MEDICAL ASSISTANCE – November 2026

1. **Please provide, where possible, excel spreadsheets/tables with details/explanation for your narrative testimony related to expenditures, eligibility, growth factors, rate changes and methodology for projections. Please include notes/comments on any related adjustments or factors that are relevant to the estimate.**

   See testimony and accompanying Excel workbook.

2. **Please update "Tab 1" of the attached file (or provide a similar file) showing average caseload and average capitation rates for all managed care product lines to reflect the Executive Office's estimates for FY 2027 and FY 2028. Please include any necessary updates for FY 2026. Please provide, where possible, details on the risks to federal funding.**

   See Attachment 7 for capitation rates and summary by product line. Additional details on caseload are included in Attachment 5a-d, and throughout testimony.

FY 2026 Closing -Update

1. **Please provide a FY 2026 closing analysis by program (in the same format that has been used for prior November testimony) with a separate column identifying any variance to the preliminary closing.**
   a. **Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position.**
   b. **Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2026 preliminary closing.**

      See **FY 2026 Fiscal Close** in the Major Developments section of testimony.

2. **Please include a column for FY 2026 preliminary closing figures in the summary tables within each section of your testimony.**

   This column is included as requested.

FY 2027 Budget

1. **Please include a status update on budget initiatives as outlined in "Tab 3a" of the attached file. Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate, and any known barriers to approval.**
   a. **a. Include all relevant details regarding the status of pending submissions to CMS, including the 1115 demonstration waiver.**

      See Attachment 2a and the **FY 2027 Budget Initiative Implementation section** within the Major Developments section of testimony.

Federal Issues and Contract Status

1. **Please provide an update to the May Caseload testimony on CMS finalized rules for its Medicaid Access Rule and Medicaid Managed Care Rule will impact projected caseload and programming. Streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Applications, Eligibility Determination, Enrollment and Renewal Processes (including but not limited to impacts on eligibility (including justice-involved youth deadline of January 1, 2025); FFS Rate Transparency & Rate Restructuring; State Directed Payments; In Lieu of Services; HCBS Payment Adequacy; HCBS Quality Measure Set; and Nursing Facility Minimum Staff Ratios and Cost Reporting).**

a. **Please also include any updated timelines for the changes and any specific impacts to these items from HR 1.**

Update on Impacts of CMS Final Rules on Caseload and Programming – CAA Section 5121

This update expands upon the November caseload testimony to reflect the anticipated impact of the CMS final rules on Rhode Island's projected caseload and programming. Particular emphasis is placed on implementation of Section 5121 of the Consolidated Appropriations Act, 2023 for justice-involved youth under age 21, as well as eligible former foster youth up to age 26. In keeping with federal rules, individuals who are incarcerated are placed on suspended Medicaid status during their incarceration and disenrolled from Medicaid Managed Care when applicable. When an individual is released from incarceration, their Medicaid status is changed to active, and they are re-enrolled in Medicaid Managed Care when applicable.

The State is building system and operational enhancements to streamline re-enrollment into Managed Care Organizations (MCOs) for individuals transitioning from both RITS and RIDOC, minimizing gaps in coverage and ensuring seamless continuity of care upon release. The CMS Access Rule supports this approach by streamlining eligibility and renewal processes, reducing administrative barriers, and improving timeliness of coverage activation and maintenance. Rhode Island anticipates a moderate increase in pre-release eligible individuals, including both youth under 21 and eligible former foster youth up to age 26, driven by improved continuity of coverage, more timely activation, and streamlined managed care re-enrollment processes.

In alignment with Section 5121, Rhode Island is implementing a phased service delivery model to ensure required services are both authorized and delivered during the pre-release period.

- The State is developing infrastructure to enable RITS and RIDOC to directly deliver and bill for Targeted Case Management (TCM) and other required pre-release services via the Fee for Service delivery system
- Operational workflows are being developed to ensure services are delivered within the pre-release window, including screening, assessment, and care planning
- Leveraging existing eligibility to initiate services, while concurrently building billing and documentation infrastructure to support reimbursement.

Programming Impact:

- Expansion of carceral facility-based care coordination capacity, including TCM delivered by RITS and RIDOC
- Development of clinical and care management workflows within carceral facilities
- Increased reliance on data sharing to support coordination and continuity

Initial efforts are focused on enabling RITS and RIDOC to directly deliver and bill for targeted case management and other required services through a fee-for-service model, while longer-term strategies include improving managed care re-enrollment processes and evaluating the role of MCOs in supporting continuity, financing, and outcomes for this population.

Medicaid Access Rule and Medicaid Managed Care Rule

In May 2024, CMS finalized its Medicaid Access Rule and Medicaid Managed Care Rule, which represent significant changes to the Medicaid program, imposing new requirements to enhance and standardize reporting, monitoring, and evaluation of Medicaid access to services. RI Medicaid completed an in-depth

review of these new rules and requirements and has mapped out initial plan of resources to implement the work, which was phased in starting July 2024. Medicaid has eight working groups developing implementation plans. The implementation is occurring based on the federal deadline. As such, any new requirement to be implemented by 7/1/2027 is taking precedence over the remaining new requirements that are to be implemented in 2028 and beyond.

- The Access Rule requires Rhode Island Medicaid, in collaboration with BHDDH, DHS, and DCYF, to establish a Home and Community Based Services (HCBS) grievance system for FFS enrollees. The effective date set by the rule was initially July 9, 2026, but CMS has issued guidance that CMS is exercising enforcement discretion until December 2027. The system would allow individuals to file complaints about state/provider performance with person-centered planning, services plans and HCBS settings requirements. The system must:
    - Accept grievances either orally or in writing and provide members with reasonable assistance in completing procedural steps
    - Allow another individual or entity to file a grievance on one's behalf with written consent
    - Ensure decisions on grievances are not made by individuals involved with the issue being addressed
    - Provide individuals with a reasonable opportunity to present evidence related to their grievance, with translation and interpreter services
    - Resolve grievances within 90 days of receipt

    EOHHS is working to establish the grievance system and will collaborate with the other agencies to ensure one centralized system exists as required by the final rule.
- By July 9, 2026, Rhode Island Medicaid was required to publish fee-for-service rates, including the date of last update, bundled rate components, with stratification by population (pediatric and adult), and geographic region, if applicable. Medicaid must conduct comparative rate analysis to Medicare for primary care, OB/GYN, and outpatient mental health and SUD services. Additionally, EOHHS must publish payment rate and utilization disclosures for certain home health, personal care, homemaker and habilitation services. EOHHS has published the required reports and can be viewed on our website: Federal Access to Medicaid Services Rule | Executive Office of Health and Human Services. Rate comparison and utilization reports must be repeated on a biennial basis, and published rates must be updated within 30 days of any changes.
- Effective for Medicaid's next rating period, SFY 2028, under 42 CFR 438.6(c)(2)(viii), any Medicaid initiatives that require a state directed payment in managed care, retroactive activity will not be permitted. EOHHS requests that any initiatives that impact Medicaid include sufficient implementation time to ensure the effective dates are possible to meet. Non-compliance with the final rules will lead to federal corrective action plans, holds on approval of federal authority requests, and future impact to Federal Financial Participation (FFP) for Rhode Island Medicaid benefit programs.

Nursing Facility Minimum Staff Ratios and Cost Reporting

In May 2024, CMS published the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting final rule, effective June 2024 with phased-in implementation over four years. The rule largely impacts survey and certification requirements overseen by CMS and the Rhode Island Department of Health. CMS data included in the final rule publication suggests that Rhode Island nursing facilities are largely meeting the new federal requirements already, although an estimated 53 facilities will need to hire at least some additional staff.

The rule also implements new transparency reporting for Medicaid institutional payments to spend on direct care worker compensation. While this reporting requirement is similar to one included in the Access rule, it does not require a minimum percentage of payments be passed through to direct care workers.

On April 7, 2025, the US District Court for Northern Texas overturned components of this rule:

- Facilities must have a registered nurse (RN) on duty 24 hours a day, 7 days a week (24/7 requirement); and,
- Facilities must have a minimum of 3.48 hours per resident per day of total nursing care, including at least 0.55 hours of RN care and 2.45 hours of nurse aide care[1]

On December 2, 2025, CMS issued an interim final rule repealing numerical staffing requirements and the 24/7 RN mandate.[2] The repeal (effective February 2, 2026):

- Removes the 24/7 RN onsite requirement; and restores the prior policy requiring an RN to be available for at least 8 consecutive hours/day, 7 days/week, and to serve as a director of nursing full-time (except when waived).
- Removes the 3.48 hours per resident per day total nursing care requirement, including removal of the 0.55 hours per resident per day RN and 2.45 hours per resident per day nurse aide minimum.

The change follows:

- Legislative moratorium: Public Law 119-21 (July 2025) imposed a 10-year enforcement moratorium on the 2024 standards until September 30, 2034.
- Court rulings: A federal court vacated the 24/7 RN and hours per resident per day requirements, finding CMS exceeded its authority under the Social Security Act.
- Policy and industry concerns: CMS cited recruitment challenges, especially in rural and tribal areas, and potential facility closures as key factors.

2. **Provide an explanation, timeline, and analysis of the impacts from HR 1 on state provider taxes.**

   See H**.R.-1 Federal Changes** section of testimony.

3. **Please provide any updates on the changes under HR 1 that are effective for FY 2027 and FY 2028, as well as their impact on Medicaid expenses. Please identify which federal guidelines have been issued, which are still pending, and the specific changes in each of the programs.**

   See H**.R.-1 Federal Changes Impacting** section of testimony.

4. **Please provide the assumptions for compliance with the community engagement requirement.**
   a. **Please indicate the number of individuals exempt and by category**
      i. **Examples– former foster care child, medically frail, compliant with TANF & SNAP requirements**
         1. **Describe the interface with DHS and its SNAP recipients who also receive Medicaid.**
   b. **How many are expected to be disenrolled because of non-compliance?**

   See H**.R.-1 Federal Changes** section of testimony.

[1] KFF, https://www.kff.org/policy-watch/texas-judge-overturns-controversial-nursing-facility-staffing-rule/, April 11, 2025.
[2] Federal Register: Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities

All Programs – Rate and Caseload Changes

1. **Please fill out the table for the specific rate and caseload changes that impact the separate programs, as has been included in testimony in the past ("Tab 2" attached file), so that the totals can be shown in the aggregate and by program.**

   See **Attachment 8**.

2. **Please provide an update on the approval and use of newer and high-cost drug therapies, such as sickle cell therapies or GLP-1 prescriptions for weight loss.**

   See **Cell and Gene Therapies (CGT) section** in Major Developments section of testimony.

3. **Please fill out Tab 3a through 3f for initiatives in the FY 2027 enacted budget and the FY 2028 savings assumed for the pharmacy containment proposal. Provide expenses/savings by program for:**
   - **a. Community Health Workers**
   - **b. Pharmacy containment**
   - **c. Hospital at Home**
   - **d. FQHC Graduate Medical Education**
   - **e. MRSS**

   The workbook is completed as requested.

Long-Term Care

1. **Please provide fee-for-service nursing home expenses and methodology.**

   Claims paid through FY 2026 nursing facility and hospice services in the FFS program total $456.2 million; of this $117.2 million was paid in the 4th quarter. The methodology uses a monthly average of FY 2026 Q4 claims as the monthly base estimate. EOHHS assumes a 1.5% utilization factor and 4.53% price increase beginning 10/1/26; this price increase includes 3.9% inflationary adjustment and 0.63% for patient share. This results in projected expenditures of $445.7 million for nursing homes and $46.0 million for in-patient hospice.

   The revised FY27 estimate is used as the base for FY 2028. EOHHS then applies a 2.5% utilization factor and 3.83% price increase beginning 10/1/27; this price increase includes 3.3% inflation adjustment and 0.53% for patient share. Combined, this results in total projected expenditures of $475.3 million for nursing facilities and $49.1 million for in-patient hospice.

   a. **If there is an increase compared to the enacted budget for FY 2027 or the closing for FY2026, how much is related to the new model?**

      See Nursing and Hospice Care section of testimony.

2. **Please provide the nursing home and hospice days needed for the long-term care financing adjustment (Sullivan-Perry). Please provide the enrollment and capitation rate information for the PACE program and, where applicable, for all the monthly Medicaid reporting of the categories of Assisted Living, PACE, A&D, Waiver, Personal Choice/HAB Waiver, Habilitation Community Services, Habilitation Group Home, Preventative Community Services, and Core Community Services. Please provide a breakdown of the type of service for home and community care expenses identified as "All Other HCBS" in the monthly Medicaid Expenditure report.**

   The Perry-Sullivan law requires that any savings or reductions achieved in Medicaid spending for nursing home care must be reinvested directly back into home- and community-based healthcare services. No Perry-Sullivan appropriation is necessary for FY 2028 as there are no anticipated savings—defined as a reduction in bed days

between FY 2025 and FY 2026. Between the two prior fiscal years spending on nursing facilities and hospice care rose by $34.5 million, or 7.8 percent, from $440.1 million to $474.6 million while the average daily census remained nearly flat from 4,487 in FY 2025 to 4,999 in FY 2026.

All other HCBS includes home delivered meals, conflict free case management, durable medical equipment (DME), day habilitation, therapies/hippotherapy, waiver case management, and other case management. Please see testimony for additional information.

3. Please provide an update on all current LTSS activities, including most current initiatives.

See an overview of LTSS initiatives and activities in the below slide deck. Also see **Attachment 2** for revised estimates for fiscal impact of the different initiatives.

QA Attachment_3b - LTSS Update.pptx

4. Please provide details on the LTSS application backlog vs. the number of applications.

Information on LTSS applications is available on the transparency portal.[3] As of October 8, 2026, the chart below shows a total of 180 overdue LTSS applications.

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	307	76	383	177	71	248	631
SNAP Non-Expedited	1137	372	1509	158	173	331	1,840
CCAP	36	155	191	8	102	110	301
GPA - Burial	0	26	26	0	2	2	28
SSP	0	65	65	0	0	0	65
GPA	28	143	171	3	3	6	177
*RIW	128	186	314	25	25	50	364
Undetermined Medical	57	400	457	92	596	688	1,145
Medicaid - MAGI	17	22	39	45	81	126	165
Medicare Premium Payments	42	316	358	77	460	537	895
Medicaid Complex	9	175	184	8	544	552	736
LTSS	35	370	405	7	173	180	585
Grand Total	1,796	2,306	**4,102**	600	2,230	**2,830**	6,932

[3] September 2026 Oversight Report-final.pdf

5. **Please provide an explanation for the separate components of the nursing home rate increase, including the adjustment for patient share.**

Nursing home per diems are comprised of the following components:

- Direct care. Reimburses for nursing salaries (RNs, LPNs, and CNAs) and fringe benefits. This component is the same for all facilities and was set at the start of the RUG-based payment methodology by reviewing each facility's costs and then setting an average for the state. From 2013 through 9/30/2024, when the average was set, this component had been adjusted by an inflationary index set by the General Assembly. The FY 2024 Rate Review rebased this component.

  With the transition from a RUG-based methodology to PDPM, the direct care rate was rebased to achieve budget neutrality. From this rebased rate, the 5.3% inflationary increase enacted by the 2025 General Assembly was applied. The Direct Care component is adjusted by a PDPM weight, to account for patient acuity. (For example, a patient on a ventilator would receive a higher rate than someone not on a ventilator). The PDPM weight acts as a multiplier on the base rate. This rate is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly. For FY 2027, the inflationary increase outlined in the Medicaid State Plan is 3.9%

- A Provider Base Rate which is the sum of the components below:
  - Other direct care reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities. As a result of the FY 2024 Rate Review, this component increased 25.5% to $84.09. The most recent increase was 3.9% to $92.00 for SY 2027. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
  - Indirect care reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
  - Fair rental value is facility specific and was determined as of 7/1/2012 based on a formula included in the current Principles of Reimbursement. Updated annually, pursuant to the State Plan which requires Medicaid to use the IHS Markit Healthcare Cost Review. The 10/1/2026 increase was 2.4%.
  - A per diem tax is facility specific and based on real estate, property taxes, and fire tax paid, and the Medicaid census days. Updated annually based on information from the BM-64 Cost Reports.

The Direct Care and Provider Base Rates are grossed up by 5.82% to make the provider's whole after the required 5.5% nursing facility provider tax (RIGL 44-51-3).

The cost to the state is not the full per diem, as there is a patient share contribution deducted from the amount paid to the providers.

Patient Share Adjustment

Prior to each testimony, Medicaid determines if it should raise the fiscal impact of its annual inflationary rate change for nursing facility and hospice payments to capture the true cost to the state of the rate increase. In general, patient share is expected to increase following cost of living adjustments under the Social Security supplemental security income programs. When rates paid to nursing facilities increase at a faster rate than changes to recipient income, the state can expect to bear a greater proportion of nursing facility costs.

With nursing facility rates increasing by 5.3% in FFY 2026 and 3.9% increase for FFY 2027, Medicaid does not expect current patient share collections will keep pace with these increases. As such, the percentage of the per diem paid by the resident will decrease, and the effective increase of Medicaid's costs will exceed that of the price increase.

Over the past seven years, the average patient share amount per day has increased about $2 annually. Meanwhile, the overall nursing home cost per day (i.e., prior to patient share) has generally increased by a greater percentage amount. If the base nursing home rate goes up faster than patient share this means that patient share will account for a smaller proportion of the total revenues collected by the nursing home and the State will need to make up the proportional shortfall from this mixed funding stream. For example, in FY 2027, the average nursing home per diem increased 3.9%. However, if the increase in patient share contribution remains steady at just $2—i.e., increasing collections from $51 per day to $53 per day—this is equivalent to just a 3.9% increase in the proportion of nursing facility's net revenue funded by patient share. As a result, the state will need to further increase its direct payments to the nursing home by $5 to keep the nursing facility whole and make up for the inability of patient share to keep pace with the overall price inflation of a nursing home stay (i.e., $53 × 13.9% - $2 = $5.37 shortfall). The result is that the effective increase for the state of a 3.9% increase to the nursing facility per diem becomes 4.53%

Patient share accounts for about 15% of total nursing home charges. If a resident's income increases 2.7% in January 2026 and 3.6% in January 2027 (a total of 6.3%), but total charges increase significantly faster, by the end of FY 2027, the patient share will account approximately 15% of charges, and rates have increased (5.3% + 3.9%, or 9.2%). An increase to the direct reimbursement by Medicaid is needed to make up for this differential.

6. **Please include the projected cost of rate changes for both FY 2027 and FY 2028, including the amount of the rate increase and the index upon which it is based.**

   See **Table IX-3** in the Nursing and Hospice Care section of testimony.

7. **Please provide an update on the implementation of the Conflict Free Case Management program, including enrollment for the IDD population. Please consult with BHDDH so that testimony regarding the status of CFCM for the IDD population is consistently reported.**
   a. **Please update enrollment information and include how many individuals are receiving case management services from DHS staff, BHDDH staff, or the certified agencies.**

      For FY 2027 the May estimate assumed 6,462 beneficiaries would receive services by June 2027 with 2,413 DD beneficiaries and 4,049 non-DD beneficiaries with 768 beneficiaries being managed by BHDDH FTEs. The November estimate assumes 7,331 beneficiaries by the end of June 2027, including 4,990 non-DD clients and 2,341 DD clients. The estimate excludes 945 beneficiaries managed by BHDDH case workers by the end of June 2026. All individuals receiving services from independent facilitators are expected to transition to a community provider by the end of January 2027.

      For FY 2028, the estimate assumes 7,571 beneficiaries receiving CFCM services, excluding case management provided by BHDDH. BHDDH has 16 case managers providing services, in addition to 2 case manager supervisors. The estimate assumes 1,170 members will be managed by BHDDH staff.

      As previously reported, DHS does not provide case management services for CFCM.

      Agencies include: Access Point, Bethel Behavioral Associates, Bethel of South County, Child and Family, Comprehensive Community Action, East Bay Community Action Program, Healthcare Connects, Healthcentric Advisors, Revive Therapeutic Services, Rhode Island Parent Information

Network (RIPIN), Seven Hills, Tri-County Community Action Agency, and Westbay Community Action Program.

b. **How will the US DOJ changes to Olmstead guidance impact the CFCM program?**

EOHHS does not anticipate any direct impact on the CFCM program because of US DOJ changes to its Olmstead guidance. Rhode Island's CFCM program operates under the authority of the state's federally approved Section 1115 demonstration, which establishes requirements for conflict-free case management. Changes to DOJ guidance do not modify the terms of the state's approved demonstration or the Medicaid requirements governing these services.

EOHHS will continue to administer CFCM consistent with its approved demonstration authority and applicable federal Medicaid and ADA requirements. We do not anticipate any changes to the program's operations or requirements as a result of the revised DOJ guidance.

SFY 27 May. Estimate vs. SFY 27 Nov Revised Estimate

Item	Enacted	Nov CEC
Total Eligible	12,677 eligible with staggered start dates based on available monthly case management.	13,150 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	6,462 (4,049 non-DD clients; 2,413 DD clients)	7,331 (4,990non-DD clients; 2,341 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16.0 FTEs	CFCM model excludes 945 DD clients managed by 21.0 FTEs
Independent Facilitators*	200 people will shift from Independent Facilitators to a community provider billing the CFCM rate each month from July 2026 through October 2026.	CFCM shifts 767 members receiving services from Independent Facilitators to a community provider over December 2026 and January 2027.
FMAP	57.73%	57.73%
Rate	$170.87 Per Month	$170.87/month through 9/30; eff. 10/1 rate is $187.48/month
Amount in Medicaid Budget	$12,582,525	$13,944,406

SFY 28 May. Estimate

Item	Nov. CEC
Total Eligible	13,174 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	7,571 (5,230 non-DD clients; 2,341 DD clients)
BHDDH FTEs	CFCM model excludes 1,170 DD clients managed by 26.0 FTEs
Independent Facilitators (IFs)	None
FMAP	57.26%
Rate	$187.48 Per Month
Amount in Medicaid Budget	$16,785,459

*The IFs originated from a Consent Decree court order for DD services. More information is available at BHDDH's website: https://bhddh.ri.gov/developmental-disabilities/services-adults/independent-facilitation). IFs are responsible for introduction, pre-planning, planning process, writing the plan, and routine check-ins.

8. **Please confirm that the statutorily required behavioral health care enhancement for certified nursing assistants and homemakers who have completed the necessary training is included in the FY 2027 and FY 2028 estimates.**

Confirmed, managed care and FFS spending assumes payment of BH enhancement for eligible agencies.

Managed Care

1. **Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2027 and FY 2028.**

   See **Managed Care** section of testimony.

2. **Please delineate those aspects of managed care programs not covered under a payment capitation system.**

   All acute services are included in capitation payments, except for dental services (dental services for children are provided in Rite Smiles, a separate capitation program) and Neonatal Intensive Care unit (NICU) for newborns. While short-term nursing services, where medically necessary, are a covered benefit on all products, only the FIDE-SNP (i.e., RHO Phase II or MMP) includes comprehensive coverage for long-term care services and supports. Relatedly, community and residential services for Rhode Island's Medicaid-eligible I/DD population is generally paid on a fee-for-service basis and included in the BHDDH budget. Enrolled members in Expansion and Rhody Health Partners may utilize LTSS services not covered under a payment capitation system.

   The Managed Care FFS line captures costs incurred in the pre-enrollment period, FQHC wrap payment for dental services not included in Rite Smiles and wrap services for Rite Share, and adult dental services.

   The table below provides a brief schedule of in-plan services. The exhibit is found in the SFY 2027 final rate certification dated April 24, 2026, and is consolidated from **Attachment A** "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

Figure 3: Medicaid Managed Care Benefit Package

Inpatient and Outpatient Hospital	School-Based Clinic Services
Therapies	Services of Other Practitioners
Physician Services	Court Ordered Mental Health and Substance Use Services
Family Planning Services	Court Ordered Treatment for Children
Prescription and Non-Prescription Drugs	Podiatry Services
Laboratory, Radiology, and Diagnostic Services	Optometry Services
Mental Health and Substance Use Inpatient and Outpatient Services	Oral Health
Home Health and Home Care Services	Hospice Services
Preventive Services	Durable Medical Equipment
EPSDT Services	Case Management
Emergency Room Services	Transplant Services
Emergency Transportation	Rehabilitation services
Nursing Home and Skilled Nursing Facility Care	Other Miscellaneous Services

Covered services are consistent with the SFY 2026 benefit package. Detailed benefit coverage information for all benefits listed in this figure can be found within Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts. In-lieu-of services may also be provided with written approval from EOHHS.

Please see **Attachment A** on page 187 of Tufts Health Plan's contract, for a more in-depth example of in-plan services, available on EOHHS' website.[4] All MCO contracts have the same structure so there is no differentiation between Tuft's contract compared to the others. Please refer to Amendment 21 for the health plans most up to date MCO contract. Note, Amendment 22 was still being reviewed by the MCOs on October 15, 2026. This contract is yet to be posted as of 10/15/2026.

For Rhody Heath Options, Medicaid carved out the CCBHC benefit for current contract through December 31, 2025. Effective January 1, 2026, CCBHC benefits transitioned back into managed care rates.

3. **Please provide the monthly capitation rate(s) for RIte Care.**
    a. **FY 2027 is different from the rate assumed in May 2026, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.**

        See the **Managed Care** section of the testimony.

    The two adjustments below were incorporated into FY 2027 MCO contracts in Amendment 22. When signed by all MCOs, the rates will be updated into MMIS. Any FY 2027 impact is captured within the draft rates used for the November CEC. These include:

    - *OHIC Rate Review*: State directed minimum fee schedules for children's services, behavioral health services, and HCBS reimbursement rates are updated based on the recommendations from the 2025 OHIC rate review.
    - *GLP-1*: Certain GLP-1 drugs will no longer be covered solely for the purpose of weight loss. Coverage will continue for members with medically necessary indications other than weight loss, such as sleep apnea.

4. **Please provide the projected CHIP funding for FY 2027 and FY 2028, as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed since the previous Conference, please provide an explanation for the change.**

    See the **Managed Care** section of the testimony.

5. **Please provide the separate payments by the managed care plans to the Accountable Entities from FY 2019 through FY 2026.**

    There are two types of payments that the managed care plans have made to the Accountable Entities; incentive payments and shared savings payments under the total cost of care model.

    Please see the spreadsheet below with incentive payments made through SFY 2025. Please note, SFY 2025 payments were updated and this reflects final incentive payments made through the program (unchanged from May).

    Please also see the second file that shows shared savings (or loss) payments made by the plans to the accountable entities based on TCOC results each year. Please note, these payments are on a significant lag due to claims run out and reporting timelines. Program Year 7, FY 2025, is the latest year with TCOC payments. FY 2026 TCOC results will be finalized at the end of FY 2027.

[4] Internet: https://eohhs.ri.gov/sites/g/files/xkgbur226/files/2023-11/THPP_Amendment_13_fully%20executed_20231024.pdf (Last Accessed October 20, 2024)


TCOC Workbook.xlsx


QA Attachment_Update

Rhody Health Partners

1. **Please provide estimates for Rhody Health Partners for FY 2027 and FY 2028. Please delineate those aspects of managed care programs not covered under a payment capitation system.**

    a. **Please provide the monthly capitated payment for the different groups enrolled in Rhody HealthPartners.**

    See the **Rhody Health Partners** section of the testimony

2. **If FY 2027 rates are different from the prior capitation rate included in the May 2026 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

    See the **Rhody Health Partners** section of the testimony

Rhody Health Options

1. **Please provide estimates for Rhody Health Options for FY 2027 and FY 2028. Please delineate those aspects of managed care programs not covered under a payment capitation system.**

    See the **Rhody Health Options** section of the testimony.

    CCBHC was moved into RHO (i.e., FIDE SNP) effective January 1, 2026 and so there are no services outside of the capitated rate.

2. **Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Options.**

    See the **Rhody Health Options** section of the testimony.

    Effective January 1, 2026, the Rhody Health Options has implemented a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) with NHPRI from the former MMP model. A FIDE SNP is a type of Medicare Advantage plan that combines Medicare and Medicaid benefits into a single health plan for individuals who qualify for both.

3. **Please begin including Rhody Health Options enrollment data on the caseload indicators tab of the monthly Medicaid Report submission.**

    Please see **Attachment 5d** as well as the detailed pay level information included in **Attachment 5a** through **Attachment 5c.**

    FIDE SNP is included in the monthly managed care enrollment report distributed by Medicaid and we will look to update the separate Gainwell reports. The Gainwell reports included in Attachment 4 have been amended to include FIDE SNP enrollment and capitation.

4. **If FY 2027 rates are different from the prior capitation rate included in the May 2026 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

    See the **Rhody Health Options** section of the testimony.

    The FY 2027 rates include the CY 2026 rates and the CY 2027 rates. The CY 2026 rates have not yet been amended for the OHIC rate increases and given prospective rating consideration applied by the state's

certifying actuary it is not yet known if a change is necessary. The CY 2027 rates reflect information from draft rates being prepared by EOHHS and include funding for the OHIC rate increase and other state directed payments.

Hospitals

1. **Please provide separate inpatient and outpatient estimates for hospital services in FY 2027 and FY 2028.**
    a. **Please provide an update on the Long-Term Behavioral Health Unit rate increase and any progress being made by the community hospitals in opening new units.**

    See **Hospitals – Regular** section of testimony and **FY 2027 Budget Initiative Implementation** section of Major Developments in testimony.

2. **What is the current DSH allotment over the next several federal fiscal years? Please cite the source.**

    See **Hospitals – DSH** section of testimony

3. **Please provide an update on the Hospital State-Directed Payment Program, including any changes to assumptions about Medicaid match rates and how changes in HR 1 impact this payment for FY 2027 and FY 2028?**

    See **H.R.-1 Federal Changes Impacting FY 2027 and 2028** section of testimony

    Total SDP Appropriation:

    - For SFY 2027, the May CEC forecast of $331.3 million in all funds financing is consistent with the enacted budget. This includes $324.7 million for payments to hospitals and $6.6 million for the premium tax paid by the MCOs.
    - For SFY 2028, the May CEC forecast equates the enacted all funds amount from the previous fiscal year ($331.3 million), inclusive of tax liability, and calculates the GR amount by applying the FFY 2028 federal Medicaid match rates and utilization mix across eligibility groups. This calculation produces a GR appropriation of $103.2 million.

    Determination of Medicaid Matching Rates:

    The following are the primary factors that impact the forecasted splits for the hospital SDP.

    - *FMAP*. Prior to FFY2028, Rhode Island had received more favorable FMAP allocations over the past four fiscal years. Therefore, holding all things equal, GR would be making up a lower percentage of the SDP each fiscal year.
        - For the traditional FMAP, i.e. RIte Care, the federal match received is 56.31% FFY in 2025, 57.50% in FFY 2026, 57.81% in FFY 2027, and 57.08% in FFY 2028 (Preliminary). For CHIP (Children's Health Insurance Program), the federal match received is 69.42% in FFY 2025, 70.25% in FFY 2026, 70.47% in FFY 2027, and 69.96% in FFY 2028 (Preliminary). For the Expansion population, the federal match received is unchanged at 90.0%.
    - *Rate Certification*. The State's actuary, Milliman, certifies a PMPM capitation rate by pay level. Pay level, also known as a rate cell, groups members by like characteristics, for example expansion female between specific ages, and develops a monthly rate based on historical enrollment/expenditures. These capitation rates vary for types of coverage, i.e. RIte Care v. Expansion, and each bring in varying magnitude of Medicaid match.

- *Enrollment*. Medicaid uses the forecasted enrollment for FY 2026 and FY 2027 and multiplies it by the appropriate rate cell to forecast the fiscal impact.

  See **H.R.-1 Federal Changes Impacting FY 2027 and 2028** section of testimony for detail on how H.R.-1 may impact this payment in the current and out-year.

Pharmacy

1. **Please provide separate estimates of pharmacy expenditures and rebates for FY 2027 and FY 2028, as well as the funding source breakout for the separate estimates.**

   See **Pharmacy** and **Major Developments** sections of testimony for consolidation of pharmacy rebates and J-code collections.

Medicaid Expansion

1. **Please provide updated caseload and expenditure estimates for FY 2027 and FY 2028 for the ACA-based Medicaid expansion population.**

   See **Expansion** section of testimony.

2. **If the FY 2027 capitation rates differ from the May 2026 estimate, please document the change and include contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs**

   See **Expansion** section of testimony.

   The two adjustments below were incorporated into FY 2027 MCO contracts in Amendment 22. When signed by all MCOs, the rates will be updated into MMIS. Any FY 2027 impact is captured within the draft rates used for the November CEC. These include:

   - *OHIC Rate Review*: State directed minimum fee schedules for children's services, behavioral health services, and HCBS reimbursement rates will be updated based on the recommendations from the 2025 OHIC rate review.
   - *GLP-1*: Certain GLP-1 drugs will no longer be covered solely for the purpose of weight loss. Coverage will continue for members with medically necessary indications other than weight loss, such as sleep apnea.

Other Medical Services

1. **Please provide an updated estimate of receipts for the Children's Health Account and expenditures for all Other Medical Services by service.**

   See **Other Services** section of testimony. At present the Children's Health Account offset for SFY 2028 is held constant at the SFY 2027 amount. This number is updated around the time of May CEC each year. Last year it increased over the prior year, but it had been declining over the years prior and so at present no change is assumed.

2. **For the expenses listed as "BHDDH Medical Services," please provide some detail on what services are included in this estimate. See Behavioral Health questions below.**

   See **Other Services** section of testimony.

   For purposes of testimony, BHDDH Medical Services includes payments to behavioral health providers for certain clients not enrolled in managed care. Most of the incurred costs are for aged, blind, and disabled Duals,

but it will also include some spending on behalf of some children with special health care needs remaining in FFS. Spending on these providers for Expansion-eligible clients or MAGI-based children and families would fall under Expansion FFS or Core FFS.

BHDDH Medical Services included spending on IHH/ACT at community mental health organizations (CMHO), but with the implementation of CCBHC Demonstration, Medicaid is differentiating between CCBHC services and non-CCBHC services.

The non-CCBHC that Medicaid has still designated as "BHDDH Medical Services" include any remaining IHH and ACT services at EBCAP and Elwynn, but approximately 90% of the remaining dollars are for MHPRR services for those not enrolled in managed care. For the appropriate funding sources, the following types of providers are mapped to the "BHDDH Medical Services" categorization.

PR_TYP_CDE	PR_TYP_DSC
060	Substance Abuse Rehab
061	CMHC/Rehab Option
066	BHDDH Behavioral Health Group
108	Centers of Excellence
109	Peer Recovery Services
123	CCBHC

3. Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2027 and FY 2028.

The forecast for Medicare Buy-In (Part A/B) is based on invoices received through September 2026 for enrollment through October 2026. In addition to the baseline expenditures reflected in the current invoices and growth assumption of 2.5%, Medicaid's estimate includes a below-the-line adjustment for the Medicare Savings Program expansion that was implemented in SFY 2026.

The estimate included in Enacted and reflected herein includes the full year cost of the expansion to the Qualifying Individuals program. The Medicare Savings Program expansion will increase Part B payments only.

At present, however, there has been no meaningful growth in EOHHS' Qualifying Individuals (QI) program beyond historical trends. Nonetheless, the full amount of the previously estimated growth is reflected in FY 2027 and FY 2028. The cost of the growth in the QI program would be funded with 100% federal funds and so this placeholder does not inflate EOHHS' general revenue costs. Ultimately, this program is expected to expand Medicare Savings Program coverage to additional 3,250 Rhode Islanders.

It should not meaningfully impact either Part A premium payments or Clawback payments. However, Qualifying Individuals may be eligible for the Extra Help program (or Low Income Subsidy), this is a federal not state benefit, to subsidize cost of Part D premium payments.

Please note that EOHHS' estimate reflects the final clawback premium amount (included in Pharmacy Clawback section) but the Part A and Part B premiums reflect a 5.0% increase effective January 2026 over the current rates paid by EOHHS. The final rates may be released prior to the conferee meets. EOHHS will communicate the marginal cost or savings of any change relative to the 5.0% placeholder used.

For CY 2028, EOHHS assumes a compounding 5.0% increase for Part A and Part B.

See **Other Services** section of testimony.

4. What are the state-only costs in FY 2027 and FY 2028?

State-only costs are shown below.

Budget Line	Description	FY 2027	FY 2028
Managed Care	Cover all Kids	$12,556,063	$13,183,866
Managed Care	Abortion Coverage	$1,000,000	$1,000,000

5. Please provide an update on the Program Integrity initiative and projected savings assumed.

See **FY 2027 Budget Initiatives** section of testimony.

Behavioral Health

1. Please provide an update on the expenses for Certified Community Behavioral Health Clinics (CCBHC) by program.

a. Please include any information on third-party liability billings and payment collections.

Table 1 below includes investments in the CCBHC program. These amounts reflect estimates for FFS claims' expenditures (less TPL collections) as well as the value of the CCBHC program included in MCO premiums and anticipated quality bonus payments. The managed care related costs are inclusive of all associated administrative costs, margins, and premium taxes.

Medicaid estimates $153.6 million in FY 2027, a decrease of $10.9 million from the enacted budget. This decrease is due to reduced enrollment in Rhody Health Partners.

Overall, the enhanced FMAP provides $15.4 million GR savings in FY 2027. For FY 2028, Medicaid estimates $161.0 million, an increase of $7.4 million compared to the revised estimate for FY 2027. The enhanced FMAP will provide $16.5 million GR savings in FY 2028.

With respect to TPL, Medicaid is the payer of last resort; however, due to monthly PPS-2 payments that greatly exceed commercial reimbursements, EOHHS pays the full PPS-2 rate to the CCBHC and retroactively recoupments for any payments collected from commercial payers for Medicaid clients with TPL. Medicaid anticipates continuing this retroactive recoupment through at least end of DY3 (September 30, 2027) with $3.0 million in collections assumed in SFY 2027 and SFY 2028.

Table 1. CCBHC-related expenditures in managed care and FFS

	SFY 2025	SFY 2026	SFY 2027			SFY 2028		
	Final	Revised Enacted	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Managed Care								
RC Core	$ 17,547,861	$ 21,438,674	$ 23,127,196	$ 24,861,094	$ 24,191,995	$ (669,099)	$ 26,119,387	$ 1,927,392
RC CSHCN	$ 4,509,934	6,104,508	6,104,307	5,759,853	6,866,708	1,106,855	7,417,550	550,843
RHP	32,533,311	38,094,352	37,583,880	42,701,337	31,518,231	(11,183,107)	34,373,271	2,855,040
Expansion	25,714,612	31,330,970	30,103,485	31,598,370	31,352,696	(245,674)	29,466,085	(1,886,611)
RHO II	0	10,070,368	9,889,688	21,675,437	20,375,752	(1,299,685)	22,281,133	1,905,381
Subtotal	$ 80,305,718	$ 107,038,873	$ 106,808,556	$ 126,596,090	$ 114,305,380	$ (12,290,710)	$ 119,657,426	$ 5,352,046
						$ 0		$ 0
Fee For Service						0		0
Other Services	$ 34,885,072	$ 35,449,856	$ 39,077,990	$ 33,769,034	$ 35,231,011	$ 1,461,976	$ 37,066,236	$ 1,835,226
Managed Care	679,773	800,000	2,086,151	2,382,688	2,086,151	(296,537)	2,086,151	0
Expansion	1,439,594	2,100,000	1,190,201	1,092,596	1,214,005	121,409	1,244,355	30,350
TPL Collections	(2,100,000)	(3,000,000)	(3,000,000)	(3,000,000)	(3,000,000)	0	(3,000,000)	0
Subtotal	$ 32,785,072	$ 35,349,856	$ 39,354,342	$ 34,244,318	$ 35,531,167	$ 1,286,849	$ 37,396,742	$ 1,865,576
						0		0
Quality Payment			3,682,261	3,664,706	3,734,696	69,991	3,909,995	175,299
						0		0
Grand Total	**113,090,790**	**142,388,729**	**149,845,159**	**164,505,113**	**153,571,243**	**-10,933,871**	**160,964,164**	**7,392,921**
								0
Additional GR Relief		***13,826,740***	***15,044,182***	***16,727,215***	***15,355,476***	***(1,371,739)***	***16,529,198***	***1,173,721***

2. **Please provide enrollment and costs expected to be incurred in FY 2027 and FY 2028, for the following programs and their relationship with the CCBHC payments. Please indicate the costs to programs individually.**
    a. **CCBHC**
    b. **MHPRR**
    c. **IHH, ACT, OTP Programs**
    d. **Behavioral Health Link Program**
    e. **Centers of Excellence**
    f. **Peer Supports Programs**
    g. **Housing Stabilization Program**

Please note that for CCBHC spending in Table 2 below reflects actual or estimates of direct provider payments for Medicaid eligible clients. No adjustment for IBNR in SFY 2026 applied. Additionally, quality payments are not included, nor are the associated managed care related costs (i.e., actual PMPM included in premiums paid to the MCOs that is inclusive of administrative component and risk margin and directly tied to actual enrollment).

Table 2. BH Spending – all payers, actuals (no IBNR for missing or outstanding claims activity)

Paid		FY 2024	FY 2025	FY 2026
CCBHC	CCBHC PPS-2 (T1041)		$96,387,056	$132,356,488
	Assertive Community Treatment (H0040)	$16,227,665	$3,903,957	
	Integrated Health Home (H0037)	$28,682,342	$6,963,159	
	Housing Stabilization (H0044)	$388,263	$111,547	
	Peer Support_Program(H0038)	$155,849	$25,990	
	Other BH/SUD Services	$11,156,687	$2,681,457	
CCBHC Total		**$56,610,806**	**$110,073,166**	**$132,356,488**
OHIC	Assertive Community Treatment (H0040)	$1,542,398	$1,815,992	$1,643,056
	Integrated Health Home (H0037)	$2,921,767	$3,158,025	$2,792,088
	BH Link (S9485)	$928,872	$1,118,087	$1,525,409
	MHPRR (H0019)	$18,306,046	$25,997,092	$26,478,500
	Opioid Treatment Program (H0037 - Provider Type 060)	$585,276	$1,024,383	$1,135,130
	Peer Support_Program(H0038)	$409,772	$245,801	$254,156
	Other BH/SUD Services	$135,560,121	$150,298,341	$156,899,433
OHIC Total		**$160,254,252**	**$183,657,721**	**$190,727,773**
Other	Housing Stabilization (H0044)	$487,894	$1,542,874	$2,249,476
	Other BH/SUD Services	$10,788,084	$14,475,130	$12,695,917
Other Total		**$11,275,978**	**$16,018,004**	**$14,945,393**
Grand Total		**$228,141,036**	**$309,748,891**	**$338,029,653**
% Managed Care		**85.75%**	**78.09%**	**78.50%**

Table 3. Average monthly and distinct count of users of outpatient BH services in SFY 2026

	Avg. Monthly Users	Distinct Users
Other BH/SUD Services	83,196	246,314
CCBHC PPS-2 (T1041)	9,566	17,187
Housing Stabilization (H0044)	566	1,728
Integrated Health Home (H0037)	429	600
MHPRR (H0019)	376	496
Peer Support Program(H0038)	353	1,446
Opioid Treatment Program (H0037 - Provider Type 060)	247	638
BH Link (S9485)	140	1,085
Assertive Community Treatment (H0040)	98	172