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MEMORANDUM

To: The Honorable Marvin L. Abney, Chairman, House Committee on Finance

From: Brian Daniels, Director Office of Management and Budget

Date: March 24, 2026

Subject: **March 4, 2026 House Finance Follow-up**

I am writing to provide clarification and additional documentation related to questions posed by members of the House Committee on Finance at the hearing held on March 4, 2026, on the topic of Articles 8, 10, and 11 in the FY 2027 Governor's Recommended Budget. As always, if you require more information or need clarification on what has been presented below, please feel free to reach out to my team and me.

Question asked by Representative Finkelman requesting data on recent Medicaid program growth trends by category, particularly pharmacy spending.

Response: Overall, Medicaid spending is projected to reach $3.98 billion on an all-funds basis, according to the November caseload estimating conference. This represents a nearly 20% increase from FY 2024 and an additional $225 million in general revenue outlays by the State. The table below shows annual growth from FY 2020 through the November estimate for FY 2027, expressed in both dollars and annual growth rate.

Table 1. Medical Benefits (Medicaid EOHHS) by State Fiscal Year with annual change

	All Funds		General Revenue	
FY 2020	$2,377.1 M	–	$871.6 M	–
FY 2021	$2,603.7 M	10%	$875.8 M	0%
FY 2022	$2,944.8 M	13%	$953.6 M	9%
FY 2023	$3,091.9 M	5%	$1,030.5 M	8%
FY 2024	$3,321.0 M	7%	$1,220.2 M	18%
FY 2025 - Prelim	$3,586.8 M	8%	$1,322.4 M	8%
FY 2026 - Nov	$3,900.8 M	9%	$1,412.7 M	7%
FY 2027 - Nov	$3,987.9 M	2%	$1,445.6 M	2%

There are many utilization and price cost drivers, including: home and community-based services, behavioral health services, pharmacy services, and hospitals services. Detail for each of these areas is included below.

Home and Community Based Services (HCBS)

Since SFY 2020, HCBS authorizations (individuals authorized to receive services) have observed a 12% compounded annual growth rate (primarily in fee-for-service). HCBS authorizations within managed care products, including the dual Medicare and Medicaid plan, as well as the Program of All-inclusive Care for the Elderly (PACE), have also seen growth. Authorizations in the duals plan are up 29% and authorizations in PACE have nearly doubled. Additionally, authorizations have increased by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals (BHDDH) for clients with intellectual and/or developmental disabilities (I/DD) receiving HCBS care, as well as by the Office of Healthy Aging (OHA) for elders receiving limited adult day or personal care services.

Significantly, alongside these increases in the number of authorizations, the State has also observed significant increases in the average number of hours utilized per client (nearly 10% per year compounded annual growth rate from 2020-2025) and in provider reimbursement rates based on legislative action (including enacting OHIC rate review recommendations). For example, reimbursement rates paid to the HCBS providers increased by as much as 50% in SFY 2025 under the enacted OHIC rate review initiative.

Behavioral Health Services

In October 2025, the Executive Office of Health and Human Services' Medicaid program, the Department of Children, Youth and Families (DCYF), and BHDDH implemented the legislatively mandated Certified Community Behavioral Health Clinics (CCBHC) program, reflecting a significant transformation on the state's behavioral health safety net. Spending on CCBHC-covered behavioral health services increased from $64 million in SFY 2024 to an anticipated $145-$150 million in SFY 2026 on an all-funds basis. In general, these increases are due to required changes in reimbursement methodology.

Please note that the CCBHC providers continue to offer other behavioral health services not included in the CCBHC program. These include SUD residential services, certain DCYF-related services, Mental Health Psychiatric Rehabilitative Residences (MHPRR) services, among others. Most of these non-CCBHC services remain under the purview of the OHIC rate review so they too have seen marked increase in spending by the State in SFY 2025 and SFY 2026.

Pharmacy

Pharmacy is another area with increasing spend. The compounded annual growth rate on net pharmacy spend from SFY 2019 to SFY 2023 was 13.5%.

Of 630 drug classes recently analyzed by EOHHS, 205 increased in total spend while 303 classes saw some magnitude of decrease. However, the mean increase in spend was 25% while the mean decrease was only 15%. This indicates that while many drug classes are becoming cheaper, the spend on drugs that are getting more expensive is outpacing the cost decreases in the declining drug classes. The largest increases in retail pharmacy spend are primarily in antiviral treatments. Per script, antiviral Main Protease (Mpro) inhibitors grew at a compound rate of 243 percent since SFY 2022, while RNA polymerase inhibitors grew at a

compound rate of 196 percent since SFY 2022. These antiviral drugs have been used to treat COVID.

GLP-1 drugs, prescribed for obesity, are also a major cost driver in retail pharmacy claiming and as a portion of managed care capitation rates. In SFY 2025, there was $28.0 million in spending for GLP-1 drugs for all diagnoses, making them the drug category with the highest total spend among all retail drugs. This represents an increase in claims costs of 4% over SFY 2024 and 17% over SFY 2022. In SFY 2026, capitation rates included $5.91 per member per month to cover GLP-1 *obesity* claims, equating to $19.4 million in estimated capitation payments for the year. In the SFY 2027 rates, the state actuarial consultant estimates PMPM costs from a relatively static position ($5.34 PMPM, for $16.8 million in estimated capitation) to as high as $8.25 PMPM ($27.0 million in total capitation).

In recent years, the FDA has approved several new cell and gene therapies (CGTs), which provide significant milestones in the treatment of cell and gene diseases, such as sickle cell disease. These therapies come with a high cost that Medicaid anticipates will drive increases in pharmacy costs for the state in the next few years. The current list of all approved and available CGTs range from $65,000 to $4.3 million, with an average of $1.8 million (does not include ancillary costs billed to medical). The majority are one-time treatments, however there are a few exceptions. Please note: Medicaid incorrectly referenced a cost of $30 million dollars for a single treatment during the hearing on March 4, 2026.

In January 2024, CMS announced that sickle cell disease would be the first focus of the CGT Access Model.[1] The CGT Access Model is a voluntary model for states and manufacturers that tests whether a CMS-led approach to developing and administering outcomes-based agreements for cell and gene therapies improves Medicaid beneficiaries' access to innovative treatment, improves their health outcomes, and reduces health care costs and burdens to state Medicaid programs. Under the program, CMS will negotiate outcome-based agreements with manufacturers, linking pricing to health outcomes, and provide states with an option to access these drugs at a negotiated rate.

Hospital Services

In SFY 2026, EOHHS testified in the November Caseload Estimating Conference that supplemental aid to hospitals, i.e., hospital funding sent directly to hospitals by the State/Medicaid program and not specific to direct patient care (managed care or FFS), is estimated to grow by 14.0 percent, or $45.0 million, compared to the previous year.

Additionally, as illustrated in the publicly published *Medicaid Expenditure Report*, inclusive of managed care/FFS spend and supplemental hospital aid, annual hospital spending has increased by approximately $373.4 million, or 42.4 percent from SFY 2020 to SFY 2024, or annual compounded growth of 9.2 percent. Note, the totals include support for Eleanor Slator and the State Psychiatric Hospital.

[1] https://www.cms.gov/newsroom/press-releases/biden-harris-administration-announces-action-increase-access-sickle-cell-disease-treatments

Question asked by Representative Tanzi regarding operational details of referrals from 988 to MRSS providers, including whether referrals occur through warm handoffs or require a separate call and how the transfer process works in practice.

All 988 calls follow protocols for addressing the need for community-based response, which include warm handoffs. Family Service of Rhode Island (FSRI) and Tides Family Services (Tides) participated in situational incidents training facilitated by the interagency state team, which includes BHDDH and DCYF staff, to coordinate warm handoffs (for example mock-calls). Tracking of warm handoffs is also monitored by the interagency team. To coordinate immediate access to services with seamless connection, callers are connected directly to a provider while remaining on the call with 988, unless the caller requests otherwise.

Question asked by Representative Tanzi to confirm whether there are plans to establish a second crisis stabilization facility beyond the current East Providence location.

Yes, there are plans for a second crisis stabilization facility. The establishment of a crisis stabilization facility in the South County area is incorporated in the State's approved plan for the Rural Health Transformation Grant.

Question asked by Representative Tanzi on clarity of which agency has regulatory authority related to concierge-style primary care practices and whether the state currently has oversight tools related to these models.

The Rhode Island Department of Health (RIDOH) does not regulate primary care practices, including concierge models. Its authority is limited to licensed healthcare professionals and certain licensed facilities.

Most concierge practices in Rhode Island are physician-owned and operated and are not subject to facility licensure as Organized Ambulatory Care Facilities. Oversight of care in these settings is therefore tied to the individual licensed practitioner, and complaints related to clinical care are referred to the Board of Medical Licensure and Discipline.

RIDOH estimates there are approximately 20–25 concierge-type practices operating in Rhode Island; however, identifying the exact number is limited, as data collection occurs through the Office of Health Systems Development as part of the Statewide Health Inventory process pursuant to R.I. Gen. Laws § 23-93-5.

Question asked by Representative Tanzi regarding whether the legislature could expand OHIC authority to cover self-insured public plans or otherwise broaden oversight authority.

OHIC acknowledges Representative Tanzi's question regarding the potential to expand its authority to cover self-insured public plans or otherwise broaden oversight. OHIC will undertake a legal and policy analysis, in consultation with appropriate staff and counsel, to assess the current regulatory landscape and the scope of state authority in this area. Findings will be shared with the Committee once the review is complete.

cc: Members of the House Committee on Finance
Sharon Reynolds Ferland, House Fiscal Advisor
Christopher O'Brien, Committee Clerk