HHS Executive Office of Health and Human Services

The Executive Office of Health and Human Services (EOHHS) was created in 2006 (Public Law 2006, Ch. 246, Art. 38, Section 19 and RIGL §42-7.2 et. seq.). EOHHS's main mission is to serve as the principal agency of the Executive Branch of state government for managing four separate state departments: the Department of Human Services, the Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals, the Department of Children, Youth and Families, and the Department of Health. EOHHS also facilitates cooperation and coordination among those state programs that administer Rhode Island's health and social service programs.

The state of Rhode Island has designated the EOHHS as the single state agency to administer the Medicaid Plan.[1] EOHHS currently administers the Medicaid program through five internal offices: Program Integrity, Legal, Budget and Finance, Policy and Innovation, and Healthcare Administration.

The intention of the law establishing EOHHS was to centralize responsibility for health and human services-related administrative, financial and legal services, communication, as well as policy, planning, and information management functions.

EOHHS is also responsible for the state's identification, solicitation, and purchase of various health and human services for various populations, which currently include the elderly, adults with intellectual and physical disabilities, and low income children and their families.[2]

Note: For all record series containing electronic data/records that the Executive Office of Health and Human Services has designated as its official record, including audio, moving images, photographic, and textual records: Retain all documentation of hardware and software for the life of the system. In the event hardware, software or system is updated, upgraded, or replaced, retain old data, documentation, and software until after completion of successful testing of system and verification of data to ensure continuing accuracy, integrity, retrievability, and usability/readability of records through all changes, and to the end of their specified retention period. Commit funds for the overall preservation of data and records through all migration and technological changes for entire retention period.

HHS1 Program Development and Review Records

The records in this section cover those records relating to EOHHS' internal administrative and program development. This series also includes records related to state Medicaid re-design and reinvention initiatives, including studies, reports, and presentations.

Retention: Permanent.
(as per GRS1.1 Correspondence and Memoranda under Executive, High-Level and Policy-Making Records section.)

[1] As health care coverage funded by CHIP (Children's Health Insurance Program) is administered through the State's Medicaid program, the EOHHS also serves as the CHIP State Agency under federal and state laws and regulations.
[2] The Department of Human Services, the Department of Children, Youth and Families, and the Department of Health have separate records retention schedules.

Note: Records relating to departmental and divisional reorganization are permanent records, as per GRS1.21 Reorganization Records.

HHS1.1 Waiver Demonstration Project Application Records

Section 1115 of Title XI of the Social Security Act gives the federal Secretary of Health and Human Services' Centers for Medicare and Medicaid Services (hereafter CMS) authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and Children's Health Insurance Program (CHIP). The purpose of these demonstrations is to give states increased flexibility to develop and evaluate policy approaches for the design and improvement of programs that promote the expansion of eligibility to individuals who are not otherwise eligible, provide medical services not typically covered by Medicaid, and to use innovative service delivery systems that improve care and increase efficiency while reducing costs. This series encompasses EOHHS applications to the CMS for approval of Medicaid-related waiver demonstration projects.

The Rhode Island Medicaid Reform Act of 2008 (RIGL §42-12.4) directed the state to apply for a global demonstration under the authority of section 1115(a). As the state's Medicaid agency, EOHHS applied to the CMS in August 2008 for approval for the state to develop a demonstration project, which was named the Rhode Island Global Consumer Choice Compact, now known as the Rhode Island Comprehensive Demonstration. Its application was approved on January 16, 2009.

In July 2015, Rhode Island and the CMS entered into a second waiver demonstration agreement that allows the state to test an Integrated Care model for a part of the state's Medicaid population that is also eligible for Medicare. This demonstration is known as the Integrated Care Initiative (ICI). This agreement is intended to last for three years, and it also includes state opt-out and extension provisions.

The ICI demonstration aims to combine Medicare and Medicaid benefits into one delivery system for members with both Medicare and Medicaid coverage. It includes primary, acute, behavioral health and long-term services and supports for Medicare-Medicaid enrollees. The ICI initiative will: coordinate care across medical, behavioral, long-term, and psychosocial supports, attend to transitions of care from the hospital or nursing home back to the community, re-balance the long-term care and community-based systems, and, finally, align financial and quality incentives.

The records in this series include initial waiver demonstration applications and all subsequent amendment documentation, and CMS Notices of Approval for Rhode Island's healthcare demonstration projects. This series also includes documentation related to the application for extensions beyond the initial demonstration period.

Retention: Permanent.

HHS1.2 Section 1115 Waiver /Medicaid Reports

By law, the EOHHS is required to prepare and submit certain reports to the state and to the federal government. The state (EOHHS) is required to prepare quarterly reports for the CMS on the operations of the Section 1115 Waiver. These reports provide an overview of

current goals for the Section 1115 Waiver, information on eligibility criteria, expenditures and activities, and highlights of the progress of the implementation and operation of the Section 1115 Waiver. This series also includes EOHHS reports to the Rhode Island General Assembly's Senate Committee on Health and Human Services, as required by a Senate Resolution promulgated in June 2010.[3] The Senate reports may include statistical data on number of Medicaid applicants, waiting lists, eligibility decisions, data concerning delivery of various Medicaid-covered services, analyses of services consumed, and financial expenditure and cost information.

Retention: Permanent.

Note: The General Records Schedule (GRS) specifies permanent retention for Policy and Procedures records (GRS1.3) and Special Plans, Publications, Studies and Reports (GRS1.6)

HHS1.3 Medicaid State Plan and Amendments Records

A Medicaid State Plan is an agreement between the state and the federal government describing how it administers its Medicaid program. It gives an assurance that the state will abide by federal requirements in order to receive federal matching funds for its program activities. The plan sets outs those populations (individuals and groups) to be covered, the kinds of services to be provided, and the methodologies by which providers will be reimbursed, and the administrative activities in place. When states intend to make changes to the state plan, they must submit proposed amendments to the CMS for review and approval. Amendments range from eligibility, benefits, and enrollment strategies to prescription drug coverage, financing and reimbursement, and service delivery mechanisms. This series consists of those EOHHS records related to Rhode Island's State Medicaid Program as well as plan amendments EOHHS periodically submits to the CMS. The records include approval documents, companion letters, attachments and Transmittal and Notice of Approval of State Plan Material (currently form CMS-179) submitted to the CMS regional office for approval.[4]

Retention: Permanent.

HHS1.4 Section 1115 Waiver Program Evaluations

The CMS requires that state Medicaid agencies contract with an External Quality Review Organization (EQRO) to conduct an annual, external quality review (EQR) of the services provided by Medicaid Managed Care Organizations (MCOs) with whom EOHHS has entered into contracts for the provision of Medicaid Services. The records include documentation related to external evaluations of the design and implementation of waiver demonstration projects.

Retention: Permanent.

[3] Rhode Island. Senate Resolution 10R303 (S2010-S2976)

[4] EOHHS' constituent agencies too, may be required to establish a "state plan" detailing compliance with authorizing federal and/or state legislative goals and outlining key priorities, policies and processes for a particular program.

HHS1.5 Interagency Service Agreements

EOHHS' relationships with its constituent departments are established through signed Interagency Service Agreements (ISAs). These agreements establish which Medicaid services each department will provide. EOHHS supports these Departments but does not directly govern their functions.[5] The Departments receive their own appropriations and maintain their own statutory authority. This series includes the agreements established between EOHHS and its constituent departments.

Retention: Permanent.

HHS1.6 Federal Claims and Disbursement Records

The federal government pays a share of states' expenditures for Medicaid (and for the Children's Health Insurance Program) under the Medicaid State Plan. States report Medicaid expenditures to CMS (Center for Medicare and Medicaid Services) on a quarterly basis. Claims made by the EOHHS to the federal government relate to contracted and purchased services on behalf of the state (see HHS2.5). The states' claim documentation includes Quarterly Medicaid Statement of Expenditures for the Medicaid Program, which indicates federally reimbursable expenditures under Title XIX, as well as supporting documentation. The documentation includes completed federal forms providing a statement of expenditures, which indicates federally reimbursable expenditures under Title XIX, as well a supporting documentation. The documentation included also reconciles the federal monetary advance made on the basis of previously submitted statements of estimated expenditures filed for the same quarter (see HHS1.7).

After the Medicaid agency has calculated its expenditures for the quarter under its Medicaid state plan, it must also return to the federal government the federal share of the net amount it has recovered as a result of various forms of overpayment (the Act § 1903(d)(3)(A)).

a) Claims and disbursements documentation involving contracted funds

Retention: Retain ten (10) years after contract close and final payment and resolution of all pending issues.

b) All other claims and disbursement documentation

Retention: Retain ten (10) years from date of disbursement.

[5] The agreements currently cover the following: (1) Department of Human Services: Medicaid eligibility for Modified Adjusted Gross Income (MAGI) Medicaid, Aged, Blind, and Disabled ((ABD) Medicaid, and financial Long-Term Care eligibility is conducted by the Department of Human Services through the ISA with EOHHS. The ISA also enables Medicaid FMAP (Federal Medical Assistance Percentage), claiming for certain Medicaid services administered by DHS's Division of Elderly Affairs, including home and community based services and supports for Medicaid-eligible elders. (2) Department of Behavioral Healthcare, Developmental Disabilities and Healthcare: The ISA between BHDDH and EOHHS enables certain Medicaid administrative claiming as well as claiming FMAP for behavioral healthcare, long-term hospital stays, and long-term services and supports for persons with developmental disabilities. (3) Department of Health: The ISA between Health and EOHHS allows for certain administrative claiming as well as FMAP claiming for targeted case management. (4) Department of Children, Youth and Families: The ISA between DCYF and EOHHS allows for certain administrative claiming related to eligibility for foster care.

Note: For claims and disbursement records documenting EOHHS transactions with Medicaid providers, see HHS2.5.

Note: If records are related to a case in litigation, then these records must be retained during litigation and for a period of seven years after the disposition of the litigation.

HHS1.7 Quarterly CMS Financial Expenditure Estimates Reports

States are required to submit quarterly financial reports to the CMS that provide a statement of the state's estimated Medicaid (and CHIP) funding requirements for a certified quarter for administrative and Medicaid payments costs. The reports also describe underlying assumptions for two fiscal years (FYs) – the current FY and the budget FY. In order to receive Federal financial participation, the report must also certify that the requisite matching state and local funds are, or will be, available for the certified quarter. The records include completed federal forms[6] along with supporting documentation.

Retention: Retain ten (10) years.

HHS1.8 Health Indicator System Reports

An Evaluation Studies Workgroup at the Department of Human Services developed a Health Indicator System to address concerns about the impact of managed care. This system continued when EOHHS was designated as the state's Medicaid agency. The Health Indicator System did not require legislative action, but emerged as a way to evaluate RIte Care, the state's managed care program for public coverage. [7]

A research plan was introduced in 1994 with the goal of selecting indicators that would help track the health of children and pregnant women who were the majority of RIte Care enrollees. In 1999, the Workgroup's efforts broadened to include additional indicators to cover additional Medicaid enrollee populations beyond RIte Care. The system is designed to use existing health data sets to design, assess, monitor and evaluate health services provided under the Medicaid program. It is also intended to provide a useful framework for data collection for all Rhode Islanders. The system helps EOHHS policymakers to identify how specific Medicaid interventions have impacted the health status of enrollees, and is used to inform future initiatives and interventions. The EOHHS publishes an annual Data Book that includes data related to demographics, access to health care, health status, social measures, and long-term care quality of care.

a) Heath Indicator Data
Retention: Retain 10 (ten) years.

b) Annual Health Indicator Data Books
Retention: Permanent.

[6] Currently Form CMS 37 Medicaid Program Budget Report

[7] RIte Care is Rhode Island's health insurance program that provides eligible uninsured children, families, and pregnant women with comprehensive health care through one of two participating health plans: Neighborhood Health Plan of RI or United Healthcare of New England. Families enroll in a health plan of their choice.

HHS1.9 Data Use Agreements

This series consists of agreements between the EOHHS and outside entities, including the Center for Medicaid and Medicaid Services, allowing for the digital exchange of HIPAA data. The agreements specify what data will be exchanged, and what it will be used for and also includes related correspondence and certificates of destruction (once data is destroyed at expiration of the agreement), and renewals of agreements.

Retention: Retain ten (10) years.

HHS1.10 Research Studies and Reports

One of the waiver demonstrations' main objectives is to measure the quality and improvement of health services and outcomes as well as financial performance under the demonstrations. The EOHHS periodically produces analyses, studies, and reports on the performance of Rhode Island's health care insurance system. The issues this documentation addresses include, but are not limited to, the performance, quality, scope, and access to health care services for various populations in Rhode Island.

Toward this end, the EOHHS may collect or access data required for analyses of diagnosis and outcomes and other measures of quality and usage. The EOHHS may also enter into data sharing agreements with the CMS, MMPs under state contract to provide insurance coverage to eligible populations under the demonstrations as well as with other pertinent sources of data. This information may include, but is not limited to, enrollee satisfaction, utilization rates, population risk profiles, encounter reporting, complaints and appeals handled by the MMP, enrollment and disenrollment rates, and other evidence-based reporting and analytic support for the monitoring and evaluation of the demonstration. The requirements may also specify the collection of data concerning populations in specific Medicaid-covered programs such as Person-Centered Care Plan Care for Older Adults – Medication Review, Nursing Facility Diversion, and Nursing Facility Transitions.

a) Data sharing agreements

Retention: Retain ten (10) years.

b) Analytical and performance reports

Retention: Permanent.
(as per GRS1.6 Special Plans, Publications, Studies and Reports)

c) Population data

Retention: Retain until no longer required for analysis and reporting.

Note: EOHHS may choose to enlist private vendors specializing in healthcare data analysis to conduct analyses and produce reports on its demonstration programs. However, the ownership, management, and retention responsibilities for the waiver demonstration data and reports ultimately remain with EOHHS.

HHS2 Provider Records

The records in this section document EOHHS responsibilities, interactions, and activities with those individuals, groups, and services that provide Medicaid and dual eligible — related services under the auspices of the state.

HHS2.1 Provider Application, Enrollment, and Monitoring Files

In order to become eligible to offer services to the state's Medicaid and dual eligible population, providers are required to apply to EOHHS for certification. Records include, but are not limited to, individual or group provider application forms, disclosure forms, exclusion letters, W-9s (Payer's request for taxpayer identification number and certification), and provider agreement forms, medical specialties billing information, and documentation of National Provider Identifier (NPI) letter received from the Center for Medicare and Medicaid Services (CMS) containing providers' NPI and taxonomy numbers, and a valid copy of license to practice.

Retention: Retain ten (10) years after performance of contract.

Note: See HHS2.5 for retention requirements for documentation related to contracted provider and other provider claims and disbursements.

HHS2.2 Trading Partner Agreements

Medicaid health service providers may employ external business entities to handle their Medicaid-related financial claims and receipt of payments, and to exchange electronic data with the Rhode Island Medicaid Program and/or use EOHHS' Healthcare Portal. These entities are required to enroll as a Trading Partner with EOHHS and its fiscal agent, currently HP Enterprise Services, LLC. This series consists of those agreements.

Retention: Retain ten (10) years after agreement expires.

RIGL § 9-1-13(a) and RIGL § 35-6-19.

HHS2.3 Managed Care Organization Contract Records

The EOHHS contracts with managed care organizations (MCOs) to provide services to Medicaid and the dual eligible population in the ICI demonstrations for a fixed capitation payment. EOHHS' contracts with MCOs specify the capitation payment rates set for the contract period for each Medicaid and dual eligible population, the MCO's reporting requirements, and the contract settlement methodology where the medical expenses are either more or less than the capitation payment rate fixed for a given period. This series consists of those contracts and related documentation.

Retention: Retain ten (10) years after termination of contract.

Note: Payments for contracted vendor payrolls may be paid with federal funds. However, the contracts are state contracts warranting a ten-year retention period based on the statute of limitations from RIGL § 9-1-13(a). This is also consistent with the ten-year statute of limitations for Medicaid fraud from RIGL § 40-8.2-4.

HHS2.4 Rate Setting Unit Records

Subject to federal approval (Centers for Medicare & Medicaid Services, Department of Health and Human Services), states can establish their own Medicaid provider payment rates. States generally pay for services through fee-for-service or managed care arrangements. In Rhode Island, the Executive Office of Health and Human Services is

responsible for this function. EOHHS includes a Rate-Setting Unit, which is responsible for setting Medicaid rates of reimbursement for eligible health care services, which currently include nursing homes, long-term care facilities, Federally Qualified Health Centers (FQHCs), and hospitals. It also develops Medicaid payment methodologies.

The Rate–Setting program establishes provider reimbursement rates based on documentation it receives from the above-named health care facilities. Individual health care facilities annually submit various reports and related documentation to the rate-setting unit, which serves as the foundation for the establishment of reimbursement rates for each provider.

Each file consists of documentation related to provider applications for reimbursement, along with supporting documentation and related correspondence. This may include, but is not limited to, cost reports forms, and accompanying back-up documentation, requests for rate adjustments, reimbursement methodology documentation, audited financial statements, rate calculation tables, audit related documentation, and rate and cost analyses and work papers. The records also include documentation submitted to the unit for desk audits and appeal requests. The files are organized by individual institutions or provider, and by year.

Retention: Retain five (5) years.

Note: EOHHS' constituent agencies must retain all provider cost reports for ten years. (Rules and Regulations - Principles of Reimbursement for Nursing Facilities, July 1, 2012.)

HHS2.5 Provider Claim and Disbursement Records

This series documents any Medicaid service provider or client payment claims made or received and subsequent payments made or received. The files include health service provider invoices, monthly billing detail statements, state bills to Medicaid, direct vendor payment plans, purchase orders, vendor census reports and related accountability documentation, A12T invoices, prior authorization forms, vouchers to Accounts and Control, payment support materials, account reconciliation documentation, and related correspondence. Payment data is stored in the Medicaid Management Information System (MMIS).

a) Claims and disbursement documentation involving contracted funds

Retention: Retain ten (10) years after contract close and after final payment and resolution of all pending issues.

b) All other claims and disbursement documentation:

Retention: Retain ten (10) years from date of disbursement.

Note: EOHHS currently uses the services of a contracted fiscal agent to administer and process Medicaid payments and reimbursements, and to manage the data. However, EOHHS remains legally responsible and accountable for ensuring that these records remain accurate, retrievable, and legible for the entire retention period specified in this schedule.

HHS2.6 Interception of Insurance Payments Records

Medicaid is a "Secondary Payer Program." This means that the Medicaid program is the health service insurer of last resort. Thus, Medicaid insurance funds may be used only after individuals have first drawn on eligible income and other eligible financial assets (as specified by regulation) to cover their share of health care insurance expenses. This series records cases related to Medicaid overpayment and EOHHS' recuperation of money from insurers in receipt of Medicaid funds before other sources of payment for Medicaid-covered services have been exhausted.

The records include files of correspondence with the insurance company and with the claimant, and financial reimbursement documentation.

Where they disagree with the interception of Medicaid payments, claimants have a right to request a hearing.

Retention: Retain ten (10) years, or seven (7) years after hearing or litigations ensues in accordance with GRS2.1 Case Files.

HHS2.7 Program Integrity Claims Investigation Case Files

The EOHHS ensures compliance, efficiency, and accountability within the health and human services programs administered by the State of Rhode Island. It does this by detecting and preventing Medicaid provider fraud, waste, and program abuse, and ensuring that state and federal dollars are spent appropriately, responsibly, and in accordance with applicable laws. The OPI conducts desk audits and reviews, onsite audits, data mining, algorithms, and site visits. In addition to SNAP, TANF (current state name is Rhode Island Works) and Medicaid, the OPI currently focuses on publicly funded health and human services programs. Included are date of death investigations, transportation claim investigations, and Personal Choice program Advisement Agency Audits.[8]

This series documents the monitoring, control, and investigation of health services provider claims and services (doctors, hospital, health labs, and other health care-related providers) to protect against the inadvertent or purposeful overpayment of claims or other fiscal misuse of service programs. The investigations may cover individual providers or target a medical practice group. The content of each file depends on the course of the case, whether it involves OHHS sanctions, warnings, and recovery of funds, or referral to the Attorney General.

This series consists of case files. Each case file may consist of incident reports, audit reports, and background investigation documentation to establish credibility of fraud and waste, and related correspondence, billing records, medical diagnostic reports, medication administration sheets, office policy and employment records, patient care plans and

[8] The Personal Choice Program (PCP) is intended for eligible Medicaid Long Term Care (LTC) beneficiaries who choose to receive home and community based medical and other services. This program covers eligible individuals with disabilities who are over the age of eighteen (18) or elders aged sixty-five (65), or who meet either a high or highest level of care. For records related to the determination of levels of care, see HHS3.1.)

treatment records, medical equipment expenses, prescription records, and physician/practitioner orders.

Decisions rendered by the review process can result in refunds to the Medicaid program for inappropriate payments, training on how to correct or improve billing practices, referrals to licensing boards, and/or referral to the RI Office of the Attorney General for suspected fraudulent practices.

RIGL § 9-1-13(a) and RIGL § 40-8.2-4.

a) Documentation resulting in a change of law, policy, or procedures
Retention: Permanent.

b) Case investigation summaries or logs
Retention: Retain ten (10) years after final resolution.

c) Case investigation files
Retention: Retain 10 years after final case resolution.

d) Cases resulting in litigation
Retention: Retain for seven (7) years after the disposition of litigation.

HHS2.8 Provider Facility Survey Records
The Rhode Island Department of Health surveys all Nursing Facilities (NF) and Intermediate Care Facilities for persons with Intellectual Disabilities (ICF/ID) for compliance with the federal participation requirements of the Medicare and Medicaid programs. As a result of these surveys, reports are issued for certification purposes. The reports cite provider deficiencies, if any exist, together with appropriate plans of correction. Subsequent corrections of deficiencies are also reported. Nursing Facilities (NF) reports are sent to the Social Security Administration (SSA) district office and the Medicaid agency. Intermediate Care Facilities/Intellectual Disabilities (ICF/ID) reports are sent to the Medicaid agency. The agency is required to send the reports for both Nursing and Intermediate Care Facilities to the appropriate Long-term Services and Supports (LTSS) Unit covering the district in which the facility is located. The agency must also send the ICF/ID reports to the SSA office covering the catchment area in which the facility is located.

Material from each survey must be held at both EOHHS and the LTSS Unit.

a) Reports, summaries, and recommendations issued, instituted, or arising from surveys/questionnaires
Retention: Permanent.

b) All other records and data
Retention: Retain three (3) years.

EOHHS Regulation 0301 Payments and providers.

HHS2.9 ICI Marketing and Enrollee Communications Approval Records
Medicare-Medicaid Plans (MMPs) are required to develop and provide marketing and communication products concerning the Integrated Care Initiative. This documentation must be approved by the CMS and EOHHS. The records in this series document EOHHS' review and approval process.

Retention: Retain three (3) years.

HHS3 Beneficiary Records
This section includes record series that document OHHS's interaction with Medicaid applicants and beneficiaries.

HHS3.1 Medicaid Waiver Demonstration Eligibility Determination and Enrollment Records
Individuals may apply for health care services and coverage through DHS, EOHHS, or HealthSourceRI portals. However, EOHHS makes final determinations concerning eligibility for certain kinds of Medicaid-covered services. Before individuals' clinical eligibility for Medicaid is considered, their financial eligibility must be established. The other health and human service agencies may conduct in-take and screening of applicants to determine what kinds of support they may be eligible for, including whether Medicaid is one of the health and human service programs for which applicants may be financially eligible. Once financial eligibility for certain kinds of Medicaid has been established, the individuals/families' application is transmitted to the EOHHS' Office of Medical Review (OMR).

The EOHHS' OMR reviews the documentation of financially eligible applicants to establish clinical eligibility and determinations of disability. As part of this process the OMR determines and approves or denies applicants' eligibility for financial support for certain kinds and levels of short and long-term health care service, which may include, but is not limited to, home and community-based service, nursing home care, respite care, assisted living, hospitalization, and rehabilitation. (Populations eligible for Medicaid services are specified in Rhode Island's Medicaid State Plan, which EOHHS periodically changes by submitting new eligibility amendments to the CMS). (See HHS1.3 Medicaid State Plan and Amendments Records.)

This series also includes eligibility and enrollment case files of individuals who apply for and are enrolled for health coverage under the Integrated Care Initiative Demonstration. Under the ICI, the CMS and the EOHHS have established protocols for automatic enrollment ("passive enrollment") and voluntary enrollment of "dual eligibles" in the state's ICI initiative with Medicare-Medicaid Plans (MMPs). Individuals may subsequently opt out or transfer to another available MMP.

Enrollment in waiver demonstrations must be renewed on an annual basis.

The records in this series consist of individual eligibility and enrollment case files. The files include, but are not limited to, Medicaid-related physicians' examination reports, documentation relating to the determination of disability, reports from hospitals reporting medical conditions, occupational and physical therapy notes, documentation related to the applicant's psychological or neurological condition(s), and information concerning existing

community supports, which are forwarded to the OMR by DHS field offices. The records also document the OMR's assessment with respect to eligibility for levels of care, or where applicable, notices of denial. The files of ICI applicants and enrollees may also include acknowledgement letters, notifications of ICI enrollment, confirmation letters, and notices of rejection, eligibility verification data, and beneficiary requests for disenrollment, disenrollment notices, and requests to opt out of the demonstration, and related correspondence. Also included are data and documentation related to applicant financial status and Medicare verification. Records may also include notices of transfer from one MMP to another MMP.

Finally, the EOHHS is moving to an Integrated Eligibility System. This system is designed to store and manage not only individuals' Medicaid eligibility data but also data related to individuals' application for certain other state health and human services benefits that fall under the aegis of EOHHS' partner agencies (DHS, DCYF, BHDDH, and Health). Each EOHHS partner agency retains custody of and accountability for eligibility data related to its programs. However, the system is structured to include shared, cross-matching application and eligibility data about individuals who may apply for multiple HHS benefit programs, including Medicaid, over time. This series, therefore, includes shared eligibility data that form part of multiple individual HHS benefit application files.

a) Approved applications and enrollment files
Retention: Retain ten (10) years.

b) Denied applications files
Retention: Retain three (3) years.

c) Shared HHS eligibility data for approved applications and enrollment records
Retention: Retain ten (10) years.

d) Shared HHS eligibility data for denied applications
Retention: Retain three (3) years.

HHS3.2 EOHHS Central Appeals Office Files

The Executive Office of Health and Human Services and the four constituent agencies of EOHHS (DHS, DCYF, BHDDH, and Health) may receive consumer complaints concerning denial, discontinuation, or modification of benefits or services. When these agencies cannot resolve a consumer complaint, the consumer has the option of appealing the decision and requesting a hearing before the EOHHS' Central Appeals Office.

The issues heard by the office may be related, but are not limited to, applications for state health and social service assistance from such programs as the Child Care Assistance Program, General Public Assistance, Medicaid, including provider appeals, Health Insurance Exchange, RI Works, and SNAP (Supplemental Nutrition Assistance Program), behavioral health services, services for persons with developmental disabilities, appeals from agency decisions covering a variety of programs and functions at the Department of Children, Youth and Families, and the "Katie Beckett" Program.

This series consists of the hearing files of the Appeals Office. The content of the hearing files depends on the type of program or benefit under review. Administrative hearing records may include, but are not limited to, the notice under appeal, the hearing notices, and the hearing officer's notes during the hearing, appellant evidence submitted at the hearing, and copies of the hearing decisions made by the EOHHS appeals office. The files may also contain recorded statements by the appeals officer reviewing the basis upon which the decision will be made, statements by claimants (or their authorized representatives) outlining their understanding of the problem at issue, statements by the state agency representative setting forth the state agency's regulations under which action was taken, as well as documentary evidence submitted by parties involved in the hearing, such as examining physicians' reports, or a record of decisions made by the medical review team, and medical assessments from parties other than those involved in the original decision.

a) Hearing decisions and documentary decisions

Retention: Retain ten (10) years unless litigation ensues, if litigation ensues, retain seven (7) years after final disposition of litigation in accordance with GRS2.1 Case Files.

b) Landmark case hearing files

Retention: Permanent.

c) Cases under litigation

Retention: Retain seven (7) years after final disposition of litigation or ten (10) after case opens, whichever is later.

HHS4 Certificates of Records Destruction

Certification of Records Destruction forms (PRA 003) signed by the authorized agency official and submitted to, and signed by, the State Archivist/Public Records Administrator. Certificates authorize the disposal of records listed in this and other applicable schedules.

RIGL § 38-1-10, § 38-3-6 (j), and § 42-8.1-10.

Retention: Permanent.