210-RICR-10-05-2

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 10 – EOHHS GENERAL PROVISIONS

SUBCHAPTER 05 – CONSUMER RIGHTS, RESPONSIBILITIES, AND PROTECTIONS

Part 2 - Appeals Process and Procedures for EOHHS Agencies and Programs

2.1 Purpose, Scope and Applicability

2.1.1 LEGAL AUTHORITY

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

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

2.1.2 PURPOSE

The purpose of this rule is to set forth the respective roles and responsibilities of the EOHHS and beneficiaries pertaining to the exercise and protection of the

right to dispute certain agency actions by filing an appeal to request an administrative fair hearing.

2.1.3 SCOPE AND APPLICABILITY

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

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

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

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

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

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

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

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

b. Child Care Assistance Program (CCAP) (See DHS Child Care Assistance Program Rules and Regulations, 218-RICR-20-00-4)

c. Supplemental Nutrition Assistance Program (SNAP), formerly “Food Stamps” (See DHS Rules and Regulations, 218-RICR-20-00-1)

d. Supplemental Security Income and State Supplemental Payment Program, (218-RICR-20-00-5)

e. Office of Child Support Services (OCSS) (See Rhode DHS Rules and Regulations, 218-RICR-30-00-1). To the extent the OCSS administers a case in Family court, those matters are not governed by or otherwise subject to this rule.

f. General Public Assistance Program (GPA) (See DHS "General Public Assistance Program Sections 0600-0626 of the DHS Manual")

g. Long-term Ombudsman, Community-Based Services, and Security Housing for the Elderly, Rhode Island Division of Elderly Affairs (DEA) of the DHS, programs and services (R.I. Gen. Laws Chapter 42-66 and DEA Rules, Regulations and Standards Governing the Home and Community Care Services to the Elderly Program (218-RICR-40-00-4); Rules, Regulations, and Standards for Certification of Case Management Agencies (218-RICR-40-00-5); Rules and Regulations Governing the Long Term Care Ombudsperson Program (218-RICR-40-00-1); Rules and Regulations Governing the Prescription Drug Discount Program for the Uninsured (218-RICR-40-00-06); Rules, Regulations, and Standards Governing the Pharmaceutical Assistance to the Elderly Program (218-RICR-40-00-2); and Rules, Regulations, and Standards Governing Security for Housing for the Elderly (218-RICR-40-00-3)

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

i. The RI Veteran’s Home, RI Veterans Cemetery, and State Veterans Office of Veterans’ Affairs (VA) (See R.I. Gen. Laws Chapter 30-17.1 and Rhode Island Veterans Home: Administrative

Procedures for the Billing and Collection of Maintenance Fees (180-RICR-10-00-2); RI Veterans Memorial Cemetery (180-RICR-20-00-1); and DHS "Rhode Island Veterans Home")

j. Medicaid, including eligibility for and the scope, amount, and duration of any Medicaid-funded health coverage, services, and/or supports authorized by the state's Medicaid State Plan or Title XIX, Section 1115 research and demonstration waiver (See the Executive Office of Health and Human Services (EOHHS), R.I. Gen. Laws § 42-7.2, Rhode Island Medicaid Code of Administrative Rules or MCAR)

k. Eligibility appeals, other than Large Employer Appeals, for HealthSource RI, the state's health benefits exchange, pursuant to R.I. Gen. Laws Chapter 42-157.

l. Programs and services offered through the Department of Behavioral Healthcare, Development Disabilities, and Hospitals to include individuals with behavioral health care needs and persons with developmental disabilities and any related institutional and home and community-based services as contained in R.I. Gen. Laws Title 40.1, "Rules and Regulations Licensing Procedure and Process for Facilities and Programs Licensed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals"; "Rules & Regulations Relating to the Definition of Developmentally Disabled Adult and The Determination of Eligibility as a Developmentally Disabled Adult"; "Rules and Regulations for the Licensing of Behavioral Healthcare Organizations".

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

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

2.1.4 DEFINITIONS

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

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

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

3. "Advance notice period" means the period of time prior to the effective date of most types of adverse agency actions. If a person appeals an agency action during this period, benefits or assistance continue or are reinstated until the appeal is resolved. This continuation or reinstatement is sometimes referred to as “aid pending.”

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

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

6. "Agency representative" is a person authorized by the state to take agency actions and, therefore, to be designated or assigned to represent the agency’s rules, policies, and positions in the appeal process.

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

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

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

10. "Appeal request" means a request by a person affected by an agency action to review and resolve a dispute of an agency action in an administrative fair hearing; or a desire to challenge agency delay or failure to act. An appeal request may also be filed to request a hearing to dispute one or more general issues related but not limited to, agency policies, standards, practices, notice requirements, and/or performance.

11. "Appellant" means the affected party who is requesting an appeal. An appellant may be:

    a. a person or

    b. provider or

    c. an individual who is an authorized representative of the appellant, either a legal guardian or an individual designated in writing by the person to represent their interests in an appeal or

    d. a person or entity making an appeal on the behalf of an individual or class of individuals affected by an agency action.

12. "Assistance" means any cash payments, benefit, service or support, or benefit card, plan or package of services provided directly or by an authorized agent or contractor of a program administered by the health and human services agencies operating under the umbrella of the EOHHS. For the purpose of this rule, assistance has the same meaning as benefit(s), service(s), and support(s) irrespective of how provided or delivered.

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

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

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

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

17. "*Ex parte* communication" means a written or oral communication about a matter on appeal that occurs between the members or employees of an agency assigned to render an order or to make findings of fact and conclusions of law in a contested case and any person or party to an appeal, or in connection with any issue of law, with any party or his or her representative, except upon notice and opportunity for all parties to participate. But any agency member may communicate with other members of the agency, and may have the aid and advice of one or more personal assistants.

    a. *Ex parte* communications are prohibited except that communications with the hearing officer for the purpose of scheduling and other administrative functions are not considered to be *ex parte*.

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

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

20. "HealthSource RI" or "HSRI" means the state's benefit exchange (also referred to as an "Exchange") established under R.I. Gen. Laws Chapter 42-157 and which meets the applicable standards of 45 C.F.R Part 155 (2012) and, as such, is authorized to make qualified health plans (QHPs) available to individuals and employers/employees who meet certain eligibility requirements. Unless otherwise identified, "HSRI" includes the

individual market for qualified individuals and the Small Business Health Options Program (SHOP) serving the state's small group market for qualified employers /employees. The "Exchange" and "HSRI" have the same meaning for the purposes of this Part.

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

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

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

24. "Modified Adjusted Gross Income" or "MAGI" means income used to determine eligibility for premium tax credits and other savings for marketplace health insurance plans and for Medicaid and the Children's Health Insurance Program (CHIP).

25. "Medicare-Medicaid Plan" or "MMP" is an integrated managed care plan under contract with the federal Centers for Medicare and Medicaid Services (CMS), EOHHS, and a managed care organization to provide fully integrated Medicare and Medicaid benefits to Medicare/Medicaid eligible (MME) beneficiaries.

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

27. "Recoupment" means the process in which an agency seeks to recover the cost for assistance provided to an affected party either in error or

during the aid pending period if an adverse action is upheld in the disposition of an appeal.

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

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

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

2.2 Appeals: General Provisions

2.2.1 APPEAL PROCESS

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

1. Notification of Appeal Rights. An agency must include on all application forms – paper and electronic - a statement of the applicant's right to appeal and request a hearing related to any agency action related to eligibility; the process for determining eligibility; or a change in the scope, amount, or duration of assistance. Such notices must also state the:

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

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

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

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

4. Procedures for Filing an Appeal. Appeal Request. An affected party may file an appeal in the format designated for such purposes, or in any other format allowed under applicable laws and regulations. The EHO will accept appeals via the state's web-based IES. An affected party may also download the EHO Appeal Form and file an appeal by traditional means (by postal mail, fax, or personal or commercial delivery). A complete and up-to-date appeal request form is located on the EOHHS website at: www.eohhs.ri.gov

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

    b. The appellant must provide an appeal request that states the reason(s) for the appeal.

5. Appeal Date –The appeal date determines whether aid pending is available and if the appeal was submitted in accordance with applicable timelines. If mailed, the appeal date is the date the form or letter is first received by either the EHO or the agency. If the appeal is filed via telephone or fax, the appeal date is the date the contact is made with the agency or EHO. If the appeal is filed online through the appellant's account with the state's web-based IES, the appeal date is the date the appeal appears in the appellant's account.

6. Agency/Appeal response. The EHO is responsible for ensuring that all appeals are documented properly upon receipt in the electronic appeal database and referred, as applicable, for responses to the appropriate unit of the agency that took the action.

    a. Components of the Response – The agency/appeal response is prepared by a representative of the agency and cites the rule,

policy, procedure, and/or statute providing the legal justification for the agency action in dispute.

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

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

7. Appeal Review. The EHO reviews the appeal to determine if it has been submitted in accordance with the applicable procedures and filing requirements and applicable federal and state laws, regulations, and/or rules.

a. Types of appeals -- For most health and human services programs, an appeal filed properly will result in a scheduled hearing. Exceptions include the circumstances identified in 42 C.F.R. § 431.220(a) related to changes in law or policy affecting an entire class of beneficiaries, or the appellant withdraws the appeal. Circumstances that shall provide an opportunity for a hearing include, but are not limited to:

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

(2) Affected party believes that an agency has acted erroneously in terminating, suspending, or reducing eligibility; or delaying the delivery of and/or terminating, suspending, or reducing the scope, amount, or duration of assistance or the manner in which it is delivered;

(3) Affected party believes that agency's determination related to initial screening, placement, periodic review, or intermittent or regular evaluation of a plan that initiates or

affects access to assistance is erroneous or contrary to prevailing standards of practice.

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

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

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

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

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

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

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

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

(12) Any program specific matters that the agency has identified publicly by rule or notice that qualifies as an agency action subject to appeal.

(13) Acknowledgement of an appeal – The EHO must send a timely acknowledgment to the appellant upon receipt of the appeal request. The acknowledgement must contain

information about the formal and informal options for resolving the appeal including the administrative fair hearing process.

b. Duration – An appeal remains open until:

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

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

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

8. Incomplete appeals. Upon receipt of an appeal request that fails to meet the requirements of this section and/or other applicable federal or state laws, regulations, and/or rules, the EHO or agency must, promptly and without undue delay, send written notice informing the affected party:

a. The appeal request has not been accepted;

b. The reasons for determining the appeal request incomplete;

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

9. Agency/program Specific Requirements. For both HSRI and Medicaid, appeals must be filed pursuant to § 2.2.1(A)(4) of this Part within thirty (30) days of the contested agency action. The 30 days begins five (5) days after the mailing date of the notice of an intended agency action. See § 2.4 of this Part for special provisions related to the Office of Child Support Services and long-term care facility/resident actions.

2.2.2 CONTINUATION OR REINSTATEMENT OF AID PENDING RESOLUTION OF AN APPEAL

A. An appellant may receive the continuation or reinstatement of eligibility or assistance in certain types of cases if an appeal is filed in the advance notice period, before an agency action takes effect. Requirements related to aid pending are as specified below:

1. Advance Notice Period. The State must institute aid pending in situations in which timely and adequate notice are not provided.

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

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

2. Scope and duration – At the time aid pending is initiated, the appellant must be informed that assistance will be continued until a hearing decision is rendered, unless:

   a. A determination is made at the hearing that the sole issue is one of a change in state or federal law, regulation/rule or policy, as indicated in 42 C.F.R. § 431.220(a); or

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

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

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

State Agency Administering Program	**Name of Program**	**Advance Notice Period**	**Potential Consequence – Adverse Action Upheld**
(a) Department of Human Services	General Public Assistance (GPA)	10 days from the mail date. Appeal request must be accompanied by or include a written statement asking specifically for continuation of GPA to stay the reduction, suspension, or discontinuance until the fair hearing decision is	Repayment may be required.

State Agency Administering Program	Name of Program	Advance Notice Period	Potential Consequence – Adverse Action Upheld
		issued.	
(b) Department of Human Services	Supplemental Nutrition Assistance Program (SNAP)	10 days from the mail date	SNAP benefits discontinued at the end of the certification period. Recoupment initiated.
(c) Department of Human Services	RI Works	10 days beginning on the fifth day after the date on the notice of intended action. If the advance notice period ends on a holiday or weekend, beneficiary is entitled to aid pending if appeal is received on the day after the holiday or weekend.	Repayment required and recoupment is initiated. For RI Works participants, appeal period may count toward time-limits
(d) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	All programs and services	10 days beginning on the fifth day after the date on the notice of intended action	
(e) Health Source RI – health benefit exchange	Qualified Health Plans, Advance Premium Tax Credits and Cost Sharing Reductions, the Small Business	Within 30 days of the eligibility redetermination occurring	Reconciliation of advance receipt of premium tax credits which may require the repayment of advanced premium

State Agency Administering Program	Name of Program	Advance Notice Period	Potential Consequence – Adverse Action Upheld
	Health Options Program		tax credits or otherwise impact a federal tax return. Payment of premium to carrier.
(f) Executive Office of Health & Human Services	All Medicaid	10 days beginning on the fifth day after the date on the notice of intended action	Repayment for Medicaid- funded services required. Recoupment or estate recovery initiated.
(g) Executive Office of Health and Human Services	Nursing facility and assisted living transfers/discharges	10 days beginning on the fifth day after the date on the notice of intended action	

2.2.3 Continuation or Reinstatement of Benefits After the Effective Date of Action

A. Where the beneficiary requests a hearing more than ten (10) days after the date of the intended action, the beneficiary's services may be continued or reinstated until a final agency decision is rendered after the hearing if the beneficiary provides verification, in the form of a signed statement with supporting documentation, of one of the following circumstances:

1. The beneficiary's life, health, or safety will be seriously impacted by the loss of benefits.

2. The beneficiary was unable to request a hearing before the date of action due to the beneficiary's disability or employment.

3. The beneficiary's caregiver or their authorized representative was unable to request a hearing before the date of action due to their health or employment.

4. The beneficiary did not receive the state's or designated service agencies notice prior to the effective date of the intended action.

B. If a Medicaid beneficiary is receiving aid pending, after appealing a decision that he/she is no longer Medicaid eligible, said beneficiary shall continue to receive the Medicaid benefits that were being received when the appeal request was filed.

2.2.4 ALTERNATIVE DISPUTE RESOLUTION OPTIONS

A. State and federal laws require that public agencies make alternative informal and formal dispute resolution options available to an appellant.

B. The mix of informal and formal options is generally as follows with the exceptions noted:

1. Informal Dispute Resolution Options. Each agency provides appellants with one or more informal options for resolving an appeal while the hearing process goes forward. The informal dispute resolution process involves a discussion between the appellant and one or more representatives of the agency that took the action.

2. Voluntary - - Participation in informal resolution is entirely voluntary on the part of the appellant. If the informal resolution process is successful and the contested agency action does not advance to a hearing, the informal resolution decision is final and binding. Administrative hearing officers do not participate in informal settlement conferences.

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

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

b. Notice of Corrected Action. Until such time as the appellant receives the updated notice and the appropriate action is in effect, the appeal remains open.

c. Appeal Withdrawal. The appellant is required to withdraw the appeal even if it is determined during the informal resolution process that the original eligibility decision was incorrect.

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

E. Pre-hearing settlement conference – An appellant may choose to pursue a pre-hearing settlement conference as a formal dispute resolution option when an agency and circumstances allow. The Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals (BHDDH) and the EOHHS often make this option available upon request to beneficiaries and providers. The pre-hearing settlement conference functions as follows:

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

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

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

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

F. Administrative Fair Hearing – The dominant formal dispute resolution mechanism is an administrative fair hearing as specified in detail in the next Subpart.

2.3 Administrative Fair Hearing Process

2.3.1 GENERAL PROVISIONS

A. The administrative hearing process is initiated when an agency or the EHO receives an appeal request.

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

C. The EHO must assure that the appellant is sent an evidentiary packet, upon request, at least three (3) days in advance of the hearing date, except when using the expedited appeal process. The evidence packet shall, at a minimum, include:

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

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

3. Any documents and explanations provided by the appellant;

4. The agency response where applicable;

5. All associated notices.

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

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

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

a. No more than two (2) requests for continuances are permitted, unless the EHO allows, in its discretion, to permit an additional continuance subsequent to a valid claim of good cause as indicated below in § 2.3.1(E)(3) of this Part.

b. A SNAP household may receive one postponement of no more than 30 days.

c. A hearing may be held open to a later date, at the discretion of the hearing officer, if an appellant requests additional time in which to submit relevant documents.

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

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

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

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

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

   d. Death in family.

4. Vacating a Dismissal – Upon determining that good cause exists, the dismissal is vacated, the hearing is rescheduled, and the EHO provides appropriate notification to the affected parties and agency. If the EHO finds that good cause does not exist, timely written notice of the denial of a request to vacate a dismissal is sent to the appellant. In HSRI appeal cases, the appellant must be advised in the notice in either case – denial or approval of request to vacate a dismissal – of the right to pursue the appeal at the federal level. An appellant choosing to exercise this right

must make a request to the federal DHHS appeal entity in no more than thirty (30) days from the date of the EHO notice indicating whether the dismissal is vacated.

F. The appellant may designate anyone, including someone who is not licensed to practice law, to serve as an authorized representative during the appeal process. The appellant may make this designation to the EHO or the agency in-person or in writing by fax, email or U.S. mail or, as appropriate, the state's web-based IES.

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

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

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

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

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

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

2. It is the responsibility of the hearing officer to record the attendance of all persons who were involved in the relevant action under appeal.

H. All parties, authorized representatives, witnesses, and other persons present at a hearing must conduct themselves with the same decorum commonly observed in any Rhode Island court. Where such decorum is not observed, the hearing officer may take any appropriate actions to restore order, including ejection of parties or adjournment, as appropriate.

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

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

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

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

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

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

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

2. A statement by the appellant and/or authorized representative outlining the appellant's understanding of the matter in dispute.

3. A statement by an agency representative, setting forth the legal basis for the agency's action that specifies applicable rules, regulations, policies, and/or procedures.

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

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

P. The appellant may submit supporting documents into evidence in-person at the time of the hearing, by mail, or by fax, the time frame for such being at the discretion of the EHO.

Q. The EHO must provide the appellant with the opportunity to:

1. Review the appeal record, including all documents and records to be used by agency at a reasonable time of no less than 72 hours before the date of the hearing, as well as during the hearing;

2. Bring witnesses to testify;

3. Establish all relevant facts and circumstances;

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

5. Present an argument without undue interference;

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

7. Testify telephonically upon request of the appellant and/or at the discretion of the EHO;

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

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

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

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

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

2.3.2 APPEAL HEARING DECISIONS

A. The full responsibility of the EHO in the hearing process is discharged when a final decision has been made, in writing, by the EHO.

B. The hearing decision must include a full report of the findings and the applicable provisions stipulated in federal and/or state policies, rules, regulations, and/or procedures and any additional relevant evidence presented during the course of the appeals process, including at the hearing, that serve as the basis for the decision.

C. The hearing decision must include findings of fact and conclusions of law, separately stated, and a concise statement of the underlying facts supporting the findings. The hearing decision must include a plain language description of the effect(s) of the decision on the appellant and, when applicable, members of the appellant's household. In addition, the EHO must indicate in writing that the appeals decision is final, unless the appellant chooses to exercise the right to

pursue legal action through the RI court system or, in HSRI cases, appeal to the federal DHHS as indicated in § 2.4.4 of this Part. For exceptions to this requirement, see § 2.4.6 of this Part.

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

E. In accordance with 7 C.F.R. § 273.15(c)(l), the state agency has sixty (60) days from the receipt of a SNAP beneficiary's request for a hearing to: (1) conduct the hearing; (2) reach a decision; and (3) notify household and agency.

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

1. Appellant/Authorized representative;

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

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

4. Agency Administrative Rules Coordinator, if applicable; and

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

G. The hearing responsibility of the state agency is considered discharged when the following steps have been completed:

1. The hearing officer renders a written decision, based exclusively on evidence and other material introduced at the hearing, on behalf of the state agency.

2. Copies of the decision are distributed to the appellant, the agency representatives including specific case managers, program administrators, and department senior staff as appropriate, and other interested parties. The decision must set forth the issue, the relevant facts brought out at the hearing, the pertinent provisions in the law and state agency policy, and the reasoning which led to the decision; and

3. Action required by the decision, if any, has been completed by the agency, and confirmed in writing to the EHO.

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

Special Hearing Requirements			
State Agency Administering Program	**Name of Program**	**Deadline for Hearing** **(From Date Appeal is Received)**	**Hearing Decision Due**
(01) Department of Human Services	General Public Assistance (GPA)	Unspecified	90 days from date the appeal request is received
(02) Department of Human Services	Child Support Services	Unspecified	30 days from date of close of hearing
(03) Department of Human Services	Supplemental Nutrition Assistance Program (SNAP)	60 days from date appeal request is received	60 days from date appeal request is received
(04) Department of Human Services	Office of Rehabilitative Services	60 days from the date appeal request is filed Note: Requests for informal resolution must take place within days of the appeal request and within 30 days of hearing date	30 days from the date of the close of the hearing
(05) Department of Human Services	Division of Elderly Affairs, Home and Community-based Services	14 days from date the appeal request is received	90 days from the date the appeal is received

Special Hearing Requirements			
State Agency Administering Program	**Name of Program**	**Deadline for Hearing** **(From Date Appeal is Received)**	**Hearing Decision Due**
(06) Department of Human Services	All Other DHS Programs including Child Care Assistance, and the State-funded Supplemental Security Program	90 days from the date the appeal is received	90 days from the date the appeal is received
(07) Department of Children, Youth, & Families	Findings of Abuse and Neglect	120 days from date appeal request is received	120 days from date appeal request is received
	Other programs	180 days from date appeal request is received	120 days from date appeal request is received
(08) Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals	Non-Medicaid Programs	15 days from the date the appeal is received	25 days from date of close of hearing
(09) HealthSource RI – health benefit exchange	Qualified Health Plan, Advanced Premium Tax Credits and Cost Sharing Reductions	Varies – See § 2.4.3 of this Part	Varies – See § 2.4.3 of this Part 90 days of the date of the appeal request as administratively feasible

Special Hearing Requirements			
State Agency Administering Program	**Name of Program**	**Deadline for Hearing (From Date Appeal is Received)**	**Hearing Decision Due**
(10) Executive Office of Health & Human Services	Medicaid	90 days from date appeal is received unless expedited	90 days from date appeal is received unless expedited See § 2.4.3 of this Part for expedited appeal requirements
(11) Executive Office of Health and Human Services	Nursing Facility/Assisted Living Transfers and Discharged	Varies – see § 2.4.7 of this Part	10 days from the date of close of a hearing unless expedited. If expedited, see § 2.4.2 of this Part

2.3.3 OPPORTUNITIES FOR FURTHER RECOURSE

A. An appeal decision is final and is the last step in the state's administrative adjudication process for resolving a contested agency action. Not all available remedies are exhausted once the appeal decision is final, however. Therefore, an appellant also must be informed by the EHO of the opportunity to pursue recourse through other legal channels if dissatisfied or aggrieved by the appeal decision as follows:

1. The appellant may file a complaint requesting judicial review of the appeal decision by the appropriate state court with jurisdiction pursuant to R.I. Gen. Laws § 42-35-15, as amended. The filing of such a complaint does not automatically stay the decision or order unless so ordered by the Superior Court.

2. Court proceedings for review are instituted by filing a complaint in the Superior Court of Providence County or in the Superior Court in the county in which the cause of action arose, or where expressly provided by the general laws in the sixth division of the district court or family court of Providence Count within thirty (30) days after mailing notice of the final decision of the agency, or if a re-hearing is requested, within thirty (30) days after that decision thereon.

3. Copies of the complaint shall be served upon the state agency and all other parties of record in the manner prescribed by applicable procedural rules within ten (10) days after it is filed in Court; provided, however, that the time for service may be extended for good cause by order of the Court.

4. Within thirty (30) days after the service of the complaint, or within further time allowed by the Court, the state agency shall transmit to the reviewing Court the original or a certified copy of the entire record of the proceeding under review.

5. Agency/program Specific Reviews as set forth in § 2.4 of this Part.

2.3.4 Agency follow-up regarding APPEAL DECISIONS

A. After the appeal hearing is held and a decision is reached, the Administrative Hearing Office prepares a written document containing the elements identified above in § 2.3.2(C) of this Part. The EHO is responsible for the appropriate dissemination of the decision and providing any additional instructions to the agency that may be necessary to ensure the decision's timely and proper effectuation.

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

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

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

2.3.5 CORRECTIVE ACTION

A. In accordance with 42 C.F.R. § 431.246, the state agency must promptly make corrective payments, retroactive to the date an incorrect action was taken, and, if appropriate, provide for admission or readmission of an individual to a facility if:

1. The hearing decision is favorable to the applicant or beneficiary; or

2. The state agency decides in the applicant's or beneficiary's favor before the hearing.

B. If the EHO decision upholds the state agency's action, a claim against the household for any over issuances shall be prepared in accordance with 7 C.F.R. § 273.18 by DHS.

2.3.6 APPEAL RECORD

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

B. The appeal record consists of:

1. The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing;

2. All papers and requests filed in the proceeding; and

3. The recommendation or decision of the hearing officer.

4. All pleadings, motions, intermediate rulings;

5. Evidence received or considered;

6. A statement of matters officially noticed;

7. Questions and offers of proof and rulings thereon;

8. Proposed findings and exceptions;

9. Any decision, opinion, or report by the EHO;

10. All staff memoranda or data submitted to the EHO or members of the agency in connection with their consideration of the case.

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

2.3.7 MOTIONS

A. General – Any party may request of the EHO any order or action not inconsistent with law, this rule and/or the Rhode Island Superior Court Rules of Civil Procedure.

1. Motions may be made in writing at any time before or after the commencement of a pre-hearing conference or hearing, and/or may be made orally during a pre-hearing conference or hearing. Each motion

must set forth the grounds for the desired order or action and state whether oral argument is requested. Certain types of motions are prohibited by law or regulation for various assistance programs. The administrative fair hearing officer is responsible for ensuring all parties to the case are notified accordingly and that the applicable laws and regulations are equitably applied.

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

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

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

2.3.8 APPELLANT RIGHTS AND RESPONSIBILITIES

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

B. Appellant Rights. It is the responsibility of the State to inform the appellant of the following:

1. Review of Evidence – The appellant has the right to examine all documents and records to be used at the hearing, at a reasonable time of no less than 72 hours before the date of the hearing, as well as during the hearing.

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

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

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

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

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

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

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

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

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

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

2.3.9 EHO/APPEAL ENTITY ROLE AND RESPONSIBILITIES

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

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

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

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

4. Truthful and Accurate Information – State agency representatives are bound to provide truthful and accurate accounts of the basis for the agency action and the materials presented at the hearing.

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

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

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

   c. the appeal is resolved in the informal dispute resolution process; or

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

2.4 Agency/Program Specific Appeal and Hearing Provisions

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

2.4.1 AID PENDING

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

B. HSRI – Commercial Health Insurance through HSRI Renewals.

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

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

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

2.4.2 MEDICAID MANAGED CARE PLAN APPEALS – EOHHS

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

B. The timelines for filing an appeal listed in the table in § 2.3.2(H) of this Part are suspended while the matter is on review with the managed care plan. However, a Medicaid beneficiary retains the right to request an Administrative Fair Hearing through the EHO, in accordance with the provisions set forth in § 2.3.1 of this Part if the matter remains unresolved after exhausting all remedies available through the managed care plan's grievance and appeals process. The final federal managed Medicaid rules allow beneficiaries 120 calendar days to request a fair hearing.

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

Medicaid Managed Care Appeals Not Related to Eligibility		
Medicaid Managed Care Delivery System	**Managed Care Plan Grievance and Appeal Process**	**Applicable Parts**
a) RIte Care Plans – Neighborhood Health Plan, United and Tufts	Medicaid beneficiary once enrolled as a plan "member" must exhaust plan grievance and appeal process before requesting hearing through EHO.	210-RICR-30-05-2 Scope of Services Plan Appeal Process Member Rights
b) Rhody Health Partners – Medicaid Affordable Care Coverage Group Adults Age 19-64	Medicaid beneficiary once enrolled as a plan "member" must exhaust plan grievance and appeal process before requesting hearing through EHO.	210-RICR-30-05-2 Scope of Services Plan Appeal Process Member Rights

c) RIte Share Premium Assistance Program	Medicaid beneficiary must appeal issues in accordance with commercial plan appeals and grievance process. Appeals on all other matters, including cost- sharing and failure to enroll, and any coverage issues that remain unresolved must be made to EHO.	210-RICR-30-05-3 Scope of Program Program and cooperation requirements
d) Rhody Health Partners – Persons who are aged, blind or with disabilities	Medicaid beneficiary must exhaust levels I and II of managed care plan's grievance and appeals process before requesting a hearing through EHO. For MCO contracts starting on July 1, 2017, Medicaid beneficiary must exhaust one level of managed care plan's grievance and appeals process before requesting a hearing	§ 40-10-1 of this Title, RHP Benefit Package § 40-10-1.2.6 of this Title, Grievances, Appeals and Hearings
e) Rhody Health Options –	Medicaid beneficiary must exhaust level I of managed care plan's appeals process before requesting a hearing through EHO.	§ 40-10-1.28 of this Title, RHO Benefit Package § 40-10-1.27.5 of this Title, Grievances, Appeals and Hearings

f) Community Health Team – RI.	Medicaid beneficiary must file appeals related to medical services directly to the EHO. If contracted entity, overseeing delivery option, fails to resolve non-medical formal appeals within set timelines, Medicaid beneficiary may request hearing through EHO.	§ 40-10-1.26.3 of this Title, Service Delivery Options § 40-10-1.41.7 of this Title, Grievances, Appeals and Hearings
g) Medicare Medicaid Plan (MMP)	Medicaid/Medicare beneficiary must exhaust level I of managed care plan's appeals process before requesting a hearing through EHO for Medicaid services or overlap services covered by both Medicare and Medicaid	§ 40-10-1.41.8 of this Title, MMP Benefit Package § 40-10-1.41.7 of this Title, Grievances, Appeals, and Hearings

2.4.3 EXPEDITED APPEAL – MEDICAID, HSRI, LTSS, SNAP

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

B. A long-term services and supports (LTSS) expedited appeal may also be granted in instances in which a state licensed nursing facility or assisted living residence initiates a transfer or discharge of a resident due to either:

1. the planned closure of the facility/residence; or

2. the resident has failed, after reasonable and appropriate notice, to pay for a stay in the facility/residence.

C. An HSRI customer may request an expedited appeal when there is an immediate need for health services because the standard appeal could jeopardize the appellant's life, health, or ability to attain, maintain, or regain maximum function.

D. A request for an expedited appeal shall include information supporting the claim that a standard appeal could jeopardize the appellant's life, health, safety, welfare, or ability to attain, maintain or regain maximum function.

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

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

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

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

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

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

I. SNAP. The State agency shall expedite hearing requests from households, such as migrant farmworkers, that plan to move from the jurisdiction of the hearing official before the hearing decision would normally be reached. Hearing requests from these households shall be processed faster than others, if necessary, to

enable them to receive a decision and a restoration of benefits if the decision so indicates before they leave the area.

2.4.4 HSRI FEDERAL REVIEW OPTION

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

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

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

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

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

    b. Retroactively, to the date the incorrect agency action became effective, at the option of the appellant.

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

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

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

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

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

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

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

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

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

   b. If the hearing has not yet been scheduled, the appellant may request the desk review at any time. Written submissions in such instances are due to the EHO within ten (10) days of the date the

request is made or at such other time as may be agreed to by the affected party, the agency, and the EHO.

2. Upon requesting a desk review, the appellant forfeits the opportunity for an in-person hearing. The agency and the EHO are responsible for ensuring that the appellant is aware that the in-person hearing option has been forfeited and provide information related to any US DHHS and judicial review opportunities.

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

A. The Office of Rehabilitative Services, of the Rhode Island Department of Human Services, sets forth the due process procedures and process for handling contested agency actions, including opportunities for pre-settlement conferences as provided for in ORS rules and regulations. Either party in an ORS contested agency action may request a review of the appeal decision of the hearing officer within twenty (20) days after the date the decision is rendered. If neither party requests this review, the decision of the hearing officer becomes the final decision of the agency on the 21st calendar day after the decision is issued.

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

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

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

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

(1) The approved ORS State Plan;

(2) The Rehabilitation Act of 1973, 29 U.S.C. § 701 *et seq*. as amended, including regulations, rules, policies, or procedures that are consistent with implementing the Act; or

2. The DHS Director shall render a final decision within thirty (30) days of the initial request to review.

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

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

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

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

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

2.4.7 DHS CHILD SUPPORT SERVICES APPEALS

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

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

a. Amount of support paid;

b. Date such payment was made;

c. Date such payment was received by the applicable state agency or RI Family Court;

d. Date and amount of pass-through and/or child support paid; and

e. Pass-through payments that were not made and the reason for non-payment.

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

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

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

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

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

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

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

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

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

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

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

   a. The reason for the transfer;

   b. The effective date of the transfer;

   c. Where the resident will be re-located;

   d. Notice to the resident of the right to appeal and request a hearing through the EHO, designate someone, including legal counsel, to act as an authorized representative during the appeals process, and to review medical and other pertinent evidence.

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

   f. Contact information for both the state's Long-term Care Ombudsman and the RIDOH Center for Health Facility Regulations for the aged. Persons with behavioral health care conditions must be provided with information about the state's Mental Health

Advocate and contact information for the RI Department of Behavioral Healthcare, Developmental Disabilities, and Hospitals and persons with developmental disabilities must be provided with contact information for the Rhode Island Disability Law Center.

E. An appeal of an involuntary discharge must be filed in writing to the EHO during the thirty (30) day appeal period. An expedited appeal request may be filed and determined to be valid in instances involving non-payment by a third party (Medicaid or Medicare) and/or imminent risk to the resident, at the discretion of the EHO, if received within ten (10) days of the notice of the intent to transfer/discharge sent by the provider. To ensure timely resolution of such cases, the EHO must notify the provider upon the appeal's receipt that a written response must be prepared within the timelines specified in § 2.4.8(D)(1) of this Part.

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

G. If a resident's appeal request is submitted within ten (10) days of the date of the notice of intent to discharge/transfer, the resident is prohibited from being relocated pending the decision of the hearing officer, including in instances in which a continuation is granted beyond the date of the intended action. In all cases where the appellant remains in the facility pending the appeal, the hearing must be scheduled no later than thirty (30) days after the receipt of the request for appeal by the EHO. If the appeal decision is rendered prior to the date of the intended action, but upholds the nursing facility's decision to discharge/transfer, the resident may remain in the facility until the date of the intended action.

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

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

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

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

1. An appellant may request a continuance of the appeal hearing by contacting the EHO prior to the date of the scheduled hearing. To the extent feasible, continued hearings must be rescheduled by the EHO for a date that is within forty (40) days from the date of the notice of intended action. The EHO may require an appellant seeking more than one rescheduling of the same hearing to provide good cause, as defined in § 2.3.1(E)(3) of this Part. Notice of the rescheduled hearing must be provided to the affected parties must be provided in a minimum of two (2) business days prior to the date of the rescheduled hearing.

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

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

2.4.9 DCYF CHILD ABUSE AND NEGLECT APPEALS

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

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

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

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

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

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

2.4.10 EQUAL ACCESS TO JUSTICE ACT (EAJA) REQUIREMENTS

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

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

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

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

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

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

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

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

D. Whenever a party prevails in contesting an agency action and has provided the state agency with timely notice of the intention to seek an award of litigation expenses as provided by law, the administrative hearing officer may request testimony, supporting documentation and evidence, briefs or other legal memoranda from the parties prior to making a decision.

E. The decision of the administrative hearing officer to make an award of reasonable attorney’s fees shall be made part of the appeal record, shall include written findings and conclusions with respect to the award, and shall be sent to the claimant, unless the same is represented by an attorney, in which case the decision shall be sent to the attorney of record.

F. No other agency official may review the award.

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

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

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

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

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

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

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

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

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

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

2.4.11 SEVERABILITY

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

210-RICR-10-05-2

TITLE 210 - EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES

CHAPTER 10 - EOHHS GENERAL PROVISIONS

SUBCHAPTER 05 - CONSUMER RIGHTS, RESPONSIBILITIES, AND PROTECTIONS

PART 2 - Appeals Process and Procedures for EOHHS Agencies and Programs (210-RICR-10-05-2)

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