November 2026
CASELOAD ESTIMATING CONFERENCE

Medical Assistance Testimony

OCTOBER 27, 2026

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I. General Considerations

Medical Benefits			
		All Funds	General Revenue
FY 2025	Revised Enacted	$3,596,394,419	$1,327,238,418
FY 2026	Revised Enacted	$3,877,900,000	$1,406,067,033
	Preliminary Final	**$3,883,542,384**	**$1,408,039,956**
	Deficit over Revised Enacted	*($5,642,384)*	*($1,972,923)*
FY 2027	Enacted	$4,137,073,275	$1,485,000,209
	Current	**$4,104,200,000**	**$1,480,085,350**
	Surplus over Enacted	*$32,873,275*	*$4,914,859*
FY 2028	Current	**$4,264,600,000**	**$1,583,775,677**

For fiscal year (FY) 2027, Medicaid anticipates benefits expenditures of **$4.104 billion**, including **$1.480 billion in general revenue (GR)**, among the Caseload Estimating Conference (CEC) budget lines. This is a **$32.9 million (0.8%) surplus**, including a **$4.9 million GR (0.3%) surplus**, compared to the Enacted.

For FY 2028, Medicaid projects expenditures to increase by $160.4 million, or 3.9%, to **$4.264 billion**, including a $103.7 million GR increase, or 7.0%, to **$1.584 billion GR**.

Table I-1 compares Medicaid's preliminary fiscal close for FY 2026 and the revised forecasts for FY 2027 and EOHHS' preliminary projection for FY 2028. The FY 2026 figure in the tables throughout the testimony reflect the agency's best attempt to update its unaudited fiscal close for spending that occurred in prior fiscal years.

Table I-2 compares these estimates by fund source.

Attachments 1a and 1b summarize Medicaid's current forecast by budget program/category and funding source and include a comparison against FY 2026 Preliminary Final.

Table I-3 shows Medicaid's revised FY 2027, average enrollment; a decrease of beneficiaries with Full Medical Assistance Benefits from **293,333** to **281,765**. Note that the decline of 11,568 beneficiaries (3.9%) is due largely to the high volume of closures each quarter that result from improvements in the state's post eligibility verification of changes to household income. The average monthly enrollment in FY 2028 is expected to further decrease by 6,079 beneficiaries, or 2.2%, to **275,686**.

A summary of the caseload in limited benefits programs is shown in **Table I-4**.

Details of Medicaid's revised caseload forecast for FY 2027 and FY 2028 are included in **Attachments 5b and 5c,** respectively. Also included are historical caseload metrics in **Attachment 5a** and a new summary of month-end actuals in **Attachment 5d**. Trend assumptions are included in **Major Developments**.

Table I-1. Summary of Rhode Island Medicaid – Medical Benefits, by Budget Line

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/ (Deficit)	Current	FY27 → FY28
CEC Budget Line						
Managed Care	$ 1,083,189,781	$ 1,173,814,294	$ 1,130,900,000	$42.9 M	$ 1,206,300,000	$75.4 M
Rhody Health Partners	344,240,383	340,249,821	337,200,000	3.0 M	359,900,000	22.7 M
Rhody Health Options	236,569,434	287,890,533	268,400,000	19.5 M	287,300,000	18.9 M
Expansion	725,817,857	734,552,792	715,900,000	18.7 M	667,300,000	(48.6 M)
Hospitals - Regular	423,911,696	413,716,599	412,400,000	1.3 M	422,900,000	10.5 M
Hospitals - DSH	8,023,770	38,900,000	38,900,000	0.0 M	38,900,000	0.0 M
Nursing and Hospice Care	442,612,089	483,725,685	493,500,000	(9.8 M)	526,200,000	32.7 M
Home and Community Care	309,029,828	340,116,096	374,800,000	(34.7 M)	404,200,000	29.4 M
Pharmacy	1,248,039	1,200,000	2,000,000	(0.8 M)	2,100,000	0.1 M
Clawback	94,484,619	95,900,000	99,600,000	(3.7 M)	111,500,000	11.9 M
Other Services	214,414,888	227,007,455	230,600,000	(3.6 M)	238,000,000	7.4 M
Subtotal - CEC Benefits	**$ 3,883,542,384**	**$ 4,137,073,275**	**$ 4,104,200,000**	**$32.9 M**	**$ 4,264,600,000**	**$160.4 M**
Health System Transformation Project	(3,281,454)	0	0	0.0 M	0	0.0 M
Special Education	36,675,703	45,400,000	36,559,000	8.8 M	36,559,000	0.0 M
ARPA HCBS Investments	0	0	0	0.0 M	0	0.0 M
Total - Benefits	**$ 3,916,936,633**	**$ 4,182,473,275**	**$ 4,140,759,000**	**$41.7 M**	**$ 4,301,159,000**	**$160.4 M**

Table I-2. Summary of Rhode Island Medicaid – Medical Benefits, by Funding Source

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Funding Source						
General Revenue	$ 1,408,039,956	$ 1,485,000,209	$ 1,480,085,350	$4.9 M	$ 1,583,775,677	$103.7 M
Federal Funds	2,502,909,751	2,686,533,792	2,649,734,376	36.8 M	2,706,444,049	56.7 M
Restricted Receipts	5,986,926	10,939,274	10,939,274	(0.0 M)	10,939,274	0.0 M
Total - Benefits	**$ 3,916,936,633**	**$ 4,182,473,275**	**$ 4,140,759,000**	**$41.7 M**	**$ 4,301,159,000**	**$160.4 M**

Table I-3. Summary of Rhode Island Medicaid Caseload (Full Medical Assistance Only)

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Funding Source						
Rite Care Core	149,372	148,506	143,222	-5,284	144,315	1,093
Rite Care CSHCN	9,723	10,079	10,083	4	10,229	146
Expansion	73,375	70,129	65,961	-4,168	57,258	-8,703
Rhody Health Partners	12,691	12,764	12,475	-289	12,611	136
Rhody Health Options (Phase II)	11,320	11,148	10,883	-265	11,070	187
PACE	466	485	475	-10	509	34
Rite Share	1,725	1,779	1,603	-176	1,676	73
Subtotal Enrolled	**258,672**	**254,890**	**244,702**	**-10,188**	**237,668**	**-7,034**
Remaining in FFS - Full Benefits:						
Children and Families	2,340	2,379	2,551	172	2,627	76
Children with Special Healthcare Needs	1,181	1,266	946	-320	973	27
Expansion	4,573	4,643	4,455	-188	4,547	92
Aged, Blind, and Disabled	29,157	30,155	29,111	-1,044	29,871	760
Subtotal Fee-for-Service	**37,251**	**38,443**	**37,063**	**-1,380**	**38,018**	**955**
Grand Total - Full Benefits:	**295,923**	**293,333**	**281,765**	**-11,568**	**275,686**	**-6,079**
Composite PMPM	*$1,094*	*$1,175*	*$1,214*	*$39*		*-$1,214*

Table I-4. Summary of Other Rhode Island Medicaid Caseload Metrics (Limited Benefits)

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Other Capitated Arrangements:						
Rite Smiles	129,796	130,410	125,258	-5,152	269,726	144,468
Rite Care EFP	1,532	934	1,271	337	1,277	6
SOBRA	3,886	4,752	3,842	-910	3,864	22
Transportation Broker	293,325	289,303	277,952	-11,351	270,883	-7,069
Medicare Premium Payments:						
Part A (Hospital)	3,637	3,751	3,759	8	3,855	96
Part B (Professional Services)	41,059	40,969	40,142	-827	41,081	939
Part D (Prescription Drugs)	38,486	37,737	37,502	-235	38,383	881

II. Major Developments

This section highlights major developments that have meaningful fiscal or policy changes or involving programs that cross several CEC budget lines.

A. FY 2026 Fiscal Close

Medicaid ended FY 2026 with a deficit of $5.6 million, which is approximately 0.1% of Medicaid's $3.884 billion benefits' budget. This included a GR deficit of $2.0 million (0.1%) against a state share of $1.408 billion.

The variances by budget line are in Table II-1 and a summary by fund source is in Table II-2. The persistence of downward enrollment trends through the last half of SFY 2026 contributed to lower managed care payments across all products; however, offsetting risk share accruals reduced the gross savings assumed by the reduced caseload. Lower enrollment but higher effective per member per month (PMPM) costs is not unexpected.

The unanticipated $11.2 million surplus in Rhody Health Options is due to two items: (1) the over-accrual in SFY 2025 for prior period withhold payments related to prior demonstration years for the Medicare Medicaid Program (MMP) and potential liability for retroactive capitation, and (2) overstatement of the blended rate for the FIDE-SNP. In contrast, the $6.5 million deficit in Rhody Health Partners is largely attributed to lower drug rebates – a consistent theme across all products – and higher risk share estimate than in May.

Increased utilization of home and community-based services (HCBS), in particular personal care services, is the primary driver for the $13.0 million deficit in Home and Community Care, a trend that continues into SFY 2027. In contrast to the deficit in HCBS, the surplus in Nursing and Hospice Care is only partially driven by lower claims expenditures than expected, with more than half of the surplus due to the accrual of $6.8 million in DSH recoupments (for hospital payments).

Table II-1. Comparison of Revised and Fiscal Close, FY 2026 – by budget line

	SFY 2026		
	Revised Enacted	Prelim Final	Surplus/ (Deficit)
CEC Budget Line			
Managed Care	$ 1,090,000,000	$ 1,083,189,781	$6.8 M
Rhody Health Partners	337,699,999	344,240,383	(6.5 M)
Rhody Health Options	247,800,000	236,569,434	11.2 M
Expansion	724,900,000	725,817,857	(0.9 M)
Hospitals - Regular	402,500,001	423,911,696	(21.4 M)
Hospitals - DSH	13,900,000	8,023,770	5.9 M
Nursing and Hospice Care	453,000,000	442,612,089	10.4 M
Home and Community Care	296,000,000	309,029,828	(13.0 M)
Pharmacy	1,300,000	1,248,039	0.1 M
Clawback	93,900,000	94,484,619	(0.6 M)
Other Services	216,900,000	214,414,888	2.5 M
Subtotal - CEC Benefits	**$ 3,877,900,000**	**$ 3,883,542,384**	**($5.6 M)**
Health System Transformation Project	0	(3,281,454)	3.3 M
Special Education	45,400,000	36,675,703	8.7 M
ARPA HCBS Investments	0	0	0.0 M
Total - Benefits	**$ 3,923,300,000**	**$ 3,916,936,633**	**$6.4 M**

Table II-2. Comparison of Revised and Fiscal Close, FY 2026 – by fund source

	SFY 2026		
	Revised Enacted	Prelim Final	Surplus/ (Deficit)
Funding Source			
General Revenue	$ 1,406,067,033	$ 1,408,039,956	($2.0 M)
Federal Funds	2,464,460,374	2,468,420,335	(4.0 M)
Restricted Receipts	7,372,593	7,082,093	0.3 M
Total - Benefits	**$ 3,877,900,000**	**$ 3,883,542,384**	**($5.6 M)**

Likely Adjustments to FY 2026 Preliminary Close

At fiscal year-end, several transactions (totaling $12.2 million) relating to the 2021 DSH Audit redistribution payments were incorrectly allocated to the Supplemental Payments budget lines (the recoupment should have been allocated instead to a holding account until all recoupments are received). As a result of this, and due to additional activity relating to one-time FY25 UPL redistribution payments ($975k) and other smaller transactions, actual Supplemental and Hospital-Regular spending shows as $21.4M over Enacted (this total will be reduced not just by the items listed above, but by the $5.9M correction to the DSH account detailed below). Medicaid has confirmed that full amount of $27.46 million enacted for UPL payments was spent and correctly allocated to hospitals. The incorrect adjustments will be reversed and corrected, bringing the FY26 UPL actuals fully back in line with the enacted budget.

Also at fiscal year-end, the $5.9 million federal portion of the 2022 DSH Audit recoupment adjustment was incorrectly credited back to the DSH budget line (the recoupment should have been allocated instead to a holding account until all recoupments are received). As a result, actual spending shows as $5.9 million under the enacted amount. All $13.9 million enacted DSH funds were spent and correctly allocated to hospitals. The incorrect adjustment will be reversed and corrected, aligning the FY 2026 DSH actuals with the Enacted budget.

Additionally, $6.8 million of DSH recoupments for a separate DSH audit was credited to the Nursing and Hospice Care budget line.

B. H.R.-1 Federal Changes Impacting FY 2027 and 2028

The reconciliation bill passed by Congress in July 2025 has changes that are effective in FY 2027 and FY 2028. CMS has published several rules and guidance documents related to H.R.-1 Medicaid changes. These are consolidated on CMS Working Families Tax Cut Legislation[1] and Community Engagement[2] web pages.

- **Section 71116** of H.R.-1 caps the total state directed payment (SDP) value at 100% of Medicare for expansion states. Previously approved payments, as defined by CMS, are "grandfathered in" and subject to a yearly phasedown of 10% until the new threshold is met. CMS released a "Section 71116 SDP Letter" on September 9, 2025[3] to "aid state planning efforts until a final rule is promulgated…" and on May 22, 2026, published the Medicaid Managed Care State Directed Payments and Medicaid Fee-For-Service Targeted Medicaid Practitioner Payments Proposed Rule (CMS-2449-P, 91 FR 30400). The rule is still in proposed status as of October 22, 2026.

  As suggested in the initial letter issued in 2025, the proposed rule extends beyond the four services mandated by section 71116 (inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center), to all services. The rule goes further and extends the Medicare limit to targeted Medicaid FFS payments. Where no Medicare rate is available for the service(s) tied to the payment, a state must demonstrate the rate is economic and efficient through alternate means. States with approved state plan payments that exceed the proposed FFS limits would be required to submit a state plan amendment to remove these payments or update them to comply no later than the first State fiscal year that begins on or after January 1, 2029 (SFY 2030). EOHHS is focused on analyzing the impact of the highest risk payments or rates (e.g., hospital services) and developing a more complete evaluation plan pending additional clarification from CMS on how rates without a Medicare equivalent will be evaluated.

  The FY 2026 hospital separate payment term SDP, paid at a percentage of the average commercial rate, was approved by CMS on November 20, 2025. The approval package stated, "based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21)..." This means the FY 2026 value of $325 million will be allowable until the FY 2029 rating period when a 10% annual reduction will be applicable until it reaches Medicare levels. The proposed rule did not appear to change this preliminary

[1] https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation
[2] https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation/community-engagement
[3] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

guidance. The FY 2026 hospital inflation of 2.9% for inpatient and outpatient services are also considered "SDPs." The uniform percentage increase preprints were approved by CMS on November 14, 2025 and the approval packages were also indicated as likely qualification for temporary grandfathering. The current FY 2028 estimate assumes an inflation rate of 2.3% (for managed care). At this time, given it is an estimate as the final inflation is not yet known and is lower than the FY 2026 approved value, EOHHS is not identifying a conflict with the current law estimate but will re-evaluate once the FY 2028 final inflation is available.

- **Section 71118** added budget neutrality as a new statutory requirement in subsection 1115(g) of the Social Security Act. Currently, CMS will not approve an 1115 demonstration project unless the project is expected to be budget neutral to the federal government, meaning the project does not result in Medicaid costs that are greater than the federal government's Medicaid costs would have been absent the demonstration. CMS has also shared significant changes to the current approach to budget neutrality, namely a more rigorous approach to evaluating the Federal budget impact of section 1115 demonstrations, beginning January 1, 2027. At that time, an application, amendment or renewal of a Medicaid section 1115 demonstration project will not be provided unless the Chief Actuary of CMS certifies that the demonstration is budget neutral. This represents a shift from an analysis of with and without waiver expenditures based on state data, to a more formal actuarial, economic, statistical or other comparable rigorous analysis of projected financial impacts of individual demonstration activities.

  Further, the changes and guidance available indicate that section 1115 demonstrations should focus on activities that can only be carried out under section 1115 authority (activities not approvable under other Medicaid authorities). States will be encouraged to use State Plan or other Medicaid authority for policy objectives that align with those authorities, where appropriate.

  There is no current caseload impact due to this section, however, any changes to the state's 1115 waiver starting January 1, 2027 will impact the overall demonstration (i.e., budget initiatives that require changes to waiver authorities). EOHHS is working to evaluate the currently approved waiver under the new guidance to understand potential impact if the waiver is opened prior to the next five-year renewal. CMS anticipates providing more detailed guidance through a proposed rule in 2027.

- **Section 71109** states that regardless of any provisions to the contrary in the applicable section of law, as of October 1, 2026, federal financial participation (FFP) is available for medical assistance provided only to U.S. citizens, lawful permanent residents (LPRs), Cuban and Haitian entrants, and Compact of Free Association (COFA) migrants. This change does not apply to children under age 19 or pregnant people. The change means that many adults who have historically been considered qualified noncitizens under federal law–such as refugees, asylees, humanitarian parolees, victims of trafficking, individuals subject to battery and other cruelty, conditional entrants, etc.–will no longer be considered qualified for purposes of full Medicaid eligibility. Impacted individuals will need to adjust their status to LPR (i.e., obtain a green card) before they will be eligible for full Medicaid and otherwise will only qualify for Emergency Medicaid coverage.

  This provision became effective on October 1, 2026; Medicaid's testimony reflects enrollment as of September 30, 2026, and closures as of October 1, therefore capturing the impact based on actual closures. Overall, there were approximately 1,000 closures due to this change, resulting in lower Medicaid payments of $7.9 million for FY 2027 and $11.1 million for FY 2028. This calculation of savings and closures may change as additional data are assessed.

  Those who lost coverage may still be eligible for emergency Medicaid. EOHHS testimony assumes an increase of $1.8 million and $2.4 million for FY 2027 and FY 2028, respectively, in the Hospitals – Regular budget line for emergency Medicaid services. This amount was derived by applying a proxy of the average Hospital PMPM among non-disabled adults to the number of member months of reduced enrollment among the non-citizen population.

  See **Table II-3** for program level impact and an estimate of the FY 2027 reductions attributed to this change.

- **Section 71119** imposes a community engagement requirement, herein referred to as Medicaid Work Requirements (MWR), effective January 1, 2027, upon some Medicaid beneficiaries that requires them to work, participate in a work program and/or in community service for at least 80 hours a month, or be in

school at least half time. People can also comply based on having income levels consistent with 80+ hours per month of work at the federal minimum wage. The requirement generally applies to those enrolled via Adult Expansion or an expansion-like waiver category. In Rhode Island, this includes the entire Expansion group (i.e., a projected 65,000 beneficiaries as of January 2026).

Current Assumptions/Estimate Approach:

- *Timing of renewals subject to* MWR*:* The first renewal cohort subject to MWR is the first renewal cohort initiated after January 1, 2027, which is the March cohort with coverage effective April 1, 2027. Additionally, the requirement for 6-month redetermination (**Section 77107**) does not apply until after their first redetermination after January 1, 2027. For example, the December 2026 cohort does not need to be renewed in June 2027; but can continue to be renewed in December 2027. Thereafter, would be renewed again in June 2028 and December 2028.

- *Exemption and Compliance with* MWR*:* CMS identified several exemptions to MWR. Previous exemption percentages in Medicaid estimates were based on claims data as a proxy to estimate the number of beneficiaries who may meet one of the exemption criteria. The current estimate uses logic currently built into the payment and eligibility systems as exemption criteria (based on the latest CMS guidance and policy decisions available as of testimony preparations) and Rhode Island's most current income information from the most recent post-eligibility verification process.

  Overall, 45% of the 65,622 beneficiaries reviewed are estimated to be passively renewed, based on either a known exemption, including medical frailty, having a substance use disorder, or other qualifying mental health condition, or having income that exceeds $580 per month. System work is still in process and guidance from CMS continues to evolve; therefore, EOHHS expects that the estimate of passive renewals will continue to be refined in the coming weeks.

- *Non-Compliance with MWR:* for the individuals identified as not likely to be passively renewed, EOHHS assumes 40% will ultimately fail to meet compliance and be closed. Among those without sufficient information to assess whether they will be actively or passively renewed and individuals subject to their 6-month renewals (beginning in October 2027), EOHHS assumes 25% will close.

  The 40% and 25% closures rate among those who will not demonstrate compliance are estimates determined after considering several factors:
  - Assumed procedural terms (Rhode Island's historical experience of procedural terms as a percentage of total active renewals is 32%)
  - Assumed missing income or education data (non-exempt who are working or in school)
  - Availability of self-attestation option through CY 2027
  - Other state experience[4,5]

- *Technical modeling of the forecasts*: Previously, the closures were evenly distributed over 12 months. For this reprojection, EOHHS used information on the size of each monthly cohort through FY 2028. The data included information on the "doubling" of the cohorts beginning in October 2027 when the 6-month renewal cycle of those first renewed in March 2027 is realized. For example, the original cohorts' range in size from 2,307 to 9,033. The assumed closures are distributed based on the underlying cohort size. For example, there are just 473 closures in April 2027 (due to the small number of beneficiaries up for renewal) versus 2,233 in January 2027 (when there are 12,830 anticipated beneficiaries up for renewal).

  Additionally, EOHHS assumes no underlying growth for the Expansion population in FY 2028. Rather, EOHHS assumes that a portion of those who are closed will regain eligibility. EOHHS modeled this churn as an offset to the gross closures from MWR by assuming that beginning 3 months after their closure 10% of those closed will regain eligibility each month for the next 6

[4] https://medicaiddirectors.org/wp-content/uploads/2025/07/RWJ-Work-Requirement.pdf
[5] https://ccf.georgetown.edu/2026/09/30/nebraska-releases-first-data-on-medicaid-work-reporting-requirement-as-expected-coverage-losses-start-to-mount-due-to-red-tape/

months. The result that is that over the period of 9 months approximately 50% of those closed will become eligible again.

- *Total Closures:* Overall, EOHHS is projecting total closures of 16,500 beneficiaries between FYs 2027 and 2028. Previously, overall, the number of closures was estimated at 28.6% of total Expansion enrollment. At an effective closure rate of 25%, EOHHS' updated estimate is similar when considering the overall population reduction since March 2026. The updated expenditure reduction as it pertains to MWR is $3.6 million ($360,000 GR) for FY 2027 and $97.2 million ($9.7 million GR) for FY 2028. See **Table II-3** for program level impact and an estimate of the reductions attributed to this change.

Table II-3. Anticipated closures related to H.R. 1

	SFY 2027	SFY 2028
Section 71109 - Non-Citizens		
Distinct Members	1,150	1,150
Member Months	10,350	13,800
Average PMPM	$578	$607
Subtotal Non-Citizen Savings	$5,985,451	$8,379,631
State Share	$1,745,297	$2,443,415
Section 71119 - Work Requirements		
Distinct Closures	2,586	14,035
Member Months	4,247	142,636
Member Month Churn		-34,536
Net Impact	4,247	108,100
PMPM	$847	$899
Subtotal Work Requirement Savings	$3,597,209	$97,182,007
State Share	$359,721	$9,718,201
Total H.R. 1		
Grand Total Savings	$9,582,660	$105,561,638
State Share	$2,105,017	$12,161,616
Prior Estimate (May CEC)		
Non-Citizens	$20,198,970	
Work Requirements	$8,403,397	
Grand Total Savings	$28,602,367	
State Share	$8,028,120	

- **Section 71115** modifies the permissible levels of provider taxes, effective October 1, 2026, and includes a phase down for taxes. This section sets the indirect hold harmless threshold equal no more than the lower of the applicable percent of net patient revenue for health care-related taxes enacted and imposed as of July 4, 2025, or the applicable phase down amount beginning in FY 2028. The phase down schedule begins at 5.5% in FFY 2028 and continues to reduce by 0.5% per year until it reached 3.5% in FFY 2032.

  On July 23, 2026, CMS published the Amending the Indirect Hold Harmless Threshold of Health Care-Related Taxes Proposed Rule to implement this section. The proposed rule documents CMS' intention to calculate and apply the threshold using actual tax collection data and net patient revenue data for the permissible classes in the state FY that includes July 4, 2025 (FY 2026) and to apply the new threshold and any applicable phase-down on a Federal fiscal year basis. Assuming the rule is finalized as proposed, states must submit interim data for purposes of calculating thresholds for each provider class by December 31, 2026 and report the actual data on a quarterly basis for monitoring. EOHHS is working with the administrators of each potential health care-related tax to gather the actual tax revenues and net patient revenue data required for compliance. Non-compliance with the reporting requirements and taxing above the established thresholds will result in repayments to taxpayers or CMS withholding of federal financial participation for the Medicaid program.

CMS also proposes the establishment of a new permissible class to include health insurer services that are not MCO services already accounted for in current regulations at § 433.56(a)(8), to provide clarity regarding the treatment of these taxes. EOHHS is working with the administrators of the potentially impacted assessments and seeking technical assistance from CMS to confirm steps needed for compliance if the rule is finalized as proposed.

The most immediate fiscal impact to the state begins in FY 2028 and is associated with forecasted changes to the hospital licensing fee that currently assesses hospitals at an aggregate rate of 5.8%, above the FFY 2028 phase down threshold 5.5%. While we do not have the final threshold as calculated by CMS, EOHHS updated its previously reported revenue impact estimate[6] using more updated net patient revenue data that is reported to the agency and estimated tax payments using the tax rates in current law. Assuming a change to the current law tax rates that are reduced proportionally to achieve an aggregate collection rate of 5.5% effective October 1, 2026, EOHHS estimates a reduction of approximately $6.0 million.

- **State Only Programs for Noncitizens Ineligible for Full Medicaid**. While not directly related to a change under H.R.-1, CMS released a State Medicaid Director letter on September 9, 2025[7] that impacts Rhode Island's state-funded programs provided via Medicaid. The letter updated interpretation of section 1903(v) of the Social Security Act (the Act), which authorizes FFP for care and services necessary for treatment of an emergency medical condition for noncitizens ineligible for full Medicaid benefits. Rhode Island Medicaid is compliant with the coverage of emergency Medicaid as it is currently provided in FFS only.

  The letter also says, "states that are currently making managed care payments on behalf of [noncitizens] ineligible for full Medicaid benefits in their Medicaid managed care programs, or utilizing the same contract for both Medicaid and state-funded programs, must revise their contracting practices and payment methodologies… Additionally, these states must ensure that Medicaid rate certifications (actuarial documentation for capitation rates) and state directed payment preprints exclude all data and assumptions associated to [noncitizens] ineligible for full Medicaid benefits."

  CMS does not expect to take enforcement action on these updates before the start of the first rating period beginning on or after one year following the date of publication of this SMDL. Effectively, this means that Rhode Island must become compliant – for example, remove the Cover All Kids program from Medicaid managed care and separate from Medicaid funded systems - by the start of FY 2028. As a transitional step, Medicaid worked with its actuary to establish separate rates for the Cover All Kids program for FY 2027. EOHHS submitted a budget initiative for the resources required to continue to comply with both state law and federal regulations.

C. Medicaid's Revised Forecast Compared to the 2027 Enacted

Medicaid's revised fiscal estimates for FY 2027 are generally consistent with its prior estimates as adopted in Enacted. However, despite the overall variance of 0.8% all funds and just 0.3% GR, there are meaningful offsetting fiscal changes that are outlined below. **Table II-4** summarizes the FY 2027 variances.

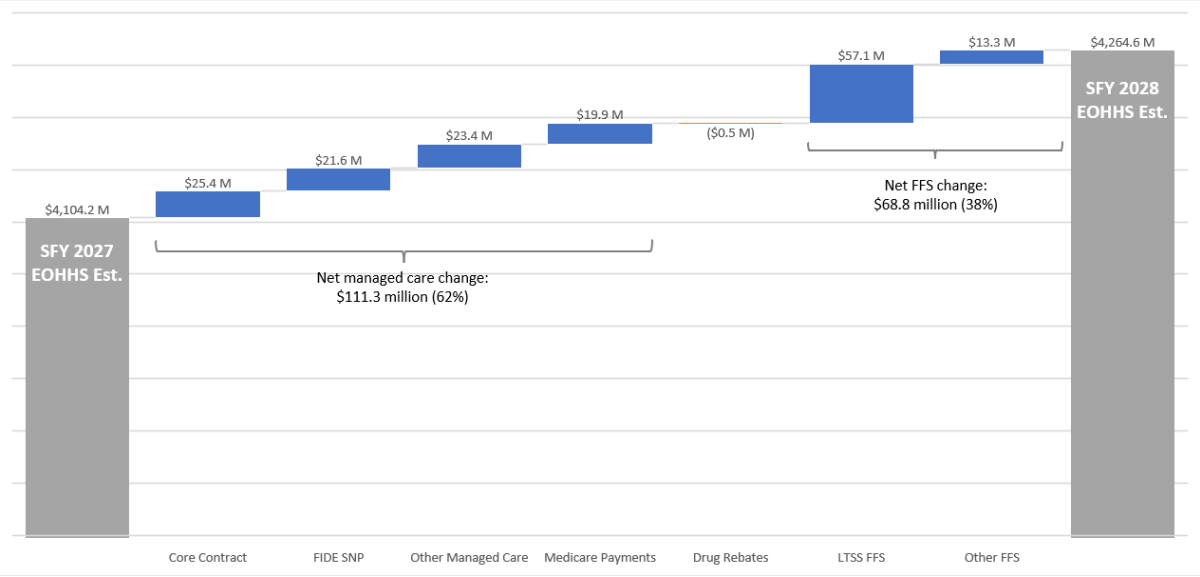
The major drivers of changes between the Enacted FY 2027 and revised 2027 estimates are outlined in **Figure II-1**. Finally, **Table II-5** summarizes the overall composite price-volume variance of Medicaid's revised estimate across fiscal years and caseload conferences.

[6] https://eohhs.ri.gov/initiatives/medicaid-initiatives/federal-compliance-advisory-group
[7] https://www.medicaid.gov/federal-policy-guidance/downloads/smd25003.pdf

Table II-4. Summary of variances for FY 2027 compared to Enacted (excludes non-CEC)

	FY 2027: Enacted	Current	Surplus/(Deficit)
Favorable Variances			
Rite Care	$985.3 M	$953.9 M	$31.4 M
Expansion	$712.2 M	$670.7 M	$41.5 M
PACE/Rite Smiles/NEMT/Rite Share	$104.9 M	$102.3 M	$2.5 M
SOBRA	$95.3 M	$77.1 M	$18.3 M
NICU FFS	$38.3 M	$30.6 M	$7.7 M
Supplemental Hospital Payments	$397.7 M	$395.9 M	$1.8 M
FIDE SNP	$284.8 M	$261.0 M	$23.8 M
RHP	$379.2 M	$367.3 M	$11.9 M
Subtotal Favorable	**$2,997.7 M**	**$2,858.9 M**	**$138.9 M**
Unfavorable Variance			
HCBS FFS	$298.2 M	$334.6 M	($36.3 M)
Nursing Home & Hospice FFS	$482.5 M	$493.5 M	($11.0 M)
Risk Share	$12.5 M	$15.5 M	($3.0 M)
Other FFS (Excl. NH/HCBS/NICU)	$303.8 M	$327.8 M	($24.0 M)
Medicare Premium Payments	$231.0 M	$233.5 M	($2.5 M)
Drug Rebates	($173.1 M)	($141.9 M)	($31.3 M)
Subtotal Unfavorable	**$1,154.9 M**	**$1,262.9 M**	**($108.0 M)**
Total	**$4,152.7 M**	**$4,121.8 M**	**$30.9 M**
By Funding Source:			
General Revenue	$1,485.0 M	$1,480.6 M	$4.4 M
Federal Funds	$2,641.1 M	$2,614.7 M	$26.4 M
Restricted Receipts	$10.9 M	$10.9 M	($0.0 M)
Total	**$4,137.1 M**	**$4,106.2 M**	**$30.9 M**

Figure II-1. Major drivers of change between FY 2027 and FY 2028



Overall reduction in managed care enrollment and premium payments

For FY 2027, managed care (incl. Rite Share) enrollment is down compared to Enacted: 254,890 as Enacted compared to a revised forecast of 244,705, a decline of 10,188 average monthly enrollment. The reductions are across all products, with the impact largest—both in absolute and percentage-based term—being among the income-based categories for Children and Families (i.e., Rite Care Core) and Expansion Adults.

The unanticipated decrease in caseload is attributed to the persistence of a high volume of closures each quarter when the state performs its post-eligibility validation (PEV) of household income. However, even between the

quarterly PEV-runs, there are months with significant decreases. Although the overall counts do not translate directly to managed care enrollment, a review of the month-over-month churn over the past twelve months show eight months with a negative decline (average net decline of 3,456 beneficiaries per month) and four months with growth (average net increase of 637 beneficiaries per month). The variance from EOHHS' May testimony is attributed to the net decrease of 5,238 in May 2026 and another 3,623 in August 2026.

Enrollment is presently at the lowest rate it has been since FY 2026, with the September 2026 snapshot 280,296 beneficiaries[8] being 4.1% below the pre-Covid/pre-Public Health Emergency snapshot of 292,195 in February 2020.

One possible reason for the persistent decline may be wage growth, due to both minimum wage increases and inflation driving growth, leading to beneficiaries losing eligibility and/or not being eligible in the first place. This may explain the continued variance between the number of beneficiaries being determined newly eligible and the larger number of beneficiaries losing eligibility due to the State's income-based eligibility verification processes.

Increased Fee-For-Service (FFS) spending

Overall FFS spending is forecasted to be $66.6 million higher in FY 2027 compared to Enacted. The increase is primarily attributed to growth in LTSS spending: both institutional and home and community based, including spending on nursing homes that is paid under other budget lines.

Some of the increase in FFS is attributed the continued decline in Rhody Health Options (i.e., FIDE SNP) and the transition of some beneficiaries who otherwise would have enrolled into managed care into the FFS estimate. However, as with the overall Medicaid population, the gross number of Aged, Blind, and Disabled beneficiaries remaining in FFS is not increasing and remains effectively flat.

The exception to the negative caseload trend is the increase in the number of beneficiaries authorized for HCBS and the number in a nursing facility. Additionally, increased utilization—in the number of hours used by the average beneficiary receiving home care or self-directed services—has a compounding effect with the increasing number of authorized users eligible for services. Finally, the increasing utilization and beneficiaries is then combined with the increased rates as recommended by the Office of the Health Insurance Commissioner (OHIC) and enacted in the FY 2027 budget. While EOHHS' budget included funding for the 8.9% OHIC-recommended rate increase for home care and other HCBS services, the induced demand was not fully captured.

On the institutional basis, FFS spending has returned to pre-Covid spending levels after years of lower utilization. Additional information on LTSS spending trends is provided in the **Nursing and Hospice Care** and **Home and Community Care** sections.

Table II-5. Summary of price-volume analysis, All Funds

	Price	Volume	Net
FY 2027 over FY 2026	$406.5 M 11.0%	($185.8 M) -4.8%	$220.7 M 5.7%
FY 2027: Current over Enacted	$130.3 M 3.3%	($163.2 M) -3.9%	($32.9 M) -0.8%
FY 2028 over FY 2027	$248.9 M 6.2%	($88.5 M) -2.2%	$160.4 M 3.9%

D. Caseload Growth and Trend Development

Rhode Island reached a peak enrollment of 373,325 beneficiaries with full Medicaid benefits in May 2023 at the end of the Public Health Emergency. The data breach in December 2024 temporarily reversed the steady decline in caseload that the state experienced during the resumption of regular renewal activities, but the overall Medicaid enrollment decline resumed when renewal activities re-commenced in September 2025. The following initiation of an income verification process that leveraged more recent data from Equifax during quarterly PEV contributed to large volumes of gross closures on October 31, 2025, and January 31, 2026, of 10,397 and 12,606 beneficiaries,

[8] The monthly managed care report for September 2026 highlighted a September 30, 2026 snapshot of 279,586. This count is not fixed as retroactive adjustments will alter. For example, there may be either accretion for newborns and other retroactive coverage adjustments or closures for deceased or out-of-state beneficiaries; in general, the number of retroactive additions exceeds the number of retroactive closures.

respectively. On April 30, 2026, another 9,613 beneficiaries were closed, underlying an unanticipated net decrease of 5,234 in May 2026 that contributes significantly to the caseload reduction in FY 2027 compared to Enacted.

As of September 2026, enrollment is 281,144 with full Medicaid (i.e., not including EFP Only, Early Intervention CNOM, or Medicare Premium Payment Only), including a full-time equivalent of 242,649 enrolled in managed care – 8,393 fewer than what EOHHS noted as the last actual prior to May CEC.

Underlying Trend Factor

Medicaid's prospective forecast assumes an underlying growth rate of 1.5% for the last three quarters of FY 2027 and 2.5% for all eligibility groups in FY 2028 except for Expansion where EOHHS eliminates the underlying growth factor. A 2.5% growth factor is also applied to PACE enrollment for both periods due to its low enrollment. This is a simplification of anticipated trends given likelihood of continued PEV-related disruption.

The H.R.-1 adjustments are applied after application of the underlying trend factor. For the non-citizen change, reductions were applied at the program level based on a prior data extract from the eligibility system. This does not reflect the exact beneficiaries who may have been disenrolled explicitly, but it does reflect actual closures among beneficiaries no longer enrolled as of October 1, 2026. Reductions attributed to work requirements are explicitly tied to each monthly cohort and the volume of Expansion beneficiaries identified as likely being complaint from the perspective of their reported income or being exempt from perspective being medically "frail."

While the recent trend is negative, EOHHS forecasts a positive trend except for the net decline attributed to the MWR within Medicaid Expansion. Given the potential for offsetting acuity adjustment to the rates that could be necessary if the enrollment trends remain negative (beyond the noted adjustments for H.R.-1), maintaining an underlying negative trend without an offsetting adjustment to the composite rates and/or inclusion of additional risk share payments in FY 2027 seems imprudent from a budgetary perspective.

Figure II-2 puts Medicaid's current enrollment snapshot in context, comparing it to Rhode Island's pre- and post-Public Health Emergency Medicaid enrollment, as well to post H.R.-1 eligibility changes as of end of FY 2027. **Figure II-3** compares Medicaid's current enrollment forecast to Medicaid's prior forecast. Medicaid's projections are in **Attachment 5b** and **Attachment 5c**. These reflect full-time equivalent beneficiaries and not distinct beneficiaries as they have been adjusted for partial month enrollment.

Figure II-2. Select Caseload Snapshots between February 2020 and June 2027

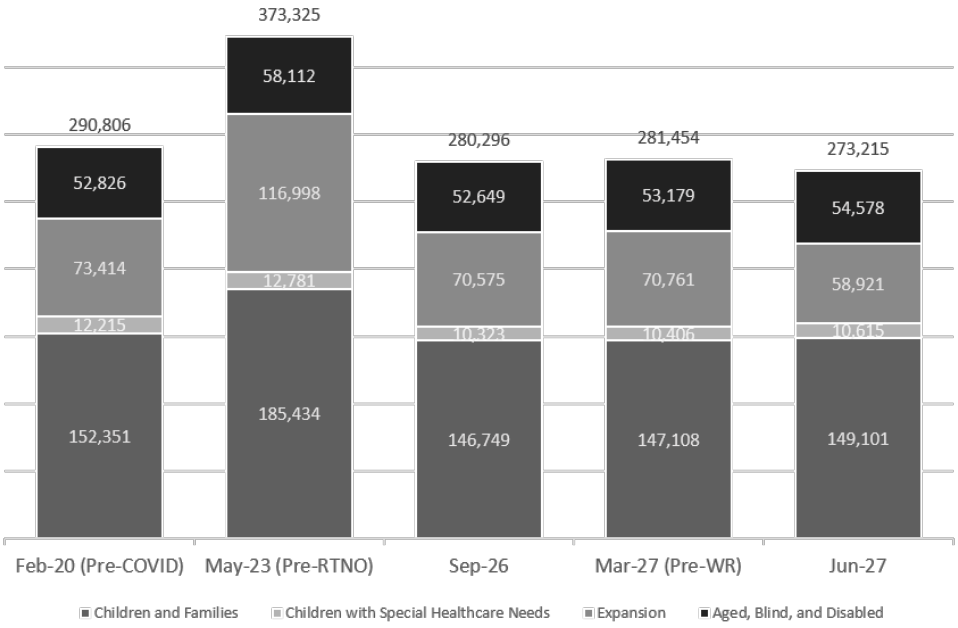
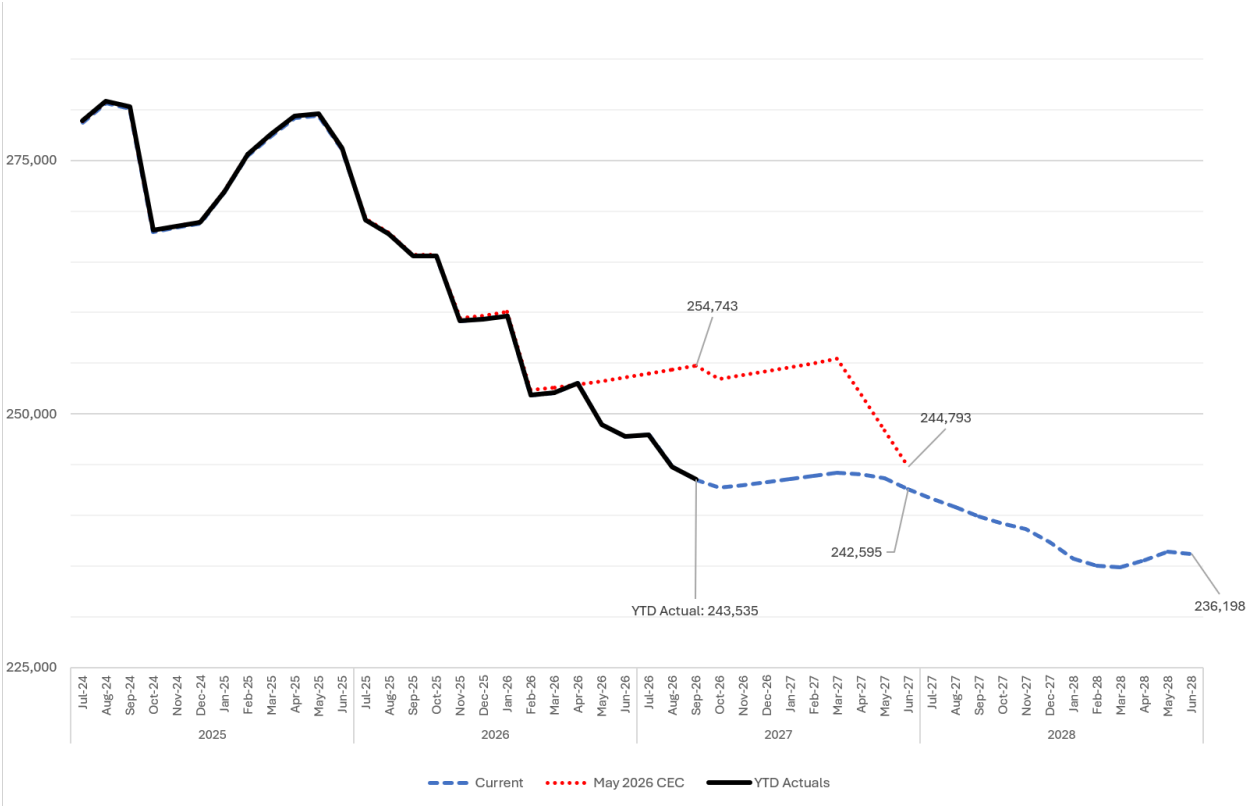


Figure II-3. Full Medicaid beneficiaries enrolled in managed care; current forecast compared to Enacted[9]



Forecasting the Overall Price Factors

Medicaid's estimate is driven by its price factors in the managed care and FFS delivery systems.

Medicaid's managed care estimate includes the final rates for FY 2027 amended for the enacted budget initiatives. The revised FY 2027 budget reflects a composite increase of 7.7% across the core contract product lines of Rite Care, Rhody Health Partners, and Expansion when comparing October 2025 to October 2026 rates. The 7.7% increase is due to multiple reasons, including:

- the increase in average utilization that followed the steady disenrollment in members over the base period of data (i.e., FY 2025) that led to a high average acuity among remaining enrollees,
- the implementation of two years of price inflation for the biannual OHIC rate increase for certain services, including behavioral health services,
- expansion of the CCBHC program to EBCAP, and
- application of multiple state directed payments mandating health plans at minimum match the CMS market basket increases for hospital services and nursing facility services.

The state's actuary made no explicit adjustment in FY 2027 for the impact of H.R. 1 on changes to overall acuity. With respect to the closure of non-citizens, the impact is minimal in terms of its magnitude relative to overall enrollment. Further, the non-citizens who are losing eligible are legally residing in the United States and prior to the change had no more of reason not to utilize their Medicaid services than any other Medicaid-eligible individual. In contrast, for the closures related to MWR, the medical frailty exemption could increase average acuity (and therefore costs) of those that remain eligible; conversely, if lower income individuals have a higher propensity for having co-morbidities than acuity could decline with their closures. Fortunately, with only three

[9] Monthly managed care enrollment included in **Figure II-3.** are used internally during trend development and for comparison to prior estimates (and alternative scenarios). The figures are not adjusted for any full-time equivalency (FTE) factor nor are the figures adjusted for rounding. As such explicit month-end snapshots will differ from other figures and attachments.

months of enrollment impacted and minimal member months, any impact, either upwards or downwards, is likely to be minimal and unpredictable. Regardless, CMS is requiring Rhode Island to review the FY 2027 rate certification assumptions when the impact of H.R.-1 is better understood.

While the core contract rates are final, albeit subject to potential revisions for H.R.-1 changes, the rates for PACE have not yet been adjusted for the OHIC rate initiative and the FIDE SNP rates, that are set on a CY-basis, are not yet complete. For PACE, the rates were rebased in June 2026 prior to finalization of the FY 2027 budget and full implementation of two-year OHIC rate initiative was applied in FY 2027. The high composite rate of 12.0% for the FIDE SNP is based on review of changes in the base data and assumptions on the impact of the OHIC rate increase.

Table II-6 summarizes the caseload, PMPM, and composite price changes given changes in the underlying enrollment mix.

Attachment 7 consolidates discrete information included in multiple tables across the subsequent sections. The PMPM in the table reflects the composite monthly premium for each product line.

For the FFS estimates, current market baskets were applied to the relevant provider-based activities. The value of these market basket increases given current utilization are reflected in **Attachment 8**.

Table II-6. FY 2026 through FY 2028: Caseload and Composite PMPM with Trends

	Caseload:			Price:			Caseload Trend		Price Trend	
	2026	2027	2028	2026	2027	2028	FY26 → FY27	FY27 → FY28	FY26 → FY27	FY27 → FY28
Full Benefits:										
Rite Care Core	149,372	143,222	144,315	$397	$436	$458	-4.1%	0.8%	9.7%	5.0%
Rite Care CSHCN	9,723	10,083	10,229	$1,643	$1,738	$1,837	3.7%	1.4%	5.7%	5.7%
Expansion	73,375	65,961	57,258	$779	$847	$890	-10.1%	-13.2%	8.8%	5.1%
Rhody Health Partners	12,691	12,475	12,611	$2,408	$2,454	$2,587	-1.7%	1.1%	1.9%	5.4%
SOBRA Payment	324	320	322	$20,789	$20,061	$21,064	-1.2%	0.6%	-3.5%	5.0%
Subtotal (Caseload subtotal excl. SOBRA)	245,161	231,741	224,413	$693	$746	$781	-5.5%	-3.2%	7.7%	4.7%
Other Major Medical Products										
CMS Demonstration	11,320	10,883	11,070	$1,784	$1,999	$2,127	-3.9%	1.7%	12.0%	6.4%
PACE	466	475	509	$5,781	$6,344	$6,701	1.9%	7.2%	9.7%	5.6%
Subtotal	11,786	11,358	11,579	$1,942	$2,180	$2,329	-3.6%	1.9%	12.2%	6.8%
Other Capitated Arrangements:										
RIte Share [1]	1,725	1,603	1,676	$137	$148	$159	-7.1%	4.6%	7.7%	7.3%
Rite Smiles	129,796	125,258	269,726	$19	$19	$14	-3.5%	115.3%	2.8%	-25.5%
Rite Care EFP	1,532	1,271	1,277	$27	$28	$30	-17.0%	0.5%	3.9%	4.7%
Non-Emergency Transportation [2]	293,325	277,952	270,883	$10	$11	$11	-5.2%	-2.5%	7.3%	4.2%
Medicare Premium Payment:										
Part A (Hospital)	3,637	3,759	3,855	$515	$553	$574	3.4%	2.6%	7.2%	3.8%
Part B (Professional Services)	41,059	40,142	41,081	$199	$214	$222	-2.2%	2.3%	7.3%	3.8%
Part D (Prescription Drugs)	38,486	37,502	38,383	$205	$221	$242	-2.6%	2.3%	8.0%	9.4%

Notes:

1. Rite Share PMPM includes employee premium payments only and does not include wrap-around payments.
2. Non-Emergency Medical Transportation includes enrollment of OHA Copay clients funded by the Office of Healthy Aging.

National Forecasts of Medicaid Enrollment/Expenditures

The Congressional Budget Office (CBO) projects varying average monthly enrollment based on populations between FY 2028 and FY 2032. The Aged and Blind and Disabled populations experience stable enrollment levels in this period. The remaining populations experiencing decrease within the five-year projection, with the Adults Made Eligible by the ACA populations encountering an average 8% decrease annually. Overall, the average monthly enrollment change across populations is anticipated to reflect a 2% annual decrease.

Regarding federal spending on benefit payments per enrollee, the five-year projection indicates positive growth across all populations. Except for a 5% increase in 2030, the CBO forecasts a steady 4% average annual growth rate. However, the projected growth rates vary among the different populations. For example:

- Aged and Blind/Disabled Populations: Spending growth is expected to range from 2% to 5% annually, reflecting moderate adjustments in response to service needs.
- Children Population: Projected spending growth is higher, ranging between 4% and 5% annually.
- Traditional Adult Eligibility Population: Growth rates are projected to remain within the 3% to 6% range annually.
- Expansion Adult Population: This group has the highest projected annual growth, between 4% and 7%, due to anticipated increases in service utilization and policy adjustments.

This forecast reflects both anticipated decrease in enrollment and varied growth in spending across population groups, driven by differing healthcare needs and policy influences within each demographic.

The CBO's forecast is in line with projections published by CMS's Office of the Actuary in June 2026, which anticipates a continued reduction in enrollment in 2026 followed by continuing Medicaid enrollment decline in 2027-2028 after the implementation of MWR and other enrollment-related requirements. This enrollment decrease is estimated to be 2.6 million over the 2027-2028 period. From 2029 to 2034, CMS forecasts enrollment to grow 3.6 million to a total of 81.8 million enrollees composite across all populations. From an overall costs' perspective, CMS estimates that Medicaid expenditures will grow 2.7% in 2027-2028 and 5.3% per year from 2029 to 2034.

E. FY 2027 Budget Initiative Implementation

Status updates on FY 2027 (and select prior year) initiatives are detailed below.

- OHIC Rate Review/Assisted Living Tier C. Increasing rates across the OHIC categories require Medicaid State Plan amendments and Waiver rate approvals. The State Plan amendments were posted for public comment in early September and submitted to CMS in October. Waiver rate updates were submitted to CMS for approval in early September (includes the additional assisted living tier C increase effective January 1, 2027). The updated rates are implemented in fee-for-service and funded in managed care rate amendments that will be retroactive to October 1st once executed and implemented. Any changes required by CMS through their review will require changes to the implemented rates.
- GLP-1 Coverage Removal. This change is effective and updates were made accordingly to rates under managed care contracts effective October 1. No federal authority was required to implement.
- Asset Limits for Certain Populations. Implementation of the increased asset limits requires coordination with DHS eligibility staff, federal approval of changes to the Medicaid State Plan, updates to state regulations, and eligibility system changes. Work is underway; EOHHS is targeting late fall 2026 for posting and submission of the required federal approval request. EOHHS' testimony assumes funding level with the enacted budget for FY 2027 and annualized for FY 2028.
- Personal Care Attendants. EOHHS submitted a request to CMS to increase rates for the self-directed Personal Choice program authorized under Rhode Island's Section 1115 demonstration, pursuant to the terms of a collective bargaining agreement. This was submitted in early October and is set to take effect thirty (30) days after CMS approval. EOHHS' testimony assumes $2.4 million from all sources, including $1.0 million in GR in FYs 2027 and 2028 for this update.
- Nursing Home Behavioral Health Per-Diem. EOHHS is drafting the state plan amendment and coordinating with BHDDH to prepare for implementation. EOHHS estimate assumes the first specialized psychiatric unit will start-up during the first half of 2027, with an estimated $0.8 million all funds, including $0.4 million from GR, assuming it is almost fully occupied by April. The FY 2028 estimate assumes one nursing facility with a fully occupied psychiatric unit for the full year at $3.6 million all funds, $1.5 million GR.
- Long Term Behavioral Health Beds. EOHHS submitted the state plan amendment to CMS in November 2025 and continues to engage with CMS. Most recently, EOHHS submitted formal RAI responses to CMS on October 13, 2026. Submission initiates a new 90-day review period; this means that EOHHS expects a response from CMS by January 11, 2027, but may occur sooner. The revised FY 2027 estimate includes $3.8 million from all sources of funds in the Hospital program assuming implementation begins in January. The FY 2028 estimate includes $11.3 million all funds.
- Conflict Free Case Management. The revised estimate for FY 2027 totals $13.9 million, $1.5 million more than enacted. It assumes 13,150 beneficiaries may be eligible for CFCM with 7,331 beneficiaries receiving services by June 2027. The increase is due to intellectual and/or developmental disabilities (I/DD) beneficiaries currently receiving services from independent facilitators (IFs) transiting to community providers over December and January; through August, there are 767 beneficiaries receiving services from IFs. The estimate excludes 655 I/DD beneficiaries who receive case management through BHDDH staff.

For FY 2028, Medicaid projects $16.9 million and assumes 7,571 beneficiaries will receive CFCM services by June 2028, including 2,341 I/DD beneficiaries and 5,230 non- I/DD beneficiaries. The model excludes beneficiaries managed by BHDDH FTEs.

- Program Integrity. Staff continue to actively review claims data and conduct investigations. There are three groups of savings or cost avoidance associated with Medicaid's Office of Program Integrity (OPI). 1) direct recoupments resulting from identification of fraud, waste, or abuse; 2) cost avoidance resulting from payment suspensions or changes in billing practices; and 3) potential future recoupments resulting from referrals to the Medicaid Fraud Control Unit (MFCU) within the Attorney General's Office for criminal investigation of fraudulent practices (can take months or years to resolve and would be generally treated on a cash basis from an accounting perspective).

    1) The forecasts for FYs 2027 and 2028 include $3.5 million in anticipated recoupments against providers that OPI has or in the process of establishing a repayment plan.
    2) OPIs work has resulted in a reassessment of the state's Community Health Worker program, reducing claims expenditures from $12.5 million in FY 2025 to less than $0.4 million in FY 2026.
    3) Since January 2025, $29.0 million in referrals were made to the MFCU (not reflected in testimony). Several referrals have led to charges from the Attorney General's office.[10]

F. Cell and Gene Therapies (CGT) & CGT Access Model

Cell and gene therapies (CGTs) are an emerging class of treatment that aims to treat or cure genetic and acquired diseases. Conditions like Sickle Cell Disease (SCD) and Duchenne Muscular Dystrophy (DMD) are targets for these types of treatment, though other conditions currently have CGTs available or in development. Cell therapy restores or alters stem cells and uses these cells to carry the treatment throughout the body. Gene therapy treats diseases by modifying the genes within cells and then introducing them into the body. CGTs are very involved and expensive treatments. Often priced in millions, the treatments themselves require long eligibility processes. Further, hospital, family lodging, and transportation costs are also significant with these treatments, as extended hospital stays are required.

To offset state costs, CMS introduced the CGT Access Model in January 2024. This is a voluntary model impacting states and manufacturers in which CMS negotiates outcomes-based supplemental rebate agreements and discounts with manufacturers where pricing is linked to health outcomes. Rhode Island applied and was approved to participate. The CGT Access Model applies first to treatments for SCD, which is a degenerative condition that disproportionately affects African-Americans and has limited available non-CGT treatments. Both Massachusetts and Connecticut cover SCD drugs as they are included in the Medicaid Drug Rebate Program (MDRP); however, only Connecticut is a model state.

Over the last several years, an estimated 50-60 Medicaid members at a given time would qualify for SCD treatment based on primary medical criteria, and while EOHHS is aware of one patient in the pipeline for treatment, it is unclear how many others are exploring the potential of CGT. It is also unclear at this time how many potential beneficiaries beyond those of which EOHHS has already been notified could seek treatment for other disorders. Rhode Island has a lower proportion of Medicaid enrollees with SCD (0.3 %) than neighboring states Connecticut (1.2 %) and Massachusetts (2.3%). State comparisons are not available for more specific information, such as the incidence of eligibility for CGT treatment.

Rhode Island's participation in the CGT Access Model began January 1, 2026. For FY 2026, the cost of the drugs included in managed care capitation rates was approximately $7.5 million for all CGTs across the three managed care organizations (MCOs). There is no historical experience for these drugs, making predicting expenditures difficult. For FY 2027 and beyond, EOHHS is utilizing an "administrative services only" (ASO) arrangement with the MCOs for these high-cost drugs (both in and out of the access model), in which the MCOs would pay up-front costs for the drug and EOHHS would reimburse the MCOs on a defined basis at actual acquisition cost (AAC) of the purchased drug. MCOs would be responsible for associated costs such as

[10] https://riag.ri.gov/press-releases/seven-charged-crimes-related-medicaid-fraud-more-1-million

hospital stays and transportation under the capitation rates. The cost of the drug will be carved out of any inpatient treatment bundle.

The MCOs advised EOHHS that there are two patients with paid invoices for Duchenne treatment and one preparing for treatment for SCD. These treatments are estimated to cost $2.4 million for the SCD drug (based on cost for Casgevy, one of the available treatments) and $3.2 million each for the DMD drug (based on cost for Elevidys, one of the available treatments). There are also four potential patients for CAR-T oncology (a type of cell therapy for cancer; many of these therapies are on the EOHHS high-cost drug list), at an estimated $0.5 million per treatment. The associated expenditures may be realized by EOHHS in FY 2027, and it is possible that more treatments will fall during this fiscal year and next. EOHHS includes $12.5 million each in FY 2027 and FY 2028 for eligible patients. This funding applies to all CGT treatments specified on an EOHHS high-cost drug list, but only SCD drugs fall into the access model.

G. Cross Budget Line Summaries: Rebates and NEMT

Drug Rebates and J-Code Collections

Rebates on prescriptions provided in a pharmacy (DRE) and in an outpatient setting (J-Code) offset the federal and state costs of most prescription drugs dispensed to Medicaid patients. Medicaid's rebate collections reduce the program's gross pharmacy spend by over 40%: i.e., X in DRE rebates against total pharmacy spend of Y, excluding J Code administered drugs.

Table II-7 summarizes Medicaid's DRE and J-Code invoices for FY 2026 through FY 2028 projected. Forecasted DRE rebates total $138.3 million and J-Codes total $4.5 million in FY 2027. Medicaid projects a total of $138.8 million in DRE rebates and $4.6 million in J-Code rebates for FY 2028. The marginal decline in FY 2027 from the FY 2027 Enacted level to current projected can be attributed to the continued reduction in caseload and lower managed care spending on drugs overall. Medicaid applied a 5.0% price factor to the calculated rebate on a Per Member Per Month (PMPM) basis.

Medicaid derived its forecast by dividing the average quarterly rebate amounts invoiced to the drug manufacturers in the four quarters through FY 2026 Q4 by the average managed care enrollment for the same period. The resulting PMPM multiplier, calculated by product line, was applied to Medicaid's enrollment.

The health plans also maintain their own financial arrangements with the pharmaceutical manufacturers. These rebates are not included in Medicaid's direct collections and are reflected as offsets to the health plans' medical expenses used to establish their capitation rates. These collections have totaled approximately $16.5 million per year over the past several fiscal years. FFS rebates and J-Code are not converted to a PMPM and are instead treated as a monthly average that is adjusted for increasing unit cost and, therefore, increased rebate collections.

Table II-7. Summary of Drug Rebate Collections

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
DRE						
Managed Care	$ (41,804,449)	$ (51,494,361)	$ (42,253,521)	($9.2 M)	$ (44,715,755)	($2.5 M)
Rhody Health Partners	(33,518,166)	(42,042,711)	(34,595,097)	(7.4 M)	(36,718,469)	(2.1 M)
Expansion	(56,396,217)	(63,325,221)	(53,230,796)	(10.1 M)	(48,515,637)	4.7 M
Fee-for-Service	(6,913,649)	(7,709,123)	(8,248,639)	0.5 M	(8,810,756)	(0.6 M)
Subtotal DRE	**$ (138,632,481)**	**$ (164,571,416)**	**$ (138,328,053)**	**($26.2 M)**	**$ (138,760,617)**	**($0.4 M)**
J-Code						
Managed Care	(948,027)	(2,418,776)	(949,345)	(1.5 M)	(1,012,285)	(0.1 M)
Rhody Health Partners	(705,117)	(1,736,982)	(727,561)	(1.0 M)	(771,778)	(0.0 M)
Expansion	(1,488,050)	(2,953,812)	(1,401,019)	(1.6 M)	(1,277,993)	0.1 M
Fee-for-Service	(1,389,028)	(1,454,665)	(1,456,714)	0.0 M	(1,570,037)	(0.1 M)
Subtotal J-Code	**$ (4,530,222)**	**$ (8,564,235)**	**$ (4,534,639)**	**($4.0 M)**	**$ (4,632,093)**	**($0.1 M)**
Total Rebates	**$ (143,162,703)**	**$ (173,135,651)**	**$ (142,862,692)**	**($30.3 M)**	**$ (143,392,710)**	**($0.5 M)**
QROA						
Managed Care	1,198,754	1,387,963	1,211,808	0.2 M	1,282,495	$0.1 M
Rhody Health Partners	975,103	911,401	1,006,433	(0.1 M)	1,068,206	0.1 M
Expansion	397,342	421,879	375,040	0.0 M	341,819	(0.0 M)
Fee-for-Service	235,876	336,999	281,423	0.1 M	300,601	0.0 M
QROA	**$ 2,807,076**	**$ 3,058,242**	**$ 2,874,704**	**$0.2 M**	**$ 2,993,121**	**$0.1 M**

Non-Emergency Medical Transportation (NEMT)

Medical Transportation Management, Inc. (MTM) provides services to Medicaid beneficiaries and seniors using the State's Elderly Transportation Program. Additionally, MTM issues RIPTA bus passes to Temporary Assistance for Needy Families (TANF) recipients. Medicaid retained MTM as its transportation broker after a competitive RFP with the contract effective July 1, 2023.

For FY 2027, Medicaid extended the existing contract and set rates based on a review of recent experience and trends. It is noteworthy that with less than 5.0% utilization across all enrollees, the higher-than-usual composite rate increase of 9.1% reflects the general insensitivity of MTM's gross transportation costs to its realized enrollment and allowances in rate development for the rising cost of fuel. For FY 2028, a more modest trend of 5.0% was assumed in projections.

The NEMT services forecast is in **Table II-8** and average monthly enrollment is in **Table II-9.** Medicaid allocates spending for the beneficiaries in its Aged, Blind, and Disabled eligibility groups based on enrollment in Rhody Health Options, Rhody Health Partners, or FFS.

Table II-8. Non-Emergency Transportation – Average Monthly Enrollment

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Medicaid						
Children and Families	164,490	162,868	157,798	-5,070	159,027	1,229
Expansion	76,417	73,007	68,559	-4,448	59,453	-9,106
Rhody Health Partners	12,684	12,734	12,449	-284	12,581	132
Rhody Health Options	11,343	11,148	10,889	-259	11,070	182
Other ABD	27,207	28,293	27,127	-1,166	27,594	467
Subtotal Medicaid	292,142	288,050	276,822	-11,228	269,724	-7,097
Overall PMPM	*$9.58*	*$10.18*	*$10.41*	$0.23	*$10.85*	$0.43
Department of Human Services						
OHA Co-Pay	1,184	1,253	1,130	-123	1,159	29
Elderly Transportation Program	$412.5k per month	$431.5k per month	$431.5k per month		$431.5k per month	

Table II-9. Non-Emergency Transportation – Annual Capitation

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Budget Line						
Managed Care	$ 9,435,161	$ 9,498,481	$ 8,653,638	$0.8 M	$ 9,157,093	$ 503,455
Expansion	11,636,832	11,940,998	10,958,457	1.0 M	9,978,060	(980,397)
Rhody Health Partners	3,217,635	3,480,830	3,694,439	(0.2 M)	3,920,137	225,697
Rhody Health Options	2,877,492	3,047,303	3,231,271	(0.2 M)	3,449,390	218,119
Other Services	6,901,914	7,734,266	8,050,209	(0.3 M)	8,598,183	547,975
Total Medicaid	**$ 34,069,033**	**$ 35,701,877**	**$ 34,588,014**	**$1.1 M**	**$ 35,102,862**	**$ 514,848**
TANF Charge Back	(500,000)	(500,000)	0	(0.5 M)	0	0
MTM Liquidated Damages	0	0	0	0.0 M	0	0
Subtotal Medicaid	**$ 33,569,033**	**$ 35,201,877**	**$ 34,588,014**	**$0.6 M**	**$ 35,102,862**	**$0.5 M**

III. Managed Care

Managed Care			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$1,060,268,157	$451,887,621
FY 2026	Revised Enacted	$1,090,000,000	$451,824,564
	Preliminary Final	**$1,083,189,781**	**$448,598,988**
	Surplus over Revised Enacted	*$6,810,219*	*$3,225,576*
FY 2027	Enacted	$1,173,814,294	$477,869,128
	Current	**$1,130,900,000**	**$458,706,508**
	Surplus over Enacted	*$42,914,294*	*$19,162,620*
FY 2028	Current	**$1,206,300,000**	**$494,600,334**

FY 2027

The FY 2027 revised all funds forecast of $1.131 billion reflects a surplus of $42.9 million (3.7%), including $19.2 million GR (4.0%), over the Enacted. Medicaid forecasts an average enrollment of 158,405 Rite Care eligible beneficiaries in FY 2027, a decrease of 5,605 compared to the Enacted. This includes 143,222 beneficiaries enrolled in Rite Care Core, 10,083 in Rite Care CSHCN, 1,603 enrolled in Rite Share, and an average of 3,497 remaining in FFS each month.

The current year's surplus is primarily attributed to the following forecast changes:

- $30.8 million reduction in Rite Care Core net premium payments, primarily driven by a forecasted decrease of 5,285 beneficiaries
- $17.1 million reduction in Rite Care SOBRA due to a decrease of 910 forecasted SOBRA births
- $7.7 million reduction for NICU stays, largely attributed to a forecasted decrease of 125 annual stays
- $2.4 million reductions in Rite Care Cover-All-Kids (CAK) attributed to the CAK enrollees having a lower average PMPM than other Rite Care Core children in the same age bracket. In July, Rhode Island moved its CAK population to separate rating categories; although this transition is budget-neutral from the perspective of the health plans, testimony captures a reduction to state only costs with an offsetting increase to its Medicaid-eligible costs.

As illustrated in **Table III-4,** the decrease in overall beneficiaries (*volume*) generates $40.1 million in savings, a 3.4% reduction compared to Enacted. Combined with $2.8 million in savings from modest overall *price* decreases (0.2%), total savings amount to $42.8 million.

Forecasted FY 2027 savings are partially offset by:

- A $10.7 million decrease in rebates due to less utilization among Managed Care beneficiaries than originally forecasted
- A $6.1 million increase in Core FFS payments, driven by a 40.6% enrollment increase compared to the Enacted
- A $2.1 million increase in Rite Care CSHCN payments, exceeding the prior forecast by 1.0%

FY 2028

Medicaid estimates expenditures of $1.206 billion, including $494.6 million GR, in FY 2028. This represents an increase of $75.4 million, or 6.7%, compared to the revised forecast for FY 2027. The drivers behind the changes in spending compared to the current year are summarized in **Table III-1** through **Table III-4** below. This includes:

- A $57.6 million increase in Rite Care (Core and CSHCN) is attributable to composite PMPM increases of $22 for Rite Care Core and $100 for Rite Care CSHCN, reflecting 5% rate increases across all categories, as well as increases in average monthly enrollment of 0.8% and 1.4%, respectively

- The introduction of an ASO arrangement for High-Cost Drugs (i.e., CGT) in FY 2028 will add $12.5 million in below the line adjustments
- An $11.9 million increase in Rite Smiles, driven by expanded program eligibility that is projected to increase enrollment by 115% to 269,726, partially offset by a 25.5% decrease in the composite rate
- Price increases are the primary driver of spending growth in FY 2028, contributing $77.9 million (6.9%), compared to a $10.0 million (0.9%) increase attributable to enrollment (volume) changes (**Table III-4**)

Increased spending is partially offset by the items below:

- The removal of $12.5 million in potential risk share included in FY 2027;
- A $2.5 million increase in collected rebates, 5.8% more than forecasted in FY 2027

Table III-1 summarizes expenditures to the health plans by product line and FFS payments made on behalf of beneficiaries eligible for managed care.

Table III-1. Summary of Managed Care Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Payments to Plans						
RIte Care Core	$ 688,800,602	$ 758,488,408	$ 727,698,007	$30.8 M	$ 770,103,626	$42.4 M
Rite Care Cover-All-Kids	20,000,000	14,982,750	12,556,063	2.4 M	13,183,866	0.6 M
RIte Care CSHCN	190,776,757	207,064,477	209,195,421	(2.1 M)	224,406,107	15.2 M
Rite Care EFP	500,889	320,100	431,469	(0.1 M)	453,934	0.0 M
Rite Care SOBRA	77,647,998	90,151,899	73,040,353	17.1 M	77,093,578	4.1 M
Withhold	4,521,487	4,897,001	4,794,842	0.1 M	5,088,374	0.3 M
Risk Share	8,938,996	0	0	0.0 M	0	0.0 M
High Cost Drug ASO Arrangement	0	12,500,000	12,500,000	0.0 M	12,500,000	0.0 M
Rite Smiles	26,913,489	27,938,938	25,496,337	2.4 M	37,375,042	11.9 M
Subtotal - Payments to Plans	**$ 1,018,100,218**	**$ 1,116,343,574**	**$ 1,065,712,493**	**$50.6 M**	**$ 1,140,204,528**	**$74.5 M**
Other Payments						
Non-Emergency Transportation	$ 9,435,161	$ 9,498,481	$ 8,653,638	$0.8 M	$ 9,157,093	$0.5 M
RIte Share	2,843,727	3,309,561	2,846,284	0.5 M	3,195,219	0.3 M
Premium Assistance Program	30,000	500,000	50,000	0.5 M	500,000	0.5 M
Core FFS	52,217,945	51,292,000	57,399,079	(6.1 M)	58,244,648	0.8 M
CSHCN FFS	2,614,125	2,930,000	2,404,000	0.5 M	2,542,000	0.1 M
Early Intervention FFS	5,205,269	5,203,000	5,533,000	(0.3 M)	5,672,000	0.1 M
NICU	30,067,218	38,300,815	30,610,192	7.7 M	31,660,678	1.1 M
State Only FFS (Non Medicaid)	1,000,000	1,000,000	1,000,000	0.0 M	1,000,000	0.0 M
Rebates	(42,752,476)	(53,913,137)	(43,202,866)	(10.7 M)	(45,728,040)	(2.5 M)
Premium Collection	(50,000)	(50,000)	(50,000)	0.0 M	(50,000)	0.0 M
Tax Intercept	(100,000)	(100,000)	(100,000)	0.0 M	(100,000)	0.0 M
Subtotal - Other Payments	**$ 60,010,969**	**$ 57,470,720**	**$ 65,143,327**	**($7.7 M)**	**$ 66,093,598**	**$1.0 M**
Subtotal - Managed Care	**$ 1,078,111,187**	**$ 1,173,814,294**	**$ 1,130,855,819**	**$43.0 M**	**$ 1,206,298,126**	**$75.4 M**
SFY 2025 accruals - SFY 25/26 risk share chang	7,629,966					
Other Adjustments/Rounding	(2,551,372)	0	44,181	(0.0 M)	1,874	(0.0 M)
Total - Managed Care	**$ 1,083,189,781**	**$ 1,173,814,294**	**$ 1,130,900,000**	**$42.9 M**	**$ 1,206,300,000**	**$75.4 M**
General Revenue	$448.6 M	$477.9 M	$458.7 M	$19.2 M	$494.6 M	$35.9 M
Federal Funds	$634.6 M	$695.9 M	$672.2 M	$23.8 M	$711.7 M	$39.5 M

Medicaid's revised average caseload forecast and a comparison to prior estimates is summarized in **Table III-2.**

Table III-2. Average Managed Care Caseload

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Full Benefits by Delivery System						
Rite Care Core	149,372	148,506	143,222	-5,285	144,315	1,093
Rite Care CSHCN	9,723	10,079	10,083	4	10,229	146
Rite Share	1,725	1,779	1,603	-176	1,676	73
Remaining in FFS - Core	2,340	2,379	2,551	172	2,627	76
Remaining in FFS - CSHCN	1,181	1,266	946	-320	973	27
Total - Full Benefits	164,341	164,009	158,405	-5,605	159,820	1,415
Overall PMPM	$549	$596	$595	($1)	$629	*$34*
% Enrolled in Managed Care	96.8%	96.7%	96.8%		96.7%	
Other Caseload Factors						
EFP Only	1,532	934	1,271	337	1,277	7
Rite Smiles	129,796	130,410	125,258	-5,152	269,726	144,468
Non-Emergency Transportation	164,490	162,868	157,798	-5,070	159,027	1,229

The forecast for the number of births and NICU stays is in **Table** III-3**.**

Table III-3. Medicaid Births and NICU Stays

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
SOBRA Births						
RIte Care	3,735	4,494	3,641	-853	3,660	19
Expansion	151	258	201	-57	204	3
Total - SOBRA Births	3,886	4,752	3,842	-910	3,864	22
Cost per SOBRA Birth	*$20,789*	*$20,061*	*$20,061*	*$0*	*$21,064*	*$1,003*
NICU Stays	443	565	440	-125	444	4
Cost per NICU Stay	*$67,872*	*$67,789*	*$69,569*	*$1,780*	*$71,308*	*$1,739*

Table III-4 shows variances between Medicaid's price and volume forecasts.

Table III-4. Managed Care Price-Volume Comparison to Enacted and Prior FY

	Price	Volume	Net
FY 2027 over FY 2026	$74.3 M	($39.1 M)	$35.2 M
	7.1%	-3.6%	3.3%
FY 2027: Current over Enacted	($15.3 M)	($40.1 M)	($55.4 M)
	-1.3%	-3.4%	-4.7%
FY 2028 over FY 2027	$77.9 M	$10.0 M	$87.9 M
	6.9%	0.9%	7.9%

The average monthly Rite Care and Rite Smiles capitation rates paid to the health plans are summarized in **Table III-5** and **Table III-6**.

Table III-5. Summary of Rite Care Core and CSHCN Monthly Premiums

	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY27 → FY28
RIte Care Core					
MF < 1 y.o.	$760	$860	$903	13.1%	5.0%
MF 1-4 y.o.	$345	$423	$445	22.9%	5.0%
MF 5-14 y.o.	$265	$299	$314	13.0%	5.0%
M 15-44 y.o.	$334	$349	$366	4.5%	5.0%
F 15-44 y.o.	$504	$521	$547	3.4%	5.0%
MF 45+ y.o.	$753	$801	$841	6.4%	5.0%
Composite	$397	$436	$458	9.7%	5.0%
Average Member Months	149,372	143,222	144,315	-4.1%	0.8%
RIte Care CSHCN					
Substitute Care	$1,157	$1,168	$1,227	1.0%	5.0%
SSI <15	$2,738	$3,029	$3,180	10.6%	5.0%
SSI 15-20	$1,831	$2,001	$2,101	9.3%	5.0%
Katie Beckett	$4,319	$3,245	$3,407	-24.9%	5.0%
Adoption Subsidy	$968	$1,034	$1,086	6.8%	5.0%
Composite	$1,643	$1,738	$1,837	5.7%	5.7%
Average Member Months	9,723	10,083	10,229	3.7%	1.4%
SOBRA Payment	$20,789	$20,061	$21,064	-3.5%	5.0%
EFP Only	$27	$28	$30	3.6%	5.0%
Katie Beckett - Care Management	$94	$82	$87	-12.0%	5.0%
Rite Share	$137	$148	$159	7.7%	7.3%

Table III-6. Summary of Rite Smiles Monthly Premiums

	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY27 → FY28
Rite Smiles					
MF 0-2	$5	$5	$5	1.9%	5.2%
MF 3-5	$17	$17	$18	0.1%	4.9%
MF 6-10	$24	$24	$25	2.2%	5.1%
MF 11-15	$26	$27	$28	2.1%	5.5%
MF 16-18	$18	$19	$23	7.0%	19.5%
MF 19-20	$18	$19	$14	7.0%	-29.8%
MF 21-64	$7	$8	$10	12.8%	32.3%
MF 21-64 (Special Healthcare Needs)			$19	n/a	n/a
MF 65+			$8	n/a	n/a
MF 65+ (Special Healthcare Needs)			$21	n/a	n/a
Composite	$19	$19	$14	2.7%	-25.5%
Average Enrollment	129,796	125,258	269,726	-3.5%	115.3%

Table III-7 and **Table III-8** identify net changes to total CHIP and family planning claiming activities that contribute to the surplus when compared to the Enacted budget.

Table III-7. CHIP Offsets

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
CHIP Offset	**$ 171,156,764**	**$ 175,720,696**	**$ 170,190,395**	**($5.5 M)**	**$ 179,896,944**	**$9.7 M**
Additional GR Relief	*$22.6 M*	*$22.3 M*	*$21.6 M*	($0.7 M)	*$23.1 M*	$1.5 M
CHIP FMAP	69.19%	70.42%	70.42%		70.09%	
Regular FMAP	55.99%	57.73%	57.73%		57.26%	

Note 1. CHIP offset does not reflect additional CHIP claiming against State Directed Payment that is reflected in Hospitals - Regular.

Table III-8. EFP Claiming

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
Family Planning Offset	**$ 9,298,096**	**$ 8,700,000**	**$ 9,763,001**	**$1.1 M**	**$ 10,251,151**	**$0.5 M**
Additional GR Relief	*$3.2 M*	*$2.8 M*	*$3.2 M*	$0.3 M	*$3.4 M*	$0.2 M
Family Planning FMAP	90.00%	90.00%	90.00%		90.00%	
Regular FMAP	55.99%	57.73%	57.73%		57.26%	

Table III-9 identifies changes to CCBHC claiming activities that partially offset the surplus compared to the Enacted budget. Additional month-by-month details are provided in **Attachment 5**.

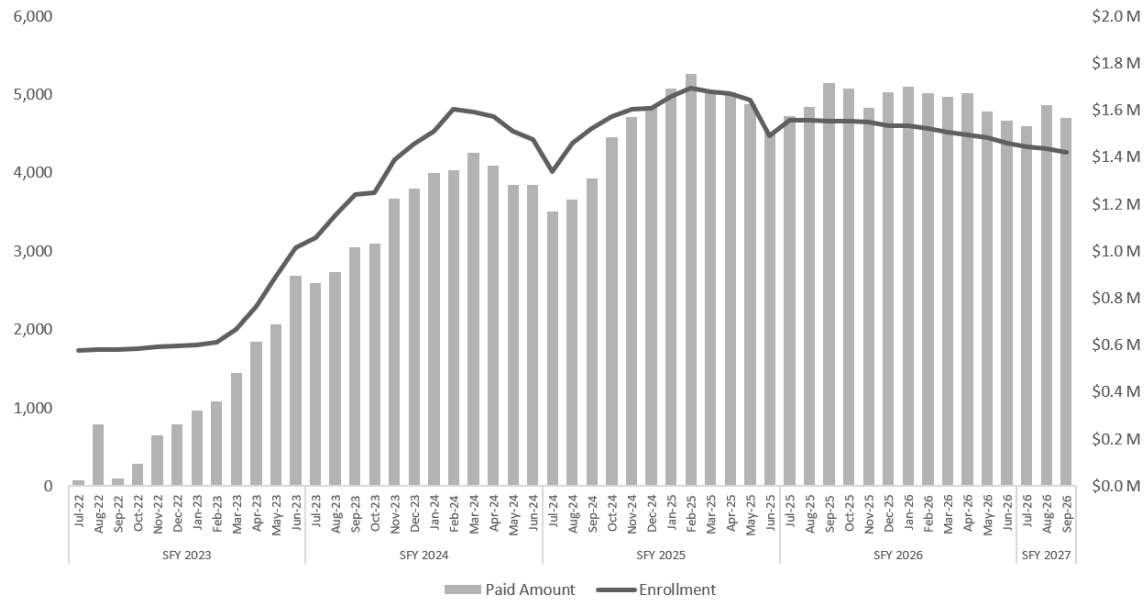
Table III-9. CCBHC Claiming

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
CCBHC Offset	**$ 31,317,654**	**$ 30,620,947**	**$ 33,144,853**	**$2.5 M**	**$ 35,623,088**	**$2.5 M**
Additional GR Relief	*$4.1 M*	*$3.9 M*	*$4.2 M*	$0.3 M	*$4.6 M*	$0.4 M
CHIP FMAP	69.19%	70.42%	70.42%		70.09%	
Regular FMAP	55.99%	57.73%	57.73%		57.26%	

Note 1. CCBHC offset does not reflect all enhanced claiming available to Rhode Island under the CCBHC Demonstration. See also Rhody Health Partners and Other Services.

Figure III-1 shows the Cover all Kids enrollment and expenditures from 2023 through September 2026.

Figure III-1. Cover All Kids Eligibility and State Only Costs (Capitation and FFS Activity)



IV. Rhody Health Partners

Rhody Health Partners			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$299,823,909	$129,082,711
FY 2026	Revised Enacted	$337,699,999	$140,319,669
	Preliminary Final	**$344,240,383**	**$145,194,753**
	Deficit over Revised Enacted	*($6,540,384)*	*($4,875,084)*
FY 2027	Enacted	$340,249,821	$139,312,801
	Current	**$337,200,000**	**$139,541,210**
	Surplus over Enacted	*$3,049,821*	*($228,409)*
FY 2028	Current	**$359,900,000**	**$150,479,375**

FY 2027

For Rhody Health Partners (RHP), Medicaid forecast expenditures of $337.2 million, including $139.5 million GR. This represents a surplus of $3.1 million (0.9%), despite a $0.2 million deficit (0.2%) GR compared to the Enacted. The surplus is primarily attributed to a decrease in membership coinciding with a $22 decrease in Composite PMPM in RHP. Medicaid forecasts an average fiscal year enrollment of 12,475 in FY 2027, a 289 beneficiary decrease over Enacted. This membership decrease accounts for $7.7 million decrease as the three most expensive rate cells saw membership declines ranging from 53 beneficiaries to 144 beneficiaries. In addition, anticipated rebate collections decreased by $8.5 million compared to Enacted.

FY 2028

The RHP forecast of $359.9 million, including $150.5 million GR for FY 2028. This represents an increase of $22.7 million (6.7%), including $10.9 million GR (7.8%), compared to the revised estimate of FY 2027. This increase is largely due to a $19.0 million increase in price as Composite RHP PMPM increased by $133, or 5.4%, to $2,587. In addition, enrollment is projected to account for an additional $3.7 million in expenditures. Medicaid forecasts an average enrollment of 12,611 beneficiaries in RHP in FY 2028; an increase of 135 members compared to FY 2027.

RHP increases are partially offset by a $2.2 million increase in pharmacy rebate collections.

Table IV-1 details expenditures to the health plans by product line and shows FFS payments made on behalf RHP eligible beneficiaries.

Medicaid's average caseload forecast is in **Table IV-2. RHP Average Enrollment**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**.

Table IV-3 summarizes the price and volume variances for FY 2026 through FY 2028.

The average monthly RHP capitation rate by pay level is shown in **Table IV-4**.

Table IV-1. Summary of RHP Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Payments to Plans						
Rhody Health Partners	$ 364,940,148	$ 377,372,898	$ 365,498,098	$11.9 M	$ 390,061,713	$24.6 M
Withhold	1,833,926	1,866,786	1,836,861	0.0 M	1,957,271	0.1 M
Risk Share	5,166,316	0	0	0.0 M	0	0.0 M
Subtotal - Payment to Plans	**$ 371,940,391**	**$ 379,239,684**	**$ 367,334,958**	**$11.9 M**	**$ 392,018,984**	**$24.7 M**
Other Payments						
Non-Emergency Transportation	3,217,635	3,480,830	3,694,439	(0.2 M)	3,920,137	0.2 M
FFS	1,406,855	1,309,000	1,418,000	(0.1 M)	1,418,000	0.0 M
Rebates	(34,223,283)	(43,779,693)	(35,322,658)	(8.5 M)	(37,490,247)	(2.2 M)
Subtotal - Other Payments	**$ (29,598,793)**	**$ (38,989,863)**	**$ (30,210,219)**	**($8.8 M)**	**$ (32,152,110)**	**($1.9 M)**
Subtotal - Rhody Health Partners	**$ 342,341,597**	**$ 340,249,821**	**$ 337,124,740**	**$3.1 M**	**$ 359,866,874**	**$22.7 M**
Other Adjustments	1,898,786	0	75,260	(0.1 M)	33,126	(0.0 M)
Total - Rhody Health Partners	**$ 344,240,383**	**$ 340,249,821**	**$ 337,200,000**	**$3.0 M**	**$ 359,900,000**	**$22.7 M**
General Revenue	*$145.2 M*	*$139.3 M*	*$139.5 M*	*($0.2 M)*	*$150.5 M*	*$10.9 M*
Federal Funds	*$199.0 M*	*$200.9 M*	*$197.7 M*	*$3.3 M*	*$209.4 M*	*$11.8 M*

Table IV-2. RHP Average Enrollment

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
Rhody Health Partners						
SSI 21-44	3,533	3,539	3,425	-114	3,453	28
SSI 45+	6,082	6,149	6,004	-144	6,065	61
SPMI	1,850	1,835	1,781	-53	1,804	23
I/DD	1,226	1,242	1,265	23	1,289	24
Total	12,691	12,764	12,475	-289	12,611	135
Composite RHP PMPM	*$2,442*	*$2,476*	*$2,454*	*-$22*	*$2,591*	*$137*
Overall PMPM (incl. of Other Payments)	*$2,260*	*$2,221*	*$2,252*	*$31*	*$2,378*	*$126*
Other Caseload Factors						
Non-Emergency Transportation	12,684	12,734	12,449	-284	12,581	132

Table IV-3. RHP Price-Volume Comparison to May CEC and Prior FY

	Price	Volume	Net
FY 2027 over FY 2026	($1.2 M)	($5.9 M)	($7.0 M)
	-0.4%	-1.7%	-2.0%
FY 2027: Current over Enacted	$4.7 M	($7.7 M)	($3.0 M)
	1.4%	-2.3%	-0.9%
FY 2028 over FY 2027	$19.0 M	$3.7 M	$22.7 M
	5.6%	1.1%	6.7%

Table IV-4. RHP Monthly Premiums

	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY27 → FY28
Rhody Health Partners					
SSI 21-44	$1,762	$1,559	$1,637	-11.5%	5.0%
SSI 45+	$2,522	$2,476	$2,599	-1.8%	5.0%
SPMI	$3,835	$4,844	$5,086	26.3%	5.0%
I/DD	$1,554	$1,495	$1,570	-3.8%	5.0%
Composite	$2,408	$2,454	$2,587	1.9%	5.4%
Average Member Months	12,691	12,475	12,611	-1.7%	1.1%

V. Rhody Health Options / FIDE-SNP

Rhody Health Options			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$217,598,267	$95,669,061
FY 2026	Revised Enacted	$247,800,000	$104,762,329
	Preliminary Final	**$236,569,434**	**$100,371,706**
	Surplus over Revised Enacted	*$11,230,566*	*$4,390,623*
FY 2027	Enacted	$287,890,533	$118,927,267
	Current	**$268,400,000**	**$110,866,997**
	Surplus over Enacted	*$19,490,533*	*$8,060,270*
FY 2028	Current	**$287,300,000**	**$119,933,351**

FY 2027

The Rhody Health Options (RHO) forecast of $268.4 million, including $110.9 million GR, represents a surplus of $19.5 million (6.8%), including $8.1 million GR (6.8%), compared to the Enacted. Medicaid forecasts a declining average enrollment of 10,883, a decrease of 264 beneficiaries per month, compared to the Enacted.

Effective January 1, 2026, Medicaid began operating a new FIDE-SNP contract with Neighborhood Health Plan of Rhode Island (NHPRI). This is a type of Medicare Advantage plan that combines Medicare and Medicaid benefits into a single plan for individuals who qualify for both. It is similar to the prior CMS Demonstration arrangement but adheres to different rate-setting methodologies that are generally viewed as more favorable to the health plan.

For example, CMS Demonstration rates used Medicaid FFS base experience (with adjustments for relative acuity of NHPRI's enrolled membership), with minimal allowance for administrative expenses and required application of significant federally mandated cost savings. The new rates follow more generally accepted actuarial guidelines and uses NHPRI's own Medicaid experience, with prospective adjustments for state-mandated rate changes. NHPRI separately submitted a "bid" to CMS for its Medicare revenues that aligned with Medicare Advantage rules, which also differed meaningfully from the Medicare parameters of the prior CMS Demonstration.

Changes in Medicaid's FY 2027 forecast are attributable to a decrease in expenditures in the FIDE-SNP. Overall enrollment declined by 2.4% compared to Enacted along with a $97 decrease in PMPM costs over the prior forecast, declining from $2,152 to $2,055. This contributed to a decrease in $12.7 million (4.5%) in expenditure just from the lower PMPM.

FY 2028

Medicaid forecasts spending for the FIDE-SNP program to increase by $18.9 million (7.0%), including $9.1 million GR (8.2%), in FY 2028 compared to FY 2027.

Total enrollment is projected to increase by 1.7%, and the growth is spread across the population. However, Community LTSS, one of the most expensive rate cells ($5,590), is projected to increase by 51 beneficiaries, the second largest increase in enrollment by a rate cell in this population. Community LTSS PMPM is forecasted to increase by 6.2% over FY 2027. Additionally, monthly premiums for the SPMI population are projected to increase by 9.6%, rising from $2,374 in FY 2027 to $2,603 in FY 2028. Similar price increases are projected for the I/DD (15.8%) and Institutional LTSS (6.2%) populations. With all the populations forecasted to see sharp PMPM increases, overall PMPM is also projected to increase by $108 (5.2%) to $2,163.

Table VI-1 summarizes RHO expenditures. Medicaid's revised average caseload forecast is summarized in **Table V-2**, with additional month-by-month detail provided in **Attachment 5a** and **Attachment 5b**.

Table V-3 calculates the price and volume-related changes between FY 2026 and FY 2028. The average monthly RHO capitation rates by pay level are summarized in **Table V-4.**

Table V-1. RHO Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Payments to Plans						
FIDE SNP	$ 231,246,657	$ 284,843,230	$ 262,081,111	$22.8 M	$ 283,801,277	$21.7 M
Withhold	4,640,911	0	0	0.0 M	0	0.0 M
Risk Share	987,669	0	3,000,000	(3.0 M)	0	(3.0 M)
Subtotal - Payment to Plans	**$ 236,875,237**	**$ 284,843,230**	**$ 265,081,111**	**$19.8 M**	**$ 283,801,277**	**$18.7 M**
Other Payments						
Non-Emergency Transportation	$ 2,877,492	$ 3,047,303	$ 3,231,271	($0.2 M)	$ 3,449,390	$0.2 M
Rebates	0	0	0	0.0 M	0	0.0 M
Subtotal - Other Payments	**$ 2,877,492**	**$ 3,047,303**	**$ 3,231,271**	**($0.2 M)**	**$ 3,449,390**	**$0.2 M**
Subtotal - Rhody Health Options	**$ 239,752,729**	**$ 287,890,533**	**$ 268,312,383**	**$19.6 M**	**$ 287,250,667**	**$18.9 M**
overaccrual for retro enrollment and withhold	(3,453,914)					
Other Adjustments	270,618	(0)	87,617	(0.1 M)	49,333	(0.0 M)
Total - Rhody Health Options	**$ 236,569,434**	**$ 287,890,533**	**$ 268,400,000**	**$19.5 M**	**$ 287,300,000**	**$18.9 M**
General Revenue	*$100.4 M*	*$118.9 M*	*$110.9 M*	*$8.1 M*	*$119.9 M*	*$9.1 M*
Federal Funds	*$136.2 M*	*$169.0 M*	*$157.5 M*	*$11.4 M*	*$167.4 M*	*$9.8 M*

Table V-2. RHO Average Enrollment

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
Rhody Health Options						
SPMI	1,054	1,288	1,234	-55	1,256	22
I/DD	1,195	1,155	1,183	29	1,209	26
Community LTSS	2,534	2,566	2,611	46	2,662	51
Institutional LTSS	544	573	507	-66	522	15
Community Non-LTSS	5,992	5,566	5,348	-218	5,422	73
Total	11,320	11,148	10,883	-264	11,070	187
Overall PMPM	*$1,742*	*$2,152*	*$2,055*	*-$97*	*$2,163*	*$108*
Other Caseload Factors						
Non-Emergency Transportation	11,343	11,148	10,889	-259	11,070	182

Table V-3. RHO Price-Volume Comparison to Enacted and Prior FY

	Price	Volume	Net
FY 2027 over FY 2026	$40.9 M 18.0%	($9.1 M) -3.9%	$31.8 M 13.5%
FY 2027: Current over Enacted	($12.7 M) -4.5%	($6.8 M) -2.4%	($19.5 M) -6.8%
FY 2028 over FY 2027	$14.3 M 5.2%	$4.6 M 1.7%	$18.9 M 7.0%

Table V-4. Summary of RHO Monthly Premiums

	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY27 → FY28
Rhody Health Options					
SPMI	$2,208	$2,374	$2,603	7.5%	9.6%
I/DD	$368	$423	$490	15.1%	15.8%
Community LTSS	$5,073	$5,264	$5,590	3.8%	6.2%
Institutional LTSS	$5,073	$5,265	$5,590	3.8%	6.2%
Community Non-LTSS	$372	$356	$349	-4.3%	-2.0%
Composite	$1,703	$1,999	$2,127	17.3%	6.4%
Average Member Months	11,320	10,883	11,070	-3.9%	1.7%

VI. Expansion

Expansion		All Funds	General Revenue
FY 2025	Revised Enacted	$698,692,382	$72,406,135
FY 2026	Revised Enacted	$724,900,000	$78,127,935
	Preliminary Final	**$725,817,857**	**$74,200,894**
	Deficit over Revised Enacted	*($917,857)*	*$3,927,041*
FY 2027	Enacted	$734,552,792	$79,169,438
	Current	**$715,900,000**	**$73,578,540**
	Surplus over Enacted	*$18,652,792*	*$5,590,898*
FY 2028	Current	**$667,300,000**	**$68,708,819**

FY 2027

Medicaid's revised FY 2027 forecast for Expansion is $715.9 million, including $73.6 million GR, reflecting a surplus of $18.7 million (2.5%), including $5.6 million GR (7.1%) compared to the Enacted. Average monthly enrollment of 70,429 represents a reduction of 4,357 beneficiaries compared to the prior CEC forecast. Of this total, 65,961 beneficiaries are enrolled in this product (excluding RIte Share and FFS), 4,167 fewer than the Enacted.

The surplus is primarily driven by reduced enrollment, resulting in a $42.8 million volume decrease, which is partially offset by a $24.1 million price increase (3.5%). Overall PMPM increased by $29 to $847. In addition to the price-volume dynamics, the surplus is also due to 57 fewer SOBRA births, resulting in $1.1 million in savings, and decrease of $11.4 million for Previously Expansion- Beneficiaries. However, a $13.4 million increase in FFS spending alongside an $11.6 million decrease in rebates collections offset the total fiscal year savings.

FY 2028

Medicaid projects Expansion expenditures of $667.3 million for FY 2027, including $68.7 million GR. This is a decrease of $48.6 million (6.8%), including $4.9 million GR (6.6%), compared to the updated forecast for FY 2027.

Excluding RIte Share and FFS, average monthly enrollment for FY 2028 is projected at 57,258, a decrease of 8,704 (13.2%) from FY 2027 with declines expected across all rate cells in Expansion. This enrollment decline is expected to have an $87.4 million savings impact in FY 2028. Year-over-year price growth (6.1%), driven in part by managed care rate increases, offsets about half of these savings ($38.8 million). Composite PMPMs are projected to increase by 5.0% across Expansion in FY 2028.

Effective January 1, 2027, EOHHS will be implementing MWR for adults in the Expansion population. The first cohort of beneficiaries will be disenrolled in April 2027, once the redetermination/eligibility process is completed. The impact of MWR is the major contributor to the reduction in expansion in FY 2028.

Previously Eligible Expansion-Eligible Beneficiaries

FY 2027 and FY 2028 include adjustments for Expansion beneficiaries who would have been previously eligible for Medicaid under criteria in place prior to January 1, 2014 (e.g., individuals who meet specific disability standards but otherwise meet Expansion eligibility criteria), as they are not eligible for the enhanced 90% FFP. Medicaid must make adjusting entries at the end of each fiscal year. The revised estimate includes $5.0 million in both FY 2027 and FY 2028 that are not eligible for a 90/10 match.

Table VI-1 summarizes all expenditures by product line to the health plans as well as various FFS payments. Medicaid's revised average caseload forecast and a comparison to prior estimates is summarized in **Table VI-2** with additional month-by-month detail provided in **Attachment 5**.

Table VI-3 calculates the price and volume related changes for FY 2026 Final, FY 2027 Enacted and Current, and FY 2028 over FY 2027. The average monthly Expansion capitation rates, by pay level, are summarized in **Table VI-4**.

Table VI-1. Summary of Medicaid Expansion Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Payments to Plans						
Expansion	$ 678,058,277	$ 692,252,109	$ 662,300,979	$30.0 M	$ 603,500,654	($58.8 M)
Expansion - Previously Eligible	4,115,648	16,400,000	5,000,000	11.4 M	5,000,000	0.0 M
RIte Smiles	1,939,775	2,006,333	1,939,775	0.1 M	7,298,409	5.4 M
SOBRA	3,139,183	5,175,610	4,032,165	1.1 M	4,297,019	0.3 M
Withhold	3,426,769	3,549,776	3,353,846	0.2 M	3,058,539	(0.3 M)
Risk Share	18,001,025	0	0	0.0 M	0	0.0 M
Subtotal - Payments to Plans	**$ 708,680,677**	**$ 719,383,828**	**$ 676,626,766**	**$42.8 M**	**$ 623,154,621**	**($53.5 M)**
Other Payments						
Non-Emergency Transportation	$ 11,636,832	$ 11,940,998	$ 10,958,457	$1.0 M	$ 9,978,060	($1.0 M)
Expansion FFS	71,541,057	69,507,000	82,885,000	(13.4 M)	83,941,187	1.1 M
Rebates	(57,884,267)	(66,279,033)	(54,631,815)	(11.6 M)	(49,793,630)	4.8 M
DRE	(56,396,217)	(63,325,221)	(53,230,796)	(10.1 M)	(48,515,637)	4.7 M
J-Code	(1,488,050)	(2,953,812)	(1,401,019)	(1.6 M)	(1,277,993)	0.1 M
Subtotal - Other Payments	**$ 25,293,622**	**$ 15,168,965**	**$ 39,211,642**	**($24.0 M)**	**$ 44,125,617**	**$4.9 M**
Subtotal - Expansion	**$ 733,974,298**	**$ 734,552,792**	**$ 715,838,408**	**$18.7 M**	**$ 667,280,238**	**($48.6 M)**
SFY 2025 accruals - SFY 25/26 risk share chang	(4,713,031)					
Other Adjustments/Rounding	(3,443,410)	(0)	61,592	(0.1 M)	19,762	(0.0 M)
Total - Expansion	**$ 725,817,857**	**$ 734,552,792**	**$ 715,900,000**	**$18.7 M**	**$ 667,300,000**	**($48.6 M)**
General Revenue	*$74.2 M*	*$79.2 M*	*$73.6 M*	*$5.6 M*	*$68.7 M*	*($4.9 M)*
Federal Funds	*$651.6 M*	*$655.4 M*	*$642.3 M*	*$13.1 M*	*$598.6 M*	*($43.7 M)*

Table VI-2. Summary Medicaid Expansion Average Enrollment

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Change	Current	FY27 → FY28
Enrolled						
F 19-24	7,316	6,947	6,642	-305	5,764	-877
F 25-29	4,243	4,016	3,805	-210	3,299	-507
F 30-39	5,393	5,072	4,853	-219	4,209	-644
F 40-49	4,469	4,335	4,153	-182	3,616	-537
F 50-64	11,024	10,734	10,144	-591	8,819	-1,325
M 19-24	7,287	6,895	6,331	-564	5,486	-845
M 25-29	5,412	5,000	4,529	-471	3,922	-607
M 30-39	10,777	10,138	9,451	-687	8,187	-1,265
M 40-49	7,346	7,152	6,848	-303	5,952	-896
M 50-64	10,109	9,841	9,205	-636	8,005	-1,200
Subtotal - Enrolled	73,375	70,129	65,961	-4,167	57,258	-8,704
Rite Share	9	16	13	-2	26	12
Remaining in FFS	4,573	4,643	4,455	-188	4,547	92
Total - Expansion	77,958	74,787	70,429	-4,357	61,830	-8,600
Overall PMPM	*$776*	*$818*	*$847*	*$29*	*$899*	*$52*
% Enrolled in Managed Care	94.1%	93.8%	93.7%		92.6%	

Table VI-3. Expansion Price-Volume Comparison to May CEC and Prior FY

	Price	Volume	Net
FY 2027 over FY 2026	$60.2 M	($70.1 M)	($9.9 M)
	9.2%	-9.7%	-1.4%
FY 2027: Current over Enacted	$24.1 M	($42.8 M)	($18.7 M)
	3.5%	-5.8%	-2.5%
FY 2028 over FY 2027	$38.8 M	($87.4 M)	($48.6 M)
	6.2%	-12.2%	-6.8%

Table VI-4. Summary of Medicaid Expansion Effective Monthly Premiums

	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY27 → FY28
Expansion					
F 19-24	$417	$450	$473	8.1%	5.0%
F 25-29	$577	$643	$676	11.6%	5.0%
F 30-39	$838	$908	$953	8.4%	5.0%
F 40-49	$1,060	$1,194	$1,254	12.6%	5.0%
F 50-64	$1,063	$1,130	$1,186	6.3%	5.0%
M 19-24	$315	$318	$334	0.9%	5.0%
M 25-29	$473	$487	$511	3.0%	5.0%
M 30-39	$691	$734	$770	6.2%	5.0%
M 40-49	$970	$1,071	$1,125	10.4%	5.0%
M 50-64	$1,112	$1,210	$1,270	8.8%	5.0%
Composite	$779	$847	$890	8.8%	5.0%
Average Member Months	73,375	65,961	57,258	-10.1%	-13.2%

VII. Hospitals – Regular

Hospitals - Regular			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$353,268,455	$117,057,409
FY 2026	Revised Enacted	$402,500,001	$130,758,833
	Preliminary Final	**$423,911,696**	**$145,262,601**
	Deficit over Revised Enacted	*($21,411,695)*	*($14,503,768)*
FY 2027	Enacted	$413,716,599	$131,275,951
	Current	**$412,400,000**	**$134,649,141**
	Surplus over Enacted	*$1,316,599*	*($3,373,190)*
FY 2028	Current	**$422,900,000**	**$140,507,799**

FY 2027

Medicaid's revised estimate for **Hospital – Regular** totals $412.4 million, including $134.6 million from GR, in FY 2027; a $1.3 million (0.3%) surplus, offsetting a $3.4 million GR deficit (2.6%), compared to the enacted budget.

The gross decline in **Hospital – Regular** expenditures is driven primarily by a reduction in projected inpatient UPL payments to hospitals ($2.8 million), which is partially offset by a $1.1 million increase in projected outpatient UPL payments and a small increase ($0.4 million) in projected hospital FFS activity.

Other notable changes include the anticipated placements in the new long-term behavioral health unit. As state plan authority is still pending with CMS, the revised FY2027 estimate assumes placements beginning in January 2027. Previous estimate assumes a May 2026 implementation. The revised FY 2027 estimate includes total expenditures of $3.8 million, including $1.6 million from GR.

Medicaid's methodology for revising its current year estimate uses FY26 claims activity, specifically the impact of FY26 Q4, and adjusts for an incurred but not reported (IBNR) factor.

FY 2028

FY 2028 hospital spending is expected to increase by $10.5 million to $422.9 million, including $140.5 million from GR.

The year-over-year increase is due to an estimated $10.0 million increase in inpatient and $0.6 million increase in outpatient hospital claims activity.

The revised estimates for FY 2027 and FY 2028 spending eliminates savings related to the closure of beneficiaries under the new HR.1 non-citizen eligibility rules. A review of actual closures effectuated October 1, 2026 did not include a material number of beneficiaries remaining in FFS and so no reduction applied to baseline expenditures. The FY 2028 estimate also includes an estimated increase of $2.5 million in hospital spending due to a projected increase in emergency Medicaid activity associated with those losing coverage relying more heavily on emergency services.

Overall, as it relates to baseline FFS spending, the estimate assumes a projected annual rate change of 3.2% for inpatient and outpatient services, pursuant to current law, which is estimated at $1.6 million. Medicaid also assumes a 2.5% utilization increase in FY 2028.

A summary of the revised estimates for FY 2027 and FY 2028 is shown in **Table VII-1**. A summary of the price changes for FY 2028 is included in **Table VII-2**.

Table VII-1. Summary of Hospital – Regular Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Supplemental Payments						
Inpatient UPL	$ 18,528,018	$ 18,528,018	$ 15,679,637	$2.8 M	$ 15,679,637	$0.0 M
Regular	13,760,069	13,843,351	11,644,683	2.2 M	11,644,683	0.0 M
Expansion	4,767,949	4,684,667	4,034,954	0.6 M	4,034,954	0.0 M
Outpatient UPL	8,926,997	8,926,997	10,016,714	(1.1 M)	10,016,714	0.0 M
Regular	6,623,857	6,477,746	7,432,430	(1.0 M)	7,432,430	0.0 M
Expansion	2,303,140	2,449,251	2,584,284	(0.1 M)	2,584,284	0.0 M
SDP - Hospital Payments	325,609,583	324,718,047	324,718,048	(0.0 M)	324,718,048	0.0 M
SDP - MCO Tax	5,735,364	6,626,899	6,626,899	0.0 M	6,626,899	0.0 M
Subtotal - Supplemental Payments	**$ 358,799,962**	**$ 358,799,961**	**$ 357,041,298**	**$1.8 M**	**$ 357,041,298**	**$0.0 M**
FFS Activity						
Inpatient FFS	$ 40,124,298	$ 45,700,000	$ 45,476,850	$0.2 M	$ 55,468,000	$10.0 M
Outpatient FFS	9,682,365	9,192,000	9,810,000	(0.6 M)	10,382,000	0.6 M
Subtotal - FFS Activity	**$ 49,806,663**	**$ 54,892,000**	**$ 55,286,850**	**($0.4 M)**	**$ 65,850,000**	**$10.6 M**
Subtotal - Hospitals - Regular	**$ 408,606,625**	**$ 413,691,961**	**$ 412,328,148**	**$1.4 M**	**$ 422,891,298**	**$10.6 M**
UPL Accounting Error	12,161,000					
Other Adjustments	3,144,071	24,638	71,852	(0.0 M)	8,702	
Total - Hospitals - Regular	**$ 423,911,696**	**$ 413,716,599**	**$ 412,400,000**	**$1.3 M**	**$ 422,900,000**	**$10.5 M**
General Revenue	*$145.3 M*	*$131.3 M*	*$134.6 M*	*($3.4 M)*	*$140.5 M*	*$5.9 M*
Federal Funds	*$278.6 M*	*$282.4 M*	*$277.8 M*	*$4.7 M*	*$282.4 M*	*$4.6 M*

Table VII-2. FY 2028 Hospital Trend Assumptions (Excludes Managed Care, Expansion FFS & LMH beds)

Inpatient	Percent	Dollar Impact	Source
Price	3.2%	$1.3 million	FFY 27 Inpatient Hospital PPS Market Basket - No Productivity Adjustment
Utilization	2.5%	$1.0 million	Medicaid
Subtotal Inpatient		***$2.3 million***	
Outpatient	**Percent**	**Dollar Impact**	**Source**
Price	3.2%	$0.3 million	FFY 27 Inpatient Hospital PPS Market Basket - No Productivity Adjustment
Utilization	2.5%	$0.3 million	Medicaid
Subtotal Outpatient		***$0.6 million***	
TOTAL		**$2.9 million**	

Note 1. Cost trends do not reflect below-the-line adjustments for:
(1) new financing of long-term behavioral health unit at Fatima and (2) offsetting changes for H.R.-1 related changes (i.e., reduced FFS claiming for beneficiaries losing coverage and increased Emergency Medicaid costs)

Upper Payment Limit (UPL)

FY 2027

The FY 2027 estimate is comprised of $15.7 million for inpatient and $10.0 million for outpatient, which reflects a $1.7 million surplus over enacted (comprised of a $2.8 million inpatient surplus, and a $1.1 million outpatient deficit). The FY 2027 estimate has been revised where applicable for latest cost reports received from participating hospitals. The updated modeling reflects the impact of the FFY 2025 Medicare cost reports. Based on Medicaid's analysis of the proportion of hospital FFS expenditures, approximately 26% of inpatient activity and 27% of outpatient activity is eligible for 90.0% federal financial participation. This allocation is reflected in the state-federal splits for the Hospital budget line.

FY 2028

The FY 2027 revised estimates are held constant for FY 2028, comprised of $15.7 million for inpatient and $10.0 million for outpatient.

Managed Care State Directed Payment (SDP) to Hospitals

FY 2027

Medicaid assumes $331.3 million from all funds for the managed care hospital SDP, including $99.1 million from GR, $0.3 million above the enacted budget. Hospitals receive $324.7 million in total payments, while $6.6 million is allocated to the premium tax paid by the MCOs. The FY 2027 SDP allocation by hospital was forecasted by distributing funds based on the FY 2026 final payment distribution.

FY 2028

Medicaid includes GR support of $103.5 million, inclusive of the tax liability incurred by the plans. The total SDP ($331.3 million) is assumed to match FY 2027, with the state share adjusted based on the FFY 2028 FMAP rates and utilization mix across the different eligibility groups, i.e., Expansion, CHIP, and Regular Medicaid.

Table VII-3 summarizes the estimated SDP forecasted and other hospital supplemental payments.

Table VII-3. Supplemental Payments by Hospital, FY 2027

	SFY 2026	SFY 2027:				
				UPL:		
	Total	SDP [1],[2]	DSH [3]	Inpatient	Outpatient	Total Supplemental
Bradley	$ 24,752,356	$ 24,752,356	$ -	$ -	$ -	$ 24,752,356
Butler	23,028,397	23,028,397	-	-	-	23,028,397
Eleanor Slater	12,900,000	-	12,900,000	-	-	12,900,000
Kent	26,926,755	24,771,348	-	1,084,978	737,918	26,594,244
Landmark	14,940,462	13,853,693	-	484,806	335,917	14,674,416
Miriam	32,550,065	29,968,940	-	1,251,209	1,364,167	32,584,316
Newport	9,106,577	8,553,722	-	287,037	214,526	9,055,285
Rehab	158,822	137,297	-	8,710	-	146,007
Rhode Island	141,106,727	130,324,597	21,464,746	4,871,536	5,256,238	161,917,117
Roger Williams	14,107,375	12,479,099	2,637,632	595,914	554,786	16,267,431
Our Lady of Fatima	11,483,820	10,087,083	656,170	600,441	447,521	11,791,215
South County	4,568,593	4,312,660	479,437	99,133	162,706	5,053,936
Westerly	2,797,450	2,583,537	762,015	106,278	77,772	3,529,602
Women & Infants	47,196,146	39,415,801	-	6,266,895	865,163	46,547,859
Encompass Rehab	449,519	449,519	-	22,700	-	472,219
Total	$ 366,073,063	$ 324,718,048	$ 38,900,000	$ 15,679,637	$ 10,016,714	$ 389,314,399

Note 1. SDP payments for SFY 2026 will be reconciled and completed in last quarter of CY 2026. Amounts do not include state premium tax included in payment to MCOs.

Note 2. Total SDP payment reflects amount included in SFY 2026 Enacted budget and distributed based on SFY 2026 True-Up payments. Actual final distribution may vary.

Note 3. DSH total may change due to allowances under uncompensated care and its interaction with the State Directed Payment. New DSH workbooks are anticipated to be submitted to EOHHS in May 2027

VIII. Hospitals - DSH

Hospitals - DSH Payments			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$27,576,371	$12,075,423
FY 2026	Revised Enacted	$13,900,000	$5,907,500
	Preliminary Final	**$8,023,770**	**$5,907,500**
	Surplus over Revised Enacted	*$5,876,230*	*$0*
FY 2027	Enacted	$38,900,000	$16,411,910
	Current	**$38,900,000**	**$16,411,910**
	Deficit over Enacted	*$0*	*$0*
FY 2028	Current	**$38,900,000**	**$16,695,880**

FY 2027

Medicaid estimates a $38.9 million DSH payment in FY 2027, no change from the adopted estimate. This includes a $12.9 million payment to Eleanor Slater hospital, and $26.0 million to the remaining DSH eligible private hospitals. Note that the inclusion of the hospital SDP makes several private hospitals ineligible for DSH payments.

FY 2028

Medicaid has not yet received its preliminary FFY 2028 / SFY 2028 federal allotment. Absent the allotment, Medicaid maintains its FY 2027 estimate, adjusted for the FFY 2028 FMAP.

Table VIII-1. Summary of Hospitals – DSH Expenditures

	SFY 2026	SFY 2027		SFY 2028		
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
DSH - Private Hospitals	$ 14,738,872	$ 26,000,000	$ 26,000,000	$0.0 M	$ 26,000,000	$0.0 M
DSH - Eleanor Slater Hospital	12,900,000	12,900,000	12,900,000	0.0 M	12,900,000	0.0 M
Other Adjustments	7,782	0	0	0.0 M	0	0.0 M
Total - Hospitals - DSH	**$ 27,646,654**	**$ 38,900,000**	**$ 38,900,000**	**$0.0 M**	**$ 38,900,000**	**$0.0 M**
General Revenue	*$12.1 M*	*$16.4 M*	*$16.4 M*	*$0.0 M*	*$16.7 M*	*$0.3 M*
Federal Funds	*$15.6 M*	*$22.5 M*	*$22.5 M*	*$0.0 M*	*$22.2 M*	*($0.3 M)*

FFY 2022 DSH Audit

The independent audit of Rhode Island's FFY 2022 DSH payments was completed in December 2025. The audit found that four hospitals (Landmark, Newport, South County, and Women and Infants) received a DSH payment that exceeded their total eligible uncompensated care costs (UCC). Estimated UCC costs are based on prior year data updated for inflation. This prior year data can differ from actual experience and lead to overpayment.

The Medicaid State Plan requires that Medicaid recoup from these hospitals the amount by which the DSH payment exceeded eligible UCC and redistribute this amount to the other qualifying hospitals. CMS mandates that the recoupment and redistribution be completed within one year of discovery, which is December 19, 2026. Medicaid has entered into legal agreements with all four hospitals to recoup the overpayment in monthly installments, with varying payment schedules between February and November 2025, depending on the amount owed. To date, these payments have been received from all hospitals as scheduled, with full repayment expected by the end of November. Once the overpayment is fully recouped, Medicaid will redistribute the funds to the remaining hospitals by the end of calendar year 2026.

Table VIII-2. FFY 2022 DSH Recoupment and Redistribution

Hospital	Recoupment	Redistribution
Landmark Hospital	($7,462,146)	
Newport Hospital	($1,620,051)	
South County Hospital	($93,213)	
Women & Infants Hospital	($4,041,162)	
Kent County Memorial Hospital		$1,713,422
Our Lady of Fatima Hospital		$189,488
Rhode Island Hospital		$9,771,394
Roger Williams Hospital		$371,281
The Miriam Hospital		$737,115
The Westerly Hospital		$433,872
	$ (13,216,572)	$ 13,216,572

FFY 2023 DSH Audit

The independent audit of Rhode Island's FFY 2023 DSH payments is expected to be completed in December 2026.

SFY 2027 DSH Allotment

CMS sent Medicaid its preliminary FFY 2027 DSH allotment in October 2026. The preliminary federal allotment of $98.8 million allows for a maximum DSH payment of $170.8 million. Medicaid maintains the enacted amount of $38.9 million; the state's share of $16.4 million reflects FFY 2027 FMAP rates.

Table VIII-3 summarizes the FY 2027 DSH amounts.

Table VIII-3. FFY 2027 / SFY 2027 DSH Summary

SFY 27	Federal Funds	General Revenue	Total DSH	General Revenue vs. Adopted	Total DSH vs. Adopted	Effective FMAP
Enacted/Adopted	$ 22,488,090	16,411,910	$ 38,900,000	$ -	$ -	57.81%
May Testimony	8,035,590	5,864,410	13,900,000	-	-	57.81%
Max DSH	$ 98,758,590	$ 72,074,467	$ 170,833,057	$ 55,662,557	$ 131,933,057	57.81%

SFY 2028 DSH Allotment

Section 6105 of the Consolidated Appropriations Act (CAA/HR 7148) of 2026 (signed into law on February 3, 2026) eliminated the FFY 2026 and 2027 DSH allotment reductions required under section 1923(f)(7)(A) of the Social Security Act (the Act). Currently, the DSH allotment reductions required under section 1923(f)(7)(A) of the Act are in effect for 2028 only, at $8 billion for that fiscal year. Medicaid has not yet received its preliminary reduced FFY 2028 federal allotment. Absent the allotment, Medicaid maintains the 2027 enacted amount of $38.9 million, updated to reflect FFY 2028 FMAP rates.

Table VIII-4. FFY 2028 / SFY 2028 DSH Summary

SFY 28	Federal Funds	General Revenue	Total DSH	General Revenue vs. Adopted	Total DSH vs. Adopted	Effective FMAP
FFY 2027 / SFY 2027 Payment	22,488,090	16,411,910	38,900,000			57.81%
FFY 2028 / SFY 2028 Payment	22,204,120	16,695,880	38,900,000			57.08%
Max DSH	98,758,590	74,259,262	173,017,852	57,847,352	134,117,852	57.08%

IX. Nursing and Hospice Care

Nursing and Hospice Care			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$402,946,046	$177,274,058
FY 2026	Revised Enacted	$453,000,000	$193,884,000
	Preliminary Final	**$442,612,089**	**$182,229,684**
	Surplus over Revised Enacted	*$10,387,911*	*$11,654,316*
FY 2027	Enacted	$483,725,685	$204,470,267
	Current	**$493,500,000**	**$208,602,450**
	Deficit over Enacted	*($9,774,315)*	*($4,132,183)*
FY 2028	Current	**$526,200,000**	**$224,897,880**

FY 2027

The FY 2027 revised estimate for the nursing and hospice budget line totals $493.5 million, including $208.6 million GR. This represents a $9.8 million (2.0%) deficit compared to the enacted budget, including $4.1 million from GR. This deficit is driven by increased utilization compared to EOHHS' prior projection as well as an underestimation of the cost of the October 1, 2026 rate increase. Effective October 1, 2026, EOHHS implemented the 3.9% increase consistent with the CMS market basket; in May, however, EOHHS incorrectly referenced a price trend of 3.2% after the application of a 0.7% productivity adjustment factor, as derived from CMS Skilled Nursing Facility PPS market basket update for FFY 2026. The productivity adjustment should not have been applied to the FFS price trend.

Some of the overall increase may be attributed to declining nursing home enrollment in FIDE SNP, meaning that growth in the FFS program is offset by declining expenses in the managed care program for this subpopulation.

The revised estimate uses expenses from the fourth quarter of FY 2026, adjusted for inflation and patient share. Medicaid implemented a 3.9% rate increase effective October 1, 2026. This follows last year's 5.3% increase and FY 2025 increase of 14.5% that was the result of a cost-based rebasing of the facility per diem. After a reduction in patient share as a proportion of total nursing facility revenues considerations (i.e., patient contributions are not expected to increase by 3.9% as well), the effective increase in direct Medicaid costs is estimated to be 4.53%. The estimate also assumes a 1.5% increase in utilization for both nursing and hospice services.

On October 1, 2025, Medicaid transitioned from a Resource Utilization Group (RUG-IV) based nursing facility payment methodology to a Patient Driven Payment Model (PDPM) methodology. This shift in methodology was implemented to be budget neutral. While changes in coding patterns could have unintended consequences in terms of gross revenues if average acuity increases because of this change, the projected increase for FY 2026 over the November estimated appears to be utilization based. As part of the PDPM Implementation, the MMIS was closely monitored for accuracy of the nursing facility and hospice payments – throughout November, December, and January all payments were successfully processed and validated – budget neutrality validations were successfully demonstrated.

As shown in **table IX-2**, average paid per diem increased from $329 per member per month beginning October 1, 2024, to $350 to October 1, 2025. This $21 increase is 6.2%, meanwhile the inflationary adjustment implemented on October 1, 2025, was 5.3%. In addition to inflationary adjustments, average per diem is impacted by a beneficiary's acuity and enrollment by facility, as each nursing facility has its own rates. There does not appear to any indication that the transition to PDPM has led to unintended consequences nor that the increase compared to the May adopted estimate is related to the new payment mode. Medicaid will continue to monitor.

FY 2028

The FY 2028 estimate totals $526.2 million, including $224.9 million from GR, reflects an increase of $32.7 million (6.6%), including $16.3 million from GR, over the current fiscal year.

This estimate reflects a price trend factor of 3.3%, as derived from CMS Skilled Nursing Facility PPS market basket update for FFY 2027. After patient share, this increases to an effective change of 3.83% from the perspective of Medicaid outlays. With respect to utilization, a 1.5% factor is applied; however, this non-price factor can be interpreted to represent a change in either average acuity or average daily census.

The components of Medicaid's estimate are summarized in **Table IX-1**.

Table IX-2 shows the average nursing facility per diem before and after patient share. Noteworthy, between 2022 and 2026, net patient revenue from Medicaid beneficiaries at nursing facilities in Rhode Island has cumulatively increased 44.9%, an average of 9.8% per year. This is nearly twice the cumulative inflation in the United States that between 2020 and 2025 (estimate) was 25.2%, equivalent to 4.6% per year.[11]

Additional information on paid days in fee-for-service is presented in **Attachment 4**.

Figure IX-1 summarizes the increase in overall spending on nursing facilities and the average monthly Medicaid census at Rhode Island nursing facilities across all payers and funding sources.

Table IX-1: Summary of Nursing Home and Hospice Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
FFS Activity						
Hospice	$ 40,773,320	$ 45,220,000	$ 46,047,000	($0.8 M)	$ 49,109,000	$3.1 M
Nursing Home	408,700,886	438,505,685	447,431,000	(8.9 M)	477,074,000	29.6 M
Subtotal FFS	**$ 449,474,206**	**$ 483,725,685**	**$ 493,478,000**	**($9.8 M)**	**$ 526,183,000**	**$32.7 M**
DSH Hospital Recoupemnts	(6,839,743)					
Balance to RIFANS/Rounding	(22,374)	0	22,000	(0.0 M)	17,000	(0.0 M)
Total - Nursing and Hospice Care	**$ 442,612,089**	**$ 483,725,685**	**$ 493,500,000**	**($9.8 M)**	**$ 526,200,000**	**$32.7 M**
General Revenue	*$182.2 M*	*$204.5 M*	*$208.6 M*	*($4.1 M)*	*$224.9 M*	*$16.3 M*
Federal Funds	*$260.4 M*	*$279.3 M*	*$284.9 M*	*($5.6 M)*	*$301.3 M*	*$16.4 M*

Table IX-2. Average Nursing Home Medicaid per diem

	Per Diem:			Annual Increase:
Rate Effective Date	Gross	Patient Share	Medicaid Paid	Per Diem
October 1, 2020	$240	$40	$200	
October 1, 2021	$249	$42	$207	3.8%
October 1, 2022	$261	$45	$216	4.7%
October 1, 2023	$283	$47	$235	8.2%
October 1, 2024	$329	$49	$280	16.6%
October 1, 2025	$350	$48	$301	6.2%
October 1, 2026	$363	$50	$313	3.9%
5 Year CAGR (2022 → 2026)	8.6%	2.4%	9.8%	

Table IX-3. FY 2028 Nursing and Hospice Care Trend Assumption (Excludes Managed Care and Expansion Lines)

Nursing and Hospice	Percent	Dollar Impact[1,2]	Source
Price Factor	3.3%	$12.9 million	FFY 27 Actual Skilled Nursing Facility PPS Market Basket - No Productivity Adjustment
Utilization	1.5%	$7.8 million	Medicaid
Patient Share	0.53%	$2.1 million	Medicaid
Total Nursing & Hospice Care		***$32.7 million***	

Note 1. The value of the rate change pertains to the Nursing and Hospice Care baseline only. Additional nursing home spending is in Expansion, Managed Care, and included in each of the managed care products.
Note 2. The "Price Factor" illustrates the impact of the annual rate increase to the State and not the full value of the rate increase received by the nursing facility. All else equal, the component of the rate paid by Medicaid (i.e., not paid by the resident) will increase by a larger percentage than the rate increase seen by the facility, as patient share collections do not necessarily increase by the same percentage as the nursing home rate increase each year.

[11] Reid and Pozdnyakova. June 2024. "Mapping the World's Prices 2025." Deutsche Bank Research Institute. Internet: http://dbresearch.com/.

X. Home and Community Care

Home and Community Care			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$237,449,962	$104,082,796
FY 2026	Revised Enacted	$296,000,000	$126,688,000
	Preliminary Final	**$309,029,828**	**$131,940,621**
	Deficit over Revised Enacted	*($13,029,828)*	*($5,252,621)*
FY 2027	Enacted	$340,116,096	$144,331,557
	Current	**$374,800,000**	**$158,427,960**
	Deficit over Enacted	*($34,683,904)*	*($14,096,403)*
FY 2028	Current	**$404,200,000**	**$172,755,080**

FY 2027

Medicaid's revised forecast for home and community care is $374.8 million, including $158.4 million GR; a $34.7 million deficit over the enacted amount, including $5.3 million GR. This deficit is the result of greater utilization than accounted for in the May estimate primarily for personal care. In May, Medicaid assumed a 1.5% increase in utilization for FY 2027; however, actual FY 2026 experience was greater than projected, therefore increasing the base amounts used to estimate FY 2027.

The revised FY 2027 estimate is based on actual FY 2026 claims experience, with greater emphasis on the fourth quarter. It is inclusive of rate increases recommended by OHIC and enacted by the legislature effective October 1, 2026. The November revised estimate assumes a 5% utilization increase for personal care and personal choice, 2.5% for shared living and other HCBS services, and 1.5% for adult day and assisted living.

The revised estimates also includes an adjustment of $0.2 million for assisted living Level 3 rates, which will increase on January 1, 2027 as enacted.

Regarding CFCM, Medicaid projects FFS expenditures totaling $13.9 million based on current utilization, $1.3 million more than projected in May. This reflects the additional certification of providers and includes the transition of all beneficiaries currently supported by IFs between December and January 2027. Expenditures are included in the Other HCBS line item shown in **Table X-1,** which summarizes Home and Community Care Expenditures from FY 2026 through FY 2028.

Figure X-1 highlights the increase by home care agencies since pre-Covid. **Table X-2** summarizes changes in HCBS authorizations; however, the count of beneficiaries authorized for HCBS is not equivalent to the number of beneficiaries utilizing LTSS services. Medicaid derives its FFS estimates from actual utilization as reflected in MMIS' claims with prospective adjustments for any anticipated changes in price and/or utilization. This approach is unlike the PMPM basis that Medicaid uses for its managed care estimates.

FY 2028

The FY 2028 forecast totals $404.2 million, including $172.8 million GR. This is $29.4 million more than the revised FY 2027 estimate, including $14.3 million from GR. The increase is driven by continued growth in utilization as well as annualized impact of the OHIC recommended rates and Level 3 assisted living rates. Consistent with FY 2027 revised estimates, EOHHS continues to assume a 5% utilization increase for personal care and personal choice, 2.5% for shared living and other HCBS services, and 1.5% for adult day and assisted living.

Select home delivered meals codes are eligible for an annual rate increase on July 1 of each year. Medicaid uses the March release of the New England CPI-U for Food at Home; however, as this information is not yet available, the FY 2028 estimate assumes 2.15% increase based on the September release, which includes August data. When applied to the blended trend and utilization assumed for HCBS services, the projected inflationary increase is equivalent to $23,243.

CFCM FFS expenditures are estimated at $16.8 million in FY 2028. This reflects the annualized impact of the transition of I/DD beneficiaries from IFs to a community provider and ongoing referrals for non- I/DD beneficiaries.

Figure X-1 provides additional detail on Home Care spending and utilization by fiscal year, between 2019 and 2026. Inclusive of all home care spending (i.e., including managed care spending), average monthly spending has increased by more than 300% since before Covid (i.e., FY 2019). The biggest driver was the OHIC-recommended rate increases that nearly doubled the reimbursement rate paid in October 2024 compared to prior month. The OHIC recommended 8.9% increase in October 2026 will further increase net spending. The net impact of this rate increase is compounded by the induced demand generated from home care agencies by delivering another 67% more hours of care per beneficiary per month since pre-Covid. Comparatively, the average number of users per month increased by less than 10% over the same period.

Program of All Inclusive Care for the Elderly (PACE)

FY 2027

Medicaid's FY 2027 forecast totals $36.1 million, a deficit of $0.7 million compared to the enacted budget. Composite PACE rates increased by 9.4% (rate certification) when compared to FY 2026 approved rates, from $5,800 to $6,348. FY 2027 rates were developed by the State's Certifying Actuary, noting federal regulators require a rate build at a minimum of every three years for PACE.

FY 2028

Medicaid's FY 2028 forecast totals $40.9 million, an increase of $4.8 million compared to the FY 27 revised forecast due to enrollment growth ($2.6 million) and rate growth ($2.2 million). Consistent with other products, FY 2028 assumes a rate increase of 5.0% for FY 2028, with the actual rates being developed in CY 2027.

Table X-3 summarizes PACE monthly caseload and premiums. **Table X-4** summarizes the price-volume comparison for PACE expenditures between FY 2026 and FY 2028.

Table X-1. Summary of Home and Community Care Expenditures

	SFY 2026	SFY 2027	SFY 2028			
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
PACE	$ 32,322,418	$ 35,416,298	$ 36,127,639	($0.7 M)	$ 40,887,195	$4.8 M
Enrollment	*466*	*485*	*475*	*-10*	*509*	*34*
FFS Activity						
Self-Directed	$ 29,483,377	$ 32,525,415	$ 35,733,320	($3.2 M)	$ 38,163,320	$2.4 M
Adult Day	7,922,768	8,961,700	11,399,000	(2.4 M)	12,363,000	1.0 M
Home Care	186,609,450	204,837,000	222,399,000	(17.6 M)	239,195,000	16.8 M
Shared Living	14,488,693	13,295,000	18,136,000	(4.8 M)	18,997,000	0.9 M
Assisted Living	28,488,884	33,859,000	36,565,375	(2.7 M)	39,165,750	2.6 M
Other HCBS	9,666,841	11,180,000	14,435,284	(3.3 M)	15,335,753	0.9 M
Subtotal FFS	**$ 276,660,014**	**$ 304,658,115**	**$ 338,667,979**	**($34.0 M)**	**$ 363,219,823**	**$24.6 M**
Subtotal - Home and Community Care	**$ 308,982,432**	**$ 340,074,412**	**$ 374,795,618**	**($34.7 M)**	**$ 404,107,018**	**$29.3 M**
Balance to RIFANS/Rounding	47,396	41,684	4,382	0.0 M	92,982	0.1 M
Total - Home and Community Care	**$ 309,029,828**	**$ 340,116,096**	**$ 374,800,000**	**($34.7 M)**	**$ 404,200,000**	**$29.4 M**
General Revenue	*$131.9 M*	*$144.3 M*	*$158.4 M*	*($14.1 M)*	*$172.8 M*	*$14.3 M*
Federal Funds	*$177.1 M*	*$195.8 M*	*$216.4 M*	*($20.6 M)*	*$231.4 M*	*$15.1 M*

Table X-2. PACE and FFS Home and Community Based Services Authorizations

	SFY 2026	SFY 2027	Current: Sep-26	FY26 → FY27
PACE	466	475	462	1.9%
HCBS Authorization in FFS				
Assisted Living	829	881	874	6.3%
Shared Living	460	551	547	19.8%
Self-Directed	778	791	785	1.7%
Home Care	4,165	4,374	4,343	5.0%
Subtotal HCBS	6,232	6,597	6,549	5.9%
HCBS Enrolled in RHO	2,940	2,926	2,926	-0.5%
% of HCBS (excl. PACE) in RHO	*32.1%*	*30.7%*	*30.9%*	

Figure X-1. Average monthly home care spending, by fiscal year and select quarters

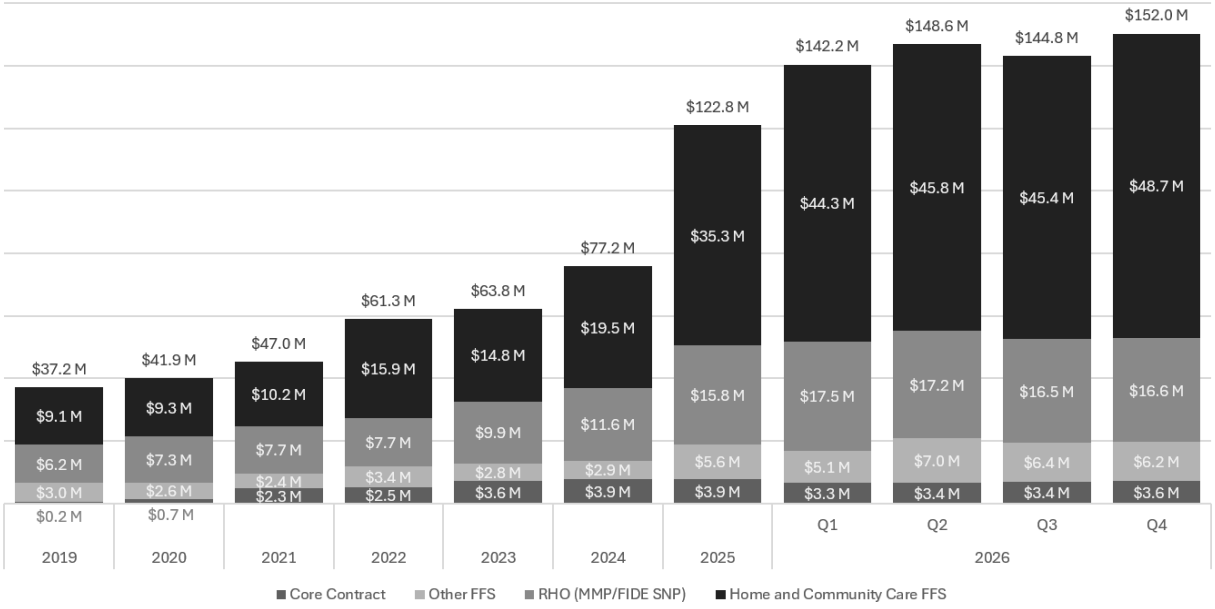


Table X-3. Summary of PACE Monthly Premiums

PACE	SFY 2026	SFY 2027	SFY 2028	FY26 → FY27	FY26 → FY28
Medicaid Only	$7,486	$8,432	$8,854	12.6%	5.0%
Dual, 55-64 y.o.	$5,471	$6,155	$6,463	12.5%	5.0%
Dual, 65+ y.o.	$5,625	$6,138	$6,445	9.1%	5.0%
Composite	$5,781	$6,344	$6,701	9.7%	5.6%
Average Member Months	466	475	509	1.9%	7.1%

Table X-4. PACE Price-Volume Comparison

	Price	Volume	Net
FY 2027 over FY 2026	$3.2 M	$0.6 M	$3.8 M
	9.7%	1.9%	11.8%
FY 2027: Current over Enacted	$1.4 M	($0.7 M)	$0.7 M
	4.1%	-2.0%	2.0%
FY 2028 over FY 2027	$2.2 M	$2.6 M	$4.8 M
	5.6%	7.1%	13.2%

XI. Pharmacy

Pharmacy			
		All Funds	General Revenue
FY 2025	Revised Enacted	$731,624	$625,532
FY 2026	Revised Enacted	$1,300,000	$870,679
	Preliminary Final	**$1,248,039**	**$808,233**
	Surplus over Revised Enacted	*$51,961*	*$62,446*
FY 2027	Enacted	$1,200,000	$844,239
	Current	**$2,000,000**	**$1,126,823**
	Deficit over Enacted	*($800,000)*	*($282,584)*
FY 2028	Current	**$2,100,000**	**$1,198,141**

FY 2027

Medicaid's revised forecast for FFS pharmacy in FY 2027 is $2.0 million from all sources, a $0.8 million deficit compared to the FY 2027 enacted level. This reflects increased FFS pharmacy activity relative to the enacted budget from a 2.5% increase in utilization and a reduction to projected offsetting rebates.

The estimate reflects average monthly spend during the second half of FY 2027 and rebate information is based on invoices issued to manufacturers through September 2026, for prescriptions incurred through June 30, 2025.

FY 2028

EOHHS forecasts $2.1 million in pharmacy expenditures for FY 2028. This amount reflects a 3.4% price increase based on the S&P Global Healthcare Cost Review 2026 Q2 forecast for pharmacy and a 2.5% projected utilization increase, resulting in a $0.8 million increase relative to the FY 2027 enacted amount; meanwhile, rebate collections are anticipated to decrease by $0.7 million. This total also reflects the shift of funding for Cell and Gene Therapies into the ASO model.

Revised FY 2027 and FY 2028 pharmacy expenditures and rebates are presented in **Table XI-1.**

Table XI-1. Summary of Pharmacy Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
FFS Activity	$ 10,422,813	$ 10,265,000	$ 11,620,000	($1.4 M)	$ 12,389,000	$0.8 M
Rebates	(8,302,677)	(9,163,788)	(9,705,353)	$0.5 M	(10,380,793)	(0.7 M)
DRE	(6,913,649)	(7,709,123)	(8,248,639)	0.5 M	(8,810,756)	(0.6 M)
J-Code	(1,389,028)	(1,454,665)	(1,456,714)	0.0 M	(1,570,037)	(0.1 M)
Subtotal - Pharmacy	**$ 2,120,136**	**$ 1,101,212**	**$ 1,914,647**	**($0.8 M)**	**$ 2,008,207**	**$0.1 M**
Balance to RIFANS - Accruals/Rounding	(872,097)	98,788	85,353	0.0 M	91,793	0.0 M
Grand Total - Pharmacy	**$ 1,248,039**	**$ 1,200,000**	**$ 2,000,000**	**($0.8 M)**	**$ 2,100,000**	**$0.1 M**
General Revenue	*$0.8 M*	*$0.8 M*	*$1.1 M*	*($0.3 M)*	*$1.2 M*	*$0.1 M*
Federal Funds	*$0.4 M*	*$0.4 M*	*$0.9 M*	*($0.5 M)*	*$0.9 M*	*$0.0 M*

Generally, rebates fluctuate due to several reasons:

- CMS' rebate formula, which, for certain drugs, can compensate for significant price changes;
- Medicaid being entitled to the full rebate amount even if it only pays a portion of a drug claim (excluding Part D drugs); and,
- Pharmacy budget line reflects J-Code rebates collected against pharmaceuticals delivered in an outpatient hospital setting, which may vary dramatically with acuity of patient and amount of FFS utilization.

XII. Pharmacy Clawback (Medicare Part D)

Pharmacy Clawback (Medicare Part D)			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$92,702,111	$92,702,111
FY 2026	Revised Enacted	$93,900,000	$93,900,000
	Preliminary Final	**$94,484,619**	**$94,484,619**
	Deficit over Revised Enacted	*($584,619)*	*($584,619)*
FY 2027	Enacted	$95,900,000	$95,900,000
	Current	**$99,600,000**	**$99,600,000**
	Deficit over Enacted	*($3,700,000)*	*($3,700,000)*
FY 2028	Current	**$111,500,000**	**$111,500,000**

Medicaid's revised FY 2027 estimate of $99.6 million reflects a $3.7 million deficit compared to the FY 2027 enacted level, attributable to a 4.5% increase in estimated spending partially offset by a small decline in volume.

Medicaid projects to increase to $111.5 million in FY 2028, $15.6 million more than the FY 2027 enacted amount. This overall increase is attributable to a significant increase in PMPM price estimates paired with a modest increase in volume.

Table XII-1 summarizes pharmacy clawback activities and **Table XII-2** details price and volume changes.

Table XII-1. Summary of Pharmacy Clawback Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Part D Premium Payments	$ 94,535,467	$ 95,821,549	$ 99,523,558	($3.7 M)	$ 111,425,108	$11.9 M
Other Adjustments	(50,848)	78,451	76,442	0.0 M	74,892	
Total - Pharmacy Clawback	**$ 94,484,619**	**$ 95,900,000**	**$ 99,600,000**	**($3.7 M)**	**$ 111,500,000**	**$11.9 M**
General Revenue	*$94.5 M*	*$95.9 M*	*$99.6 M*	*($3.7 M)*	*$111.5 M*	*$11.9 M*
Part D Muliplier	$204.59	$211.78	$221.32	$9.55	$242.08	$20.76
July - September	$194.08	$204.64	$204.64		$207.57	
October - December	$194.78	$199.07	$199.07		$206.06	
January - March	$204.64	$207.57	$207.57		$214.75	
April - June	$204.64	$207.57	$207.57		$214.75	
Average Enrollment	38,486	37,737	37,502	-235	38,383	881

Table XII-2. Pharmacy Claw Back Price-Volume Comparison

	Price	Volume	Net
FY 2027 over FY 2026	$7.5 M	($2.4 M)	$5.1 M
	8.2%	-2.6%	5.4%
FY 2027: Current over Enacted	$4.3 M	($0.6 M)	$3.7 M
	4.5%	-0.6%	3.9%
FY 2028 over FY 2027	$9.6 M	$2.3 M	$11.9 M
	9.4%	2.3%	11.9%

XIII. Other Services

Other Services			
		All Funds	General Revenue
FY 2025	Revised Enacted	$205,337,135	$74,375,561
FY 2026	Revised Enacted	$216,900,000	$79,023,524
	Preliminary Final	**$214,414,888**	**$79,040,357**
	Surplus over Revised Enacted	*$2,485,112*	*($16,833)*
FY 2027	Enacted	$227,007,455	$76,487,651
	Current	**$230,600,000**	**$78,573,811**
	Deficit over Enacted	*($3,592,545)*	*($2,086,160)*
FY 2028	Current	**$238,000,000**	**$82,499,019**

FY 2027

Medicaid's revised FY 2027 estimate totals $230.6 million, including $78.6 million GR, for Other Services. This is a deficit of $3.6 million (1.6%), and a deficit of $2.1 million GR compared to the Enacted.

The deficit is largely driven by a $7.8 million net reduction for BH services. For the purpose of the following summary table, Medicaid has split CCBHC expenses from other BHDDH Medical Services. Medicaid also projects $1.8 million fewer expenses for other practitioners, Physician Services, DME, and Tavares claiming. This is offset by $1.2 million less for Medicare Premium Payments for Part A ($0.2 million more) and Part B ($1.4 million less) due to updated premium costs, $0.8 million for rehabilitation and targeted case management, and $5.5 million for CCBHC services.

See **Table XIII-3** for summary of Medicaid's average monthly caseload and composite PMPM for Part A and Part B Medicare Premiums.

FFS claiming estimates are based on a blend of actual claims data from FY 2026, which emphasizes the median average monthly expenditures and the last quarter of that year. Utilization is also expected to be generally consistent with the year-to-date experience, except for CCBHCs, for which Medicaid assumes a 2.5% increase in utilization.

With respect to recoveries, EOHHS includes $21.5 million or $1.1 million less than enacted. This reflects estate recoveries as well as recoveries anticipated to be collected by Medicaid's program integrity efforts. Note the budgeted amount includes estate recoveries that increased from $16.0 million to $18.0 million, based on our current collection activities. An additional $3.5 million in each year is included within the "recoveries" line for anticipated cash recoupments collected from providers for inappropriate billing practices.

FY 2028

The FY 2028 estimate totals $238.0 million, including $82.5 million from GR. This reflects an increase of $7.4 million, including $3.9 million from GR, compared to the enacted budget. The year-over-year increase is primarily due to an additional $1.6 million for Part A and $6.4 million for Part B Medicare Premium Payments, reflected expected increase in the cost of premiums as notified by CMS. The forecast for Medicare Buy-In (Part A/B) is based on invoices received through September 2026 for enrollment through October 2026. While no growth in enrollment has been experienced to date, the 2027 and 2028 estimates continue to reflect the increased allotment. In addition, there is a 2.1 million increase between BHDDH Medical Services ($0.4 million) and CCHBC Services ($1.7 million).

This is partially offset by $3.2 million in other practitioners.

The methodology for the FY 2028 estimate is consistent with FY 2027, with a blend of median average expenditures from FY 2026 and specifically the fourth quarter for the base analysis. The FY 2028 estimate assumes

a 2.0% price increase in the BHDDH Medical services budget line to capture the required Medicare Economic Index inflationary increase for CCBHCs. Medicaid expects utilization to be consistent with FY 2026 thus far except for BHDDH Medical services, for which Medicaid assumes a 2.5 % increase.

A summary of FY 2027 and FY 2028 expenditures by service type is shown in **Table XIII-1**. **Table XIII-2** summarizes all Other Medical Services expenditures subject to a non-regular matching rate.

Table XIII-1. Summary of Other Medical Services Expenditures

	SFY 2026	SFY 2027			SFY 2028	
	Prelim Final	Enacted	Current	Surplus/(Deficit)	Current	FY27 → FY28
Medicare Premium Payments						
Part A	$ 22,491,526	$ 24,712,983	$ 24,923,509	($0.2 M)	$ 26,534,118	$1.6 M
Part B	98,231,835	110,485,945	109,039,375	1.4 M	115,459,438	6.4 M
Subtotal - Supplemental Payments	**$ 120,723,361**	**$ 135,198,928**	**$ 133,962,884**	**$1.2 M**	**$ 141,993,556**	**$8.0 M**
Non-Emergency Transportation	6,901,914	7,734,266	8,050,209	(0.3 M)	8,598,183	0.5 M
Recoveries	(25,014,619)	(22,600,000)	(21,500,000)	(1.1 M)	(21,500,000)	0.0 M
FFS Activity						
BHDDH Medical Services	19,123,429	11,355,766	19,177,381	(7.8 M)	19,565,754	0.4 M
CCBHC Services	32,785,072	35,449,856	29,996,315	5.5 M	31,656,241	1.7 M
Rehab & TCM	23,568,170	24,219,000	23,454,000	0.8 M	23,454,000	0.0 M
Tavares	6,687,860	6,533,000	6,566,000	(0.0 M)	6,566,000	0.0 M
DME	3,758,708	3,643,000	3,864,000	(0.2 M)	3,864,000	0.0 M
Physician Services	18,808,882	18,626,000	20,129,000	(1.5 M)	20,129,000	0.0 M
Other Practitioners	6,741,761	6,771,000	6,826,000	(0.1 M)	3,622,586	(3.2 M)
Subtotal - FFS Activity	111,473,882	106,597,622	110,012,696	(3.4 M)	108,857,581	(1.2 M)
Subtotal - Other Services	**$ 214,084,537**	**$ 226,930,816**	**$ 230,525,789**	**($3.6 M)**	**$ 237,949,321**	**$7.4 M**
Balance to RIFANS/Conferees/Rounding	330,351	76,639	74,211	0.0 M	50,679	(0.0 M)
Total - Other Services	**$ 214,414,888**	**$ 227,007,455**	**$ 230,600,000**	**($3.6 M)**	**$ 238,000,000**	**$7.4 M**
General Revenue	*$79.0 M*	*$76.5 M*	*$78.6 M*	*($2.1 M)*	*$82.5 M*	*$3.9 M*
Federal Funds	*$128.3 M*	*$139.6 M*	*$141.1 M*	*($1.5 M)*	*$144.6 M*	*$3.5 M*
Restricted Receipts	*$7.1 M*	*$10.9 M*	*$10.9 M*	*($0.0 M)*	*$10.9 M*	*$0.0 M*

Table XIII-2. Non-Regular FMAP Sources of Funds Applied to Other Medical Services

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
Restricted - Children's Health Account	$ 7,372,593	$ 10,939,274	$ 10,939,274	$0.0 M	$ 10,939,274	$0.0 M
Enhanced FMAP - CCBHC	39,077,990	33,769,034	35,231,011	(1.5 M)	37,076,545	1.8 M
100% Federal - Qualifying Individuals	1,750,000	9,560,000	7,785,000	1.8 M	7,785,000	0.0 M
100% State - Breast & Cervical Cancer	(200,000)	(200,000)	(200,000)	0.0 M	(200,000)	0.0 M

Table XIII-3. Medicare Monthly and Part B Premiums

	SFY 2026	SFY 2027			SFY 2028	
	Final	Enacted	Current	Change	Current	FY27 → FY28
Part A PMPM	$ 515.29	$ 549.03	$ 552.58	$ 3.55	$ 573.57	$ 21.00
July-December	542.21	562.81	562.81			
January-June	562.81	584.20	584.20			
Part A - Average Enrollment	3,637	3,751	3,759	8	3,855	96
Part B PMPM	$ 213.83	$ 213.83	$ 213.83	$ 0.00	$ 221.97	$ 8.13
July-December	209.83	209.83	209.83			
January-June	217.80	217.80	217.80			
Part B - Average Enrollment	41,059	40,969	40,142	(827)	41,081	939

Attachments