STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE

[redacted]

V. Docket #: 26-1755 & 26-1942

The Fogarty Center – Options &

The Department of Behavioral Healthcare, Developmental Disabilities and Hospitals

DECISION

INTRODUCTION

The Appellant, [redacted], initiated this matter to appeal several issues with The Fogarty Center – Options (Options) and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH). A Microsoft Teams hearing in this matter occurred on Tuesday, May 19, 2026, at 9:00 AM and resumed on Wednesday, June 24, 2026, at 1:00 PM. The Appellant elected the option of a video hearing. For the reasons discussed in more detail below, the Appellant's appeal is denied.

JURISDICTION

The Executive Office of Health and Human Services (EOHHS) is authorized and designated by R.I.G.L. § 42-7.2-6.1 and 210-RICR-10-05-2 to be the entity responsible for appeals and hearings related to BHDDH programs. EOHHS is also authorized and designated by 212-RICR-10-05-1.6 to hear administrative appeals related to the outcome of a participant's grievance with a BHDDH licensed Developmental Disability Organization. The administrative hearing was held in accordance with 210-RICR-10-05-2 and the Administrative Procedures Act (R.I.G.L. § 42-35-1 et. seq.).

ISSUE

The issues are:

1) Can the Appellant be reimbursed for items covered by the Individualized Service Plan (ISP) that were purchased out of pocket without providing a bank/credit card statement?
2) Is Options' grievance policy in compliance with 212-RICR-10-05-1.5?
3) Can a Direct Support Professional (DSP) be paid $37 an hour?
4) Can a DSP be provided with paid time off?

STANDARD OF PROOF

It is well settled that in adjudications modeled on the Federal Administrative Procedures Act, a preponderance of the evidence is required to prevail. This means that for each element to be proven, the factfinder must believe that the facts asserted are more probably true than false. 2 Richard J. Pierce, Administrative Law Treaties § 10.7 (2002) & see *Lyons v. Rhode Island Pub. Employees Council 94*, 559 A.2d 130, 134 (R.I. 1989). When there is no direct evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. *Narragansett Electric Co. vs. Carbone*, 898 A.2d 87 (R.I. 2006).

PARTIES

In attendance at the hearing were:

- Heather Alge – Chief Executive Officer for Options
- Heather Mincy – Assistant Director of Administrative Services for BHDDH's Division of Developmental Disabilities
- Jackie Camilloni – Coordinator of Community Planning & Development for BHDDH's Division of Developmental Disabilities
- Jeff Kasle, Esq. – Legal Counsel for Options
- Linda Vollaro – Director of Self-Direction at Options

- [redacted] – Authorized Representative of the Appellant
- Thomas Corrigan, Esq. – Senior Legal Counsel for BHDDH

EXHIBITS

The following exhibits were presented as evidence:

- Letter from BHDDH to the Appellant dated February 27, 2026
- The Appellant's appeal requests in Dockets 25-5836, 26-1755, & 26-1942
- Options' Grievance and Appeals Policy (pre-February 2026 revision)
- Options' Grievance and Appeals Policy (revised February 2026)
- Options' letter to the Appellant's Authorized Representative dated December 22, 2025
- Options' letter to the Appellant's Authorized Representative dated February 12, 2026
- Options' letter regarding the Motion for Reconsideration in Docket #25-5836, dated February 27, 2026
- First page of a Centers for Medicare and Medicaid Services cover letter to the Rhode Island State Medicaid Director and select pages of the Centers for Medicare and Medicaid Services – Special Terms and Conditions for the Rhode Island Comprehensive Demonstration for January 2026 through December 2030
- BHDDH – Division of Developmental Disabilities' Technical Bulletin 24-02 – Employing DSPs in the Self-Direct Service Model, dated April 29, 2024
- BHDDH – Division of Developmental Disabilities' Technical Bulletin 19-02 – Self-Directed Services: Allowable Individual Goods and Services, dated April 4, 2025
- Blank Options' Reimbursement Request Form & Receipt Log
- The Appellant's Participant Budget Statement for September 2024 through August 2025
- Spreadsheet of the Appellant's budget with Options for September 2025 through August 2026

- Appellant's faxes to Options related to reimbursement of pool supplies, [redacted] lessons, and [redacted] lessons with accompanying documentation dated: July 13, 2015, August 28, 2015, October 24, 2016, February 3, 2023, April 25, 2025, & July 15, 2025
- Options Reimbursement Request Form completed by the Appellant related to reimbursement of pool supplies, pool closure, [redacted] lessons, and [redacted] lessons with accompanying documentation dated August 5, 2025, August 14, 2025, October 20, 2025, December 8, 2025, and April 14, 2026
- Check from Options to the Appellant dated May 23, 2025
- Appellant's Self-Directed Spending Plan for September 2025 through August 2026
- EOHHS decision on Respondent's Joint Motion to Dismiss in Docket #25-5836
- Printout from Medicaid.gov on Self-Directed Services
- EOHHS Motion for Reconsideration Received/Notice of Opportunity to Respond issued on June 11, 2026, in Docket #26-1755
- EOHHS Decision on Appellant's Motion for a Reconsideration in Docket #25-5836
- Options' "Self-Directed Support Agreement" BHDDH – memorandum of understanding
- Options' Policy for Payments to Vendors
- Emails of: September 15, 2021; September 16, 2021; September 17, 2021; September 28, 2021; September 29, 2021, at 7:21 AM, 11:09 AM, 2:51 PM, and 4:46 PM; October 1, 2021; November 22, 2021, at 3:50 PM and 3:51 PM; January 6, 2022; January 7, 2022, at 8:33 AM, 11:42 AM, and 1:04 PM; January 21, 2022; June 28, 2024; August 6, 2024; March 13, 2025; March 14, 2025; April 16, 2025, at 1:54 PM and 6:10 PM; April 24, 2025, at 8:59 AM, 4:17 PM, 2:57 PM, and 5:26 PM; May 13, 2025; May 14, 2025; August 15, 2025; August 17, 2025; August 27, 2025, at 4:59 PM, 7:51 PM, and 7:55 PM; October 20, 2025; October 21, 2025, at 6:12 AM and 5:40 PM; October 22, 2025, at 6:16 AM, 11:00 AM, 11:12 AM, 11:24

AM, and 11:27 AM; December 3, 2025; December 8, 2025; December 11, 2025; December 12, 2025, at 9:58 AM, 9:59 AM, 11:21 AM, 11:37 AM, 12:59 PM, 1:06 PM, and 3:40 PM; December 15, 2025, at 10:44 AM and 2:36 PM; December 22, 2025; December 23, 2025, at 10:34 AM, 10:55 AM, and 10:58 AM; January 20, 2026; January 29, 2026; February 17, 2026; March 18, 2026; June 9, 2026; June 11, 2026; June 12, 2026, at 2:44 PM, 2:47 PM, and 2:55 PM; and June 19, 2026

MOTION REGARDING AID-PENDING

RELEVANT LAW/REGULATIONS

210-RICR-10-05-2.2.2 permits discontinued or reduced benefits to be reinstated or continue unchanged while pending appeal. This is known as aid pending. Aid pending does not apply for new requests which got denied as there was nothing prior to the appeal to reinstate or continue.

FINDINGS OF FACT

The Appellant has been on BHDDH's Self-Directed program for several years. This required the creation and renewal of an ISP. With Options enforcement of the need for bank/credit card statements, the Appellant has not been reimbursed this plan year for expenses on the ISP that have been reimbursed in previous plan years without a bank/credit card statement. The Appellant argues that they should be entitled to aid pending and be able to get reimbursed pending the outcome of the appeal without the need for bank/credit card statements. The Appellant must submit a new reimbursement request with supporting documentation for every transaction that occurs. Each request is handled separately.

DISCUSSION

Aid pending is intended to cover cases where ongoing benefits are being reduced or terminated. This allows the Appellant to remain on the benefits till the appeal is resolved. The Appellant argues that since these items have been in their ISP for years, these are not new requests and therefore they should be able to get aid pending. However, this is not a correct interpretation of the situation. Each request for

reimbursement is submitted separately, as they need to be submitted within 30-45 days. As such, each request for reimbursement is a separate decision and therefore it is a new denial for each request in this case. When an agency has historically been lenient in enforcing its own policy, such as the requirement for bank/credit card statements for reimbursements, and then starts to enforce that existing policy, aid pending is not appropriate to keep the lenient non-compliant procedures in place pending appeal.

CONCLUSION OF LAW

After careful review of the testimony and evidence presented at the administrative hearing, this tribunal concludes:

1. Each request for reimbursement is a new action and therefore aid pending is not available.

ISSUE #1: OPTIONS' REIMBURSEMENT REQUIREMENTS

RELEVANT LAW/REGULATIONS

Federally, the state must ensure financial accountability for Medicaid funds provided to its Home and Community-Based Services. This includes providing for an independent audit of the waiver program, as well as making available appropriate financial documents showing the costs of services provided under the waiver. 42 C.F.R. § 441.302 (b). The state plan between the Centers for Medicare and Medicaid Services and the state of Rhode Island also requires that all fiscal intermediaries be licensed by BHDDH. This plan requires the fiscal intermediary to submit annual audited financial statements with any findings, recommendations, and corrective action plans. Centers for Medicare and Medicaid Services – Special Terms and Conditions - Rhode Island Comprehensive Demonstration at 8.12.

On the state level, BHDDH requires Developmental Disability Organizations to have written policies and procedures for the handling and management of participants benefits. This includes provisions to ensure the benefits are safeguarded and they are managed in compliance with all federal and state statutes, rules, and regulations. 212-RICR-10-05-1.10.3 (S, T, U, Y, & Z).

Options has established written policies related to the handling of participants benefits. Specifically, Options has the Policy for Payments to Vendors which requires service providers to be vendors of Options. This allows for direct payment to the vendors by Options and to ensure timely, accurate, and efficient payments while fostering good vendor relationships and upholding the company's financial integrity. In cases of goods, the participant can purchase the approved goods and then get reimbursed by Options. This requires back up of a receipt and proof of payment. The policy also requires record keeping for audit purposes, including those done for the Centers for Medicare and Medicaid Services and/or BHDDH, to be maintained by Options.

FINDINGS OF FACT

Included in the Appellant's ISP are pool supplies, music lessons, and dance lessons. Historically, the Appellant paid for these goods and services out of pocket and then submitted claims to Options to get reimbursed by sending a completed reimbursement form, receipt, and invoice. This was despite policies being in place that require payments to be made directly to service vendors and bank/credit card statements being needed for reimbursement of goods. These policies are written in Options' Policy of Payments to Vendors. In previous plan years, the Appellant signed an agreement to abide by the policy. The Appellant refused to sign the agreement for the current plan year. Options' reimbursement request form has listed the requirement for bank/credit card statements since, at least, September of 2022. In 2025 and into 2026, Options began requiring strict compliance with these policies.

DISCUSSION

At issue here is the balance between the oversight of federal and state funds versus the Appellant's interest in easily accessing their Medicaid benefits. Options argued that they need bank/credit card statements to ensure they are reimbursing the person who actually paid for the item(s) and to meet audit requirements. The Appellant argues that the receipt and invoice should be enough.

The Appellant analogized the reimbursement process with that of making a return to a store of a consumer good. They argued at hearing that a receipt is enough for a return and therefore the invoice and

receipt should be enough for the reimbursement. This argument fails to consider that many stores put other restrictions related to a return such as requiring a driver's license and/or limiting refunds to the original source/card. As such it is reasonable that Options will have a requirement to verify the reimbursement goes to the correct source (person) as a store would be doing by requiring the refund to go onto the original card.

Additionally, federal and state regulations require that an audit trail exists and for the periodic auditing of these Medicaid funds. See 42 C.F.R. § 441.302 (b) and 212-RICR-10-05-1.10.3 (S, T, U, Y, & Z). An audit trail would require documentation and paperwork showing how monies were distributed. As such, Options' requirement for a bank/credit card statement to verify payment for goods before reimbursement is made to the payee, is permissible.

CONCLUSION OF LAW

After careful review of the testimony and evidence presented at the administrative hearing, this tribunal concludes:

1. Considering the auditing and oversight needs of Medicaid funds, the requirement for bank/credit card statements for reimbursement is permissible.

ISSUE #2: OPTIONS' COMPLIANCE WITH 212-RICR-10-05-1.5

RELEVANT LAW/REGULATIONS

212-RICR-10-05-1 sets forth regulations related to the licensing and operation of Developmental Disability Organizations.

Under 212-RICR-10-05-1.5, Developmental Disability Organizations are required to have an internal grievance process that includes certain elements.

212-RICR-10-05-1.6 allows participants to appeal the Developmental Disability Organization grievance decision with EOHHS.

FINDINGS OF FACT

Based on the decision in 25-5836, the Appellant filed a grievance with Options. As a result, Options implemented changes to their grievance policy. The Appellant argues that Options' new grievance and appeals policy is not incompliance with 212-RICR-10-05-1.5.

DISCUSSION

The purpose of 212-RICR-10-05-1 is to establish standards for the licensing of Developmental Disability Organizations. While the policy permits the outcome of grievances to be appealed to EOHHS by participants, it does not provide a blanket permission for participants to appeal to EOHHS every aspect of those regulations. 212-RICR-10-05-1.6 limits EOHHS' jurisdiction to reviewing participant's grievance decisions.

Issues of regulation compliance belong to BHDDH to address via the licensing process. This does not bar a participant from filing a complaint with BHDDH on the issue, but it remains with BHDDH to decide whether to act.

CONCLUSION OF LAW

After careful review of the testimony and evidence presented at the administrative hearing, this tribunal concludes:

1. The issue of Options' grievance policy complying with 212-RICR-10-05-1.5 is a licensing issue. Any belief that Options' policy is non-compliant should be addressed with BHDDH who, if appropriate, can make a licensing decision.

ISSUE #3: BHDDH'S DENIAL OF A $37/HOUR PAY RATE FOR THE APPELLANT'S DSP

RELEVANT LAW/REGULATIONS

Federally, the state must provide assurances that the rates paid for Home and Community Based Services, such as DSP's, are adequate to ensure that the workforce can provide sufficient direct care that meets the Medicaid recipients need. 42 C.F.R. § 441.302 (k). However, the state also ensures that each

service is sufficient in amount, duration, and scope to reasonably achieve its purpose. Furthermore, the state can place appropriate limits on services, including utilization control procedures. 42 C.F.R. § 440.230 (b & d).

In implementing these measures, BHDDH has issued Technical Bulletin #24-02: Employing DSPs in the Self-Directed Service Model which lists the pay rate available for DSPs from $20/hour to $35/hour.

FINDINGS OF FACT

With the 2025/2026 plan year, the Appellant wanted to pay their DSP $37/hour. This was denied by BHDDH for exceeding the $35/hour max under the Technical Bulletin. The Appellant's ISP was approved at the $35/hour rate while the issue was litigated under appeal.

DISCUSSION

BHDDH has a duty to ensure that participants are paying their DSP's sufficiently enough to allow participants to recruit competent staff for their care. See 42 C.F.R. § 441.302 (k). BHDDH also has the ability to impose utilization limits on services. This can include putting a cap on the maximum pay rate participants can pay their DSPs. Here BHDDH set a $20-$35 limit for DSP's hourly wages. This is to ensure that appropriate staff are hired but to also ensure that the budget is not fully spent before the end of the plan year.

The Appellant argues that they have budget authority and should be able to set the rate they want. However, this is limited by federal and state authority to impose utilization controls and oversight of the Medicaid program and Medicaid funds. It is completely reasonable for BHDDH to impose a maximum to DSP wages. Without limits, someone could pay an exurbanite rate to their DSPs at the expense of depleting their budget too quickly. Again, BHDDH has the ability and duty to ensure that the client does not completely spend their benefits for the year prematurely.

To the extent that the Appellant disagrees with the limits being written in a guidance document versus as a codified regulation, they can petition BHDDH to replace it with a rule under R.I.G.L. § 42-35.2.12 (g & h).

CONCLUSION OF LAW

After careful review of the testimony and evidence presented at the administrative hearing, this tribunal concludes:

1. The $35/hour limit for a DSP is a valid utilization control that can be imposed by BHDDH.
2. Any issues with this limit in a guidance document as opposed to codified regulations should be addressed through R.I.G.L. § 42-35-2.12 (g) and not through an administrative appeal.

ISSUE #4: BHDDH'S DENIAL OF PAID TIME OFF FOR THE DSP

RELEVANT LAW/REGULATIONS

The Centers for Medicare and Medicaid Services set forth the scope of the Medicaid program. However, states can apply to have the Centers for Medicare and Medicaid Services waive some of those requirements to allow states to develop cost effective programs that are tailored to the state's needs. BHDDH's self-directed program is established under a waiver.

In the Rhode Island's state plan, there are three delivery systems for Long-Term Care Services. This includes care provided 1) through a Managed Care Organization, i.e., a health plan, 2) through Fee-For-Service, or 3) through a Self-Directed option. These describe how the services are provided. Centers for Medicare and Medicaid Services – Special Terms and Conditions - Rhode Island Comprehensive Demonstration at 7.1. Payments for those services are made either in accordance with a health plan's contractual agreement or as Fee-For-Service. 210-RICR-20-00-1.4 (B).

BHDDH's Technical Bulletin #24-02: Employing DSPs in the Self-Direct Service lists some potential benefits that participants can offer their DSP, such as health insurance, ISP goal-related training, and ISP goal-related travel cost reimbursement and/or mileage. The technical bulletin does not list paid

time off as an example. In several places the technical bulletin stresses that DSPs are paid for services provided/while they are working with a participant, such as when performing work in alignment with the ISP.

Federally, the state must provide assurances that the rates paid for Home and Community Based Services, such as DSPs, are adequate to ensure that the workforce can provide sufficient direct care that the Medicaid recipients need. 42 C.F.R. § 441.302 (k). However, the state also ensures that each service is sufficient in amount, duration, and scope to reasonably achieve its purpose. Furthermore, the state can place appropriate limits on services, including utilization control procedures. 42 C.F.R. § 440.230 (b & d).

FINDINGS OF FACT

With the 2025/2026 plan year, the Appellant wanted to be able to offer their DSP paid time off. This was denied by BHDDH. The ISP was approved with the omission of the paid time off while the issue was litigated under appeal.

DISCUSSION

DSPs cannot be given paid time off for two reasons. First, as discussed with the $35/hour pay cap, BHDDH can impose utilization control procedures to ensure that participants do not exhaust funds too quickly and as a result not be able to pay for some of the care they need. It is reasonable that BHDDH would impose a utilization control to ensure that the state is providing the care needed to these Medicaid recipients.

Second, Medicaid services are delivered through a Managed Care Organization (i.e., a health plan), through a Fee-For-Service model, or through a Self-Directed model. However, these services are paid for either directly from the state (as Fee-For-Service) or through a health plan contracted to manage the services. 210-RICR-20-00-1.4 (B). While, the Self-Directed model is a third way to provide services, it is not its own payment method under 210-RICR-20-00-1.4. As such services provided under a Self-

Directed model must be funded either through a health plan contract or as Fee-For-Service. Here there is no evidence that a health plan is involved in providing the Appellant's services and as such the funding must therefore be under Fee-For-Service.

As the name Fee-For-Service implies, payment is made for each service rendered. This is evident in the Technical Bulletin #24-02. In at least three different places the technical bulletin provisions emphasized this pay per service nature. This includes under "Employer Authority" which lists that DSPs cannot be paid to sleep over and that participants pay for services provided based on the occurance of the respective service. Under "Managing Employees," employees are only paid for the time they are working with a participant. Finally, under "Providing Support Durning a Participant's Vacation," the technical bulletin states that self-direct funding can only be used for directed services and not be used to cover the employee's cost, such as travel expenses or hotel costs, while they accompany the participant on vacation.

The very nature of paid time off is that the individual is not working, or in the case of a DSP, while they are not providing a service. As a result, the Appellant is not allowed to give their DSP paid time off as there is no service being provided.

CONCLUSION OF LAW

After careful review of the testimony and evidence present at the administrative hearing, this tribunal concludes:

1. The prohibition on giving DSPs paid time off is a proper utilization control measure
2. Medicaid services provided under a Self-Directed program are funded under Fee-For-Service. This requires a service to be provided to allow payment. The absence of services being provided while a DSP is on paid time off prohibits payment for the paid time off.

DECISION

Based on the foregoing findings of fact, conclusions of law, evidence, and testimony, it is found that a final order be entered that:

- The Appellant is not eligible for aid pending in this case.
- The Appellant is not eligible for reimbursement without providing a bank/credit card statement.
- The issue of Options grievance policy being non-compliant with 212-RICR-10-05-1.5 is a licensing issue for BHDDH to act on and not one the Appellant can appeal.
- The Appellant cannot pay their DSP $37 an hour or offer the DSP paid time off.
- The Appellant cannot offer the DSP paid time off.

APPEAL DENIED

/s/ Shawn J. Masse

Shawn J. Masse

Appeals Officer

NOTICE OF APPELLATE RIGHTS

This decision is a final order under R.I.G.L. § 42-35-12. Under R.I.G.L. § 42-35-15, this Order may be appealed to court within thirty (30) days of the mailing of this decision. Such appeal, if taken, must be completed by filing a complaint in court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

Appeals are generally filed in the Providence County Superior Court. However, appeals affecting or concerning children under the age of eighteen (18) and/or appeals of a DCYF action may need to be filed in Providence Family Court. If you have any questions about which court a

complaint for appeal should be made, you should seek the advice of an attorney, Rhode Island Legal Services, or the clerk of the court where you wish to file your appeal. The courts' contact information can be found on the judiciary's website (https://www.courts.ri.gov). Copies of the appeal must be served upon all parties in your case within ten (10) days of the filing of your appeal.

If you exercise any of these appellate rights, please inform the EOHHS Appeals Office of this so we can prepare a copy of the record for the court. You can contact the Appeals Office at OHHS.AppealsOffice@ohhs.ri.gov, 401.462.2132 (Phone), 401.462.0458 (Fax), or at 3 West Road, Virks Building, Cranston, RI 02908.

CERTIFICATION

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to [redacted] Heather Alge at The Fogarty Center – Options, 310 Maple Avenue, Suite 102, Barrington, RI 02806, Linda Vollaro at the Fogarty Center – Options, 310 Maple Avenue, Suite 102, Barrington, RI 02806, and to Cindy Lachance at the Fogarty Center – Options, 310 Maple Avenue, Suite 102, Barrington, RI 02806; copies were sent, via email, to [redacted], Heather Alge at [redacted], Linda Vollaro at [redacted], Cindy Lachance at [redacted], Kate Breslin-Harden, Thomas Corrigan, Esq., Donna Standish, Karen Lowell, and Natalie Munoz on this 7th day of August, 2026.