years.

4) What is the Sherlock premium when employment is lost or terminated?

Answer: The premium that has been calculated stays in effect for 4 months if no other employment has been obtained. The individual remains on the Sherlock Plan for the four months, as long as the premium is made.

INTEGRATED COMMUNITY EMPLOYMENT INCOME DISREGARD FORM (ICE-ID)

1) What would cause delays in the processing of the ICE-ID forms?

Answer: Delays will occur if the wage income and recertification has not been updated in the last year. Eligibility technicians will have delays in calculating the appropriate cost of care without the most recent information that includes monthly wage verification.

2) Many folks with ID/DD work part time and their hours are constantly changing. Does this mean they should submit a monthly ICE-ID form and paystubs?

Answer: In order to calculate a month's earnings, a month's verification of earnings is needed. A notation can be made on the ICE-ID form to indicate the hours vary each week. DHS would only need a new ICE-ID form and new pay stubs if there was a significant change in the number of average hours worked over the course of the month or if the person terminated employment. The wage information is used to calculate the applied income/cost of care for subsequent months.

Cost of Care

1) Why do we pay for Cost of Care?

Answer: Rhode Island has the State and Federal Authority. Please see state and federal authority regulations in this document.

2) Who does the individual pay for Cost of Care?

Answer: Payment is made to the Provider.

3) What happens if I do not pay my cost of care?

Answer: You could potentially lose your long term care services.

4) What do I do when I disagree about the calculation for my Cost of Care?

Answer: Contact the DHS Long Term Care worker handling the case. The name of the worker and phone number appears on the notices sent from DHS. If unsure of the worker call the main number for the Long Term Care Office that covers the city/town in which the individual resides. **The individual or responsible party can also follow the Appeals Process as defined in Section V of this document.**

5) How is the cost of care notification made from DHS to BHDDH?

Answer: The CP-30A interagency form will be used as communication for the cost of care, monthly integrated employment disregard and Sherlock Premium. The information will be e-mailed to **bhddh.askdd@bhddh.ri.gov** **or** sent to the DD social worker/supervisor.

6) How will information be communicated to families and clients who do not open or understand their mail with the cost of care communications?

Answer: Awareness and education to DD advocacy groups, such as the Community Provider Network of Rhode Island (CPNRI), The Rhode Island Developmental Disabilities Council, Rhode Island Disability Law Center and Sherlock Center for Disabilities. The following information provides information on when changes occur through the Department of Human Services.

A NEW DHS LETTER/NOTICE is issued when the following occurs:

- **System wide notices** are issued late in December for the following January when there is a Cost of Living Increase (COLA) to Social Security benefit;
- **System wide notices** are issued in March/April if the Categorically Needy Maintenance Needs Allowance changes to reflect change in FPL. (Federal Poverty Level)
- **System wide notices are issued to any standard changes** to the Shelter allowance calculation for married couples. Those individuals that continue to have a $0 cost of care **are not issued new notices.**
- **Any time a Manual change is done by the** long term care worker to the Cost of Care calculation as a result of new information. (Other examples: Annual recertification changes, ICE-ID receipt for change to Income Disregard)

Also BHDDH, as part of the annual Individualized Service Plan (ISP) process will inform families of the cost of care that may be paid to the provider on a monthly basis. Page eight (8) of the ISP communicates this issue:

I, "Participant", or my representative understand and agree with the following:

If the RI Department of Human Services or Department of Behavioral Healthcare, Developmental Disabilities & Hospitals notifies me that as part of my Waiver eligibility and per Medicaid regulation I am required to contribute to the cost of my supports, I understand and agree to pay this amount to the Agency each month. I also agree to disclose to the "Agency/DDO" my earned and unearned income when requested.

7) If I receive SSI will I have a cost of care?

Answer: No. Cost of Care is $0 for SSI recipients.

V-State and Federal Authority and Rhode Island Appeals Process

The State of Rhode Island has State and Federal Authority to implement Cost of Care regulations. The following are the current regulations used by the state. Federal and State regulations are subject to change. The State regulation process provides public comment for any rule changes.

Similarly, Rhode Island also has an appeals process that is in state regulation.

State Authority

0392.15 INCOME APPLIED TO COST OF CARE

REV: 06/1994

For each month in which Medical Assistance is requested to pay for the individual's institutional care, the individual must contribute his/her income to pay for institutional services, deducting only certain allowable amounts. The individual's income remaining after allowable deductions is paid to the institution as his/her contribution to the cost of the institutional care. Such income is known as APPLIED INCOME. The Medical Assistance payment to the institution is reduced by the applied income amount.

The calculation of applied income starts with the individual's gross income, which includes the deduction and disregards amounts which were subtracted from gross income in the determination of eligibility. To determine applied income, certain allowable deductions are subtracted from the recipient's gross income. The deductions and the order in which they are subtracted from the recipient's gross income are:

Personal Needs Deduction (Regular) or $90 Reduced Pension Deduction;

- Personal Needs Deduction (Expanded);
- Personal Needs Deduction (Guardian and Legal);
- Community Spouse Allowance;
- Community Dependent Allowance;
- Medical Insurance Premiums;
- Medical/Remedial Items;
- Home Maintenance Deduction;

0386.10 TREATMENT OF INCOME

REV: 06/1994

Section 0366 sets forth the treatment of income rules for spouse to spouse deeming of income when both members of a couple live together in the community, and when an ineligible parent lives in the same household with an eligible child under 18. DEEMING STATUS IS CHANGED WHEN AN ELIGIBLE INDIVIDUAL BECOMES INSTITUTIONALIZED.

If an eligible individual moves into a medical facility, deeming stops for the purpose of determining MA eligibility effective with the month following the month of separation.

Eligibility determinations for persons applying for or receiving services under a Waiver are conducted AS IF THE PERSON WERE ACTUALLY INSTITUTIONALIZED. This means that deeming of spousal/parental income does NOT apply after the month of separation due to institutionalization.

0386.15 RECIPIENT INCOME APPLIED TO COST OF CARE

REV: 01/1996

If the institutionalized individual is eligible for MA, either as Categorically Needy or Medically Needy, and Medical Assistance payment is requested for the individual's institutional care expenses, a determination is made regarding the amount of income the institutionalized individual must allocate to his/her cost of share.

0396.15.05 Post-Eligibility Treatment of Income

REV: April 2014
The following is a list of allowable deductions in the order they are to be deducted:

- **Maintenance Needs Allowance**

The Maintenance Needs Allowance is nine hundred and ninety-two dollars and fifty cents ($992.50) per month. This amount is in lieu of the Personal Needs Deduction and the Home Maintenance Deduction available to other institutionalized (non-Waiver) individuals.

For employed individuals eligible under the Waiver for the Developmentally Disabled (Section 0398.10), the Maintenance Needs Allowance is equal to nine hundred and ninety-two dollars and fifty cents ($992.50) plus all gross earned income per month, an amount not to exceed the federal cap. To qualify for this expanded Maintenance Needs Allowance, the individual's employment must be in accordance with the plan of care.

- **Spouse/Dependent Allowance**

This deduction is an allowance for the support of a spouse and any dependents. The basic allowance for a spouse is equal to the monthly medically needy income limit for an individual, less any income of the spouse.

If there are also dependent children to be supported, the Medically Needy Income Limit for the number of children is used.

- **Medical Insurance Premiums**

This deduction is insurance premiums paid by the individual, such as Medicare and Medigap policies such as Blue Cross and Plan 65.

- **Allowable Costs Incurred for Medical or Remedial Care**

This deduction is reasonable costs for medical services recognized under state law but not covered in the scope of the Medicaid Program.

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan worked out with the Case Manager.

0396.15.10 Allowable Income Deductions

REV: April 2014

Beginning with the second (2nd) month in which the individual receives services, income is allocated toward the cost of home-based services in the manner indicated below. The LTC/AS staff will calculate costs for individuals receiving services under the Aged and Disabled Waiver.

0396.15.10.05 Calculation of Income Allocation

REV: 01/2012

From the full gross income of a single individual the following amounts are deducted in order:

- Maintenance Needs Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

Any balance of income remaining after these expenses are deducted is allocated toward the cost of home-based services according to the plan developed with the Case Manager.

*NOTE: To qualify as Medically Needy, an individual must have income within the Medically Needy income limit or incur allowable medical expenses (including the anticipated cost of Waiver services) which exceed the amount of the individual's monthly income which is over the Medically Needy Income Limit.

0396.15.10.10 Individual with Community Spouse/Dependent

REV: 01/2012

When an eligible individual lives with a spouse (or a parent in the case of a child with an ineligible parent), the individual is considered to be a single individual.

The spouse's (or parent's) income is not considered in determining the amount the individual must pay for the cost of services.

Deduct from the applicant's full, gross income the following amounts, in the order presented:

- Maintenance Needs Allowance
- Spousal and Dependent Allowance
- Medical Insurance Premiums
- Allowable Costs Incurred for Medical or Remedial Care.

0396.15.10.15 Medicaid Payment for Waiver Service

REV: April 2014

The Waiver services recipient is responsible to pay the income allocation toward cost of home-based services according to the plan worked out with the Case Manager.

The Medicaid payment for Waiver services is reduced by the amount of the income allocation each month.

Federal Authority

ELECTRONIC CODE OF FEDERAL REGULATIONS

Title 42 → Chapter IV → Subchapter C → Part 435 → Subpart H → §435.726

Title 42: Public Health
PART 435—ELIGIBILITY IN THE STATES, DISTRICT OF COLUMBIA, THE NORTHERN MARIANA ISLANDS, AND AMERICAN SAMOA
Subpart H—Specific Post-Eligibility Financial Requirements for the Categorically Needy

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§435.726 Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

(a) The agency must reduce its payment for home and community-based services provided to an individual specified in paragraph (b) of this section, by the amount that remains after deducting the amounts specified in paragraph (c) of this section from the individual's income.

(b) This section applies to individuals who are eligible for Medicaid under §435.217 and are receiving home and community-based services furnished under a waiver of Medicaid requirements specified in part 441, subpart G or H of this subchapter.

(c) In reducing its payment for home and community-based services, the agency must deduct the following amounts, in the following order, from the individual's total income (including amounts disregarded in determining eligibility):

(1) An amount for the maintenance needs of the individual that the State may set at any level, as long as the following conditions are met:

(i) The deduction amount is based on a reasonable assessment of need.

(ii) The State establishes a maximum deduction amount that will not be exceeded for any individual under the waiver.

(2) For an individual with only a spouse at home, an additional amount for the maintenance needs of the spouse. This amount must be based on a reasonable assessment of need but must not exceed the highest of—

(i) The amount of the income standard used to determine eligibility for SSI for an individual living in his own home, if the agency provides Medicaid only to individuals receiving SSI;

(ii) The amount of the highest income standard, in the appropriate category of age, blindness, or disability, used to determine eligibility for an optional State supplement for an individual in his own home, if the agency provides Medicaid to optional State supplement beneficiaries under §435.230; or

(iii) The amount of the medically needy income standard for one person established under §§435.811 and 435.814, if the agency provides Medicaid under the medically needy coverage option.

(3) For an individual with a family at home, an additional amount for the maintenance needs of the family. This amount must—

(i) Be based on a reasonable assessment of their financial need;

(ii) Be adjusted for the number of family members living in the home; and

(iii) Not exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's AFDC plan or the medically needy income standard established under §435.811 for a family of the same size.

(4) Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including—

(i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and

(ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.

Rhode Island Appeals Process

STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVCES
Statement of Need for Emergency Filing
MEDICAID CODE OF ADMINISTRATIVE RULES
SECTION 0110: COMPLAINTS & HEARINGS

The Executive Office of Health & Human Services (EOHHS) is filing this “emergency” amendment to the Medicaid Code of Administrative Rules, section #0110 “Complaints and Hearings” to clarify the application of "aid pending" requests for Medicaid versus other programs (see section 0110.30.20). Additionally, a specific time frame related to a request for an expedited hearing involving a Medicaid-Medicare overlapping service has been inserted in section 0110.30.30.

The State is adopting these amended rules to set forth these provisions in a timely manner in order to prevent wrongful denial, discontinuance, or interruption of benefits for Medicaid applicants and beneficiaries. These rules will be posted for public review and comment shortly.

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.

0108.15 Application/Awards of Litigation Expenses

REV: 08/2013

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

REV: 08/2013

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
- Medicaid
- MAGI Medicaid: The portion of the Medicaid program with eligibility subject to Modified Adjusted Gross Income ("MAGI"), pursuant to 42 C.F.R. 435.119
- OCSS: Office of Child Support Services
- GPA: General Public Assistance Program
- SS: Social Services Program

• ORS: Office of Rehabilitation Services' Vocational Rehabilitation (VR) Program and Services for the Blind and Visually Impaired (SBVI) Program
• VA: Veterans' Affairs (VA) Program
• DCYF: Department of Children, Youth, and Families programs and services
• DOH: Department of Health (DOH) programs and services
• BHDDH: Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals programs and services
• DEA: Division of Elderly Affairs programs and services.

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:
o A particular decision or delay in a decision rendered by an agency representative;
o The manner in which agency services have been delivered; and/or
o 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.

0110.15 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.

0110.15.05 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.

0110.20 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.

0110.30 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.

0110.30.05 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-I2I (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 The Hearing Request/Advance Notice Period Requirement for the Continuation and/or Reinstatement of Benefits, Services, and/or Assistance Pending an Appeal

REV: 08/2013 September 2014
If a request for a fair hearing is made within the 10 day an advance notice period, following the beneficiary's receipt of the notice of action, the state agency must continue or reinstate the benefits, services, and/or other assistance of an individual or family that has filed an appeal. This is sometimes referred to as “aid pending” an appeal outcome. The appropriate state agency shall in understanding the implications of continuing to receive the current amount of cash benefits, services, and/or other 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.
Unless otherwise indicated in this section, the advance notice period for the above continuation or reinstatement pending hearing is ten (10) days from the date on the notice.
For Medicaid only, the advance notice period is ten (10) days from the date the notice is received by the beneficiary. The date on which the Medicaid 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 withdrawals 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.

0110.30.25 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 September 2014
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 of such treatment.
If an expedited request for hearing involving a Medicaid-Medicare overlapping service is received and approved by the EOHHS appeals office, the expedited appeal must be resolved within three (3) working days from the receipt of the beneficiary's request.
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

REV: 08/2013

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-I2lB, Form OHHS-121, and/or the completed Form DHS-I2l 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, time, and/or place of a hearing necessary.

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-I2IB 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, etc.

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 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, Louis Pasteur Building, 57 Howard Avenue, Cranston, Rhode Island, between the hours of 9:00 A.M. to 11:00 A.M. and l: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:

• 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.

• 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, master file, 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.