MEDICAL ASSISTANCE – November 2026

Responses to questions pertaining to EOHHS' testimony on October 27, 2026

1. **Major Developments – p. 7: Inpatient/Outpatient Hospital State Directed Payment Inflation Approved Preprint Value & Additional context on SDPs**

   The below figures represent the approved 2026 preprint values for the annual inflation. Please note, this only reflects the value under managed care.

   - Inpatient hospital services preprint value: $10,509,201 (RI_Fee_IPH_Renewal_20250701-20260630.pdf)
   - Outpatient hospital services preprint value: $10,205,734 (RI_Fee_OPH_Renewal_20250701-20260630.pdf)

   Additional State Directed Payment (SDP) Background and Context

   Generally, in Medicaid risk-based managed care, managed care plans are responsible for negotiating provider payment rates. An SDP is an arrangement in which the State directs a managed care plan's expenditures regarding provider reimbursement. Certain SDPs require approval by CMS through what is called a "preprint." The preprints detail the total value of the SDP – that is, the value of the item we are requiring the MCOs to pay to providers. For example, if we require that MCOs pay 5% above their previous year's inpatient hospital rates, we have to calculate the value of that 5% and present within the preprint.

   Other SDPs do not require preprint submissions, including those structured as minimum or maximum fee schedules. As an example, the OHIC Rate Review rates are implemented in managed care as a minimum fee schedule where we require the MCOs to pay no less than the fee-for-service fee schedule for certain services. A complete list of minimum fee schedules is included in the MCO contracts. A list of the SDP and minimum fee schedules are included in the MCO rate certification and MCO contracts. A summary is included in the table below. Not included is the Hospital SDP that is paid under separate payment terms.

   Changes were made to SDPs under H.R.-1/WFTC legislation. Beginning with the rating period on or after July 4, 2025, all States must reduce the payment rate for certain SDPs with inpatient hospital services, outpatient hospital services, nursing facility services, and qualified practitioner services at an academic medical center to 100 percent of the total published Medicare payment rate (for an expansion State). There are no exceptions to this SDP payment limit for certain providers of applicable services, unless the SDP qualifies for the temporary grandfathering period (until the rating period beginning on or after January 1, 2028 – SFY 2029). CMS issued guidance on the grandfathering period prior to the release of the proposed rule.

   As described in EOHHS testimony, the proposed rule extends the payment limit under section 71116 of the WFTC legislation to all SDPs for all services in all States beginning with the rating period on or after January 1, 2029 (SFY 2030).

Figure 23: Description of State Directed Payments

Control Name of State Directed Payment	Type of Payment	Brief Description	Is the Payment Included as a Rate Adjustment or Separate Payment Term?	Section of other references to the state directed payment
Inpatient Hospital Increase (including Level IV Detoxification Services)	Uniform Percentage Increase	Uniform increase to inpatient hospital reimbursement	Rate Adjustment	I.3.B.iii
Hospital Labor and Delivery Services	Minimum fee schedule	Minimum fee schedule for inpatient hospital labor and delivery services	Rate Adjustment	I.3.B.iii
Outpatient Hospital Increase	Uniform Percentage Increase	Uniform increase to outpatient hospital reimbursement	Rate Adjustment	I.3.B.iii
Nursing Home Increase	Uniform Percentage Increase	Uniform increase to nursing home reimbursement	Rate Adjustment	I.3.B.iii
OHIC Rate Review	Minimum fee schedule	Minimum fee schedule for children's services, behavioral health services, and HCBS	Rate Adjustment	I.2.B.iii.(d)
CCBHC PPS-2 Rates	Minimum fee schedule	Minimum fee schedule for CCBHC PPS-2 rates	Rate Adjustment	I.3.B.ii
Primary Care Services	Minimum fee schedule	Minimum fee schedule for primary care	Rate Adjustment	I.3.B.ii
Care Transformation Collaborative of Rhode Island (CTC) state directed value-based purchasing	Performance-based incentive payments	Incentive payment of $3.00 PMPM to qualifying providers and $0.84 PMPM to CTC to promote accessible, comprehensive, coordinated care	Rate Adjustment	I.5.B.i.(a)
Accountable Entity (AE) program state directed value-based purchasing	Performance-based incentive payments	Shared savings or losses are determined by comparing the total cost of care of an accountable entities' attributed population to cost thresholds derived using a methodology generally consistent with the MCO capitation rate development	Rate Adjustment (no explicit rate adjustment)	N/A
Home Delivered Meals	Minimum fee schedule	Minimum fee schedule applied for home delivered meals	Rate Adjustment (included in base experience)	I.3.B.viii.(a)
Dental Anesthesia Services	Minimum fee schedule	Minimum fee schedule for dental anesthesia services	Rate Adjustment (included in base experience)	I.3.B.viii.(a)
Chiropractic Services	Minimum fee schedule	Minimum fee schedule for chiropractic services	Rate Adjustment (included in base experience)	I.3.B.viii.(a)
Ambulance Services	Minimum fee schedule	Minimum fee schedule for ambulance services	Rate Adjustment (included in base experience)	I.3.B.viii.(a)
E-Consult Services	Minimum fee schedule	Minimum fee schedule for e-consult services	Rate Adjustment (Immaterial)	I.3.B.viii.(a)

2. Provide table outlining adjustments to SFY 2026 fiscal close

EOHHS is continuing to work on its fiscal close and will propose any necessary adjustments to realign expenditures against specific appropriation sequences. Such adjustments should net to $0.

Additionally, the RIOAG office may propose additional adjustments, as is normal, to some of EOHHS' original accrual estimates based on more recent information (e.g., updated risk share reporting, final IBNR reports,

latest rebate collections, etc.) Such adjustments, either proposed by EOHHS or RIOAG, will be forthcoming and may impact the final close. For example, at present we anticipate some modest changes to risk share accruals that net to less than a $1.0 million GR favorable change; but these may be deemed immaterial from overall expenditure perspective. The updated fiscal close presented below does not reflect such potential adjustments.

The errors in the preliminary close that EOHHS identified are related to the 2021 DSH audit that EOHHS initiated in SFY 2025 and therefore were reflected in accrual reversals at the start of SFY 2026. In making the final recoupments and completing the payments, the net effect should have been $0 to the impacted budget lines. However, the actual payments were incorrectly spent against Hospital Supplemental budget lines in Hospital – Regular as opposed to the DSH and Nursing and Hospice Care state only accounts, creating an imbalance between the SFY 2025 accruals and the SFY 2026 expenditures.

Funds related to the overpayment to hospital(s) are collected (i.e., credit transaction) into the state only account in nursing home budget line. These are then transferred out of this same account (i.e., debit transaction, netting to $0 against this state only account) and transferred (i.e., credit transaction) to the state and federal accounts in DSH account to be subsequently paid (i.e., debit transaction) out of these same state and federal accounts to the hospitals (therefore also netting to $0). The supplemental payments accounts in Hospitals – Regular should not have been used as it pertains to the DSH payments.

Also in SFY 2026, EOHHS initiated the redistribution for the 2022 DSH audit – recouping $6.4 million of a total of $13.2 million from four hospitals that will be redistributed in December 2026. It appears that EOHHS correctly accrued for these payables and outstanding receivables as well as the subsequent payables. This should have a net $0 impact on both SFY 2026 and SFY 2027 assuming the correct appropriation sequences are used when making the final payments.

	2026 Revised Enacted	2026 Prelim Final	Accounting Errors	2026 Adjusted Prelim Final
Hospitals - Regular	$402,500,001	$423,911,696	-12,161,000	411,750,696
Hospitals - DSH	13,900,000	8,023,770	+5,876,230	13,900,000
Nursing and Hospice Care	453,000,000	442,612,089	+6,284,770	448,896,859
Home and Community Care	296,000,000	309,029,828		309,029,828
Managed Care	1,090,000,000	1,083,189,781		1,083,189,781
Rhody Health Partners	337,699,999	344,240,383		344,240,383
Rhody Health Options	247,800,000	236,569,434		236,569,434
Expansion	724,900,000	725,817,857		725,817,857
Pharmacy	1,300,000	1,248,039		1,248,039
Clawback	93,900,000	94,484,619		94,484,619
Other Services	216,900,000	214,414,888		214,414,888
Subtotal - CEC Benefits	**$3,877,900,000**	**$3,883,542,384**	**0**	**$3,883,542,384**
HSTP	0	(3,281,454)		(3,281,454)
Special Education	45,400,000	36,675,703		36,675,703
ARPA HCBS	0	-		-
Total - Benefits	**$3,923,300,000**	**$3,916,936,633**		**$3,916,936,633**

3. Home and Community Care – revision for adult day health estimate for SFY 2028

Given EOHHS' methodology, the agency's forecast as included in original testimony for **Home and Community Care** in FY 2028 is overstated by $3,025,006 due to claims that will no longer be present.

Calculation of recommended correction:

The November estimate is based on actual FY 2026 expenditures, which include the impact of DD Adult Day services beginning in March 2026. The FY 2027 revised estimate uses a monthly average of $754,182 for the first three months of FY 2027, increased by 32.6% for remaining months from implementing the OHIC rate recommendations on October 1, 2026. The estimate also includes a 1.5% increase for utilization. This brings total projected adult day expenses to $11,394,988 FY 2027. The revised FY 2027 estimate is the basis for the FY 2028 estimate, resulting in monthly base claims of $1,015,048, which is then adjusted for a 1.5% increase in utilization.

Total Adult Day expenses in the FY 2028 caseload testimony are $12,363,290. However, EOHHS did not exclude DD related Adult Day claims from the base data when estimating FY 2028. By excluding months in which there were DD claims (i.e., March to June 2026), the monthly base that should have been used is $766,690. Adjusting for a 1.5% increase in utilization, total FY 2028 projected expenditures are revised downwards to $9,338,284. This is reduction of $3,025,006.

4. **Managed Care – p. 21: Additional information on Rite Smiles Adult expansion including changes from initial proposal**

As part of the SFY 2025 agency budget submission, EOHHS submitted a decision package to expand Rite Smiles to all adults and increase reimbursement for dental anesthesia. Specifically, EOHHS requested $2.3M all funds, $0.3M in general revenue which included: (1) shifting most Adult Fee-For-Service (FFS) dental benefits to the managed care delivery system, and (2) increasing reimbursement for dental care under anesthesia.

The package noted we would redirect resources to preventative treatments that can reduce the need for more costly care. Therefore, it was assumed that the proposal would lead to savings in medical expenditures, which is the main driver of the $2.7 million increase compared to the estimate from the 2025 budget cycle. As noted in testimony, EOHHS assumes, as in prior years, a 5.0% rate increase for most managed care product lines. The actual increase will differ and in subsequent years as actual experience is incorporated into the base data used for rate setting, EOHHS assumes costs will decline marginally compared to the counterfactual of no expansion to provision of dental care. For example, if cavity protection and outpatient extractions help avoid more serious health complications that would otherwise have resulted in an emergency department visit or hospital admissions the gross cost of the Rite Smiles expansion will be offset with a reduction in managed care and/or FFS expenditures. Such cost avoidance, however, is inherently difficult to assess but could be considered through detailed claims analysis once sufficient time has passed.

For the Rite Smiles expansion, the new spending is being budgeted to Managed Care and Expansion. All spending on parents and aged, blind and disabled are assumed will be expended against the Managed Care appropriation sequences, but all spending on Expansion clients will be expended against the Expansion appropriation sequences. However, the base FFS spending is in Managed Care (Core FFS), Expansion FFS, and Other Services FFS. For SFY 2028 we have backed out these expenditures from the experience.

SFY 2027 spending on Rite Smiles is $29.0M (shown in the following table). EOHHS forecasts this to increase to $46.3M in SFY 2028. (Note that 1.6M of this growth is for existing enrollment due to 5.0% rate increase and caseload change). After savings for reduced FFS spending, the net increase in spending for the expansion of Rite Smiles to include adults is $8.2M, including $2.7M GR.

Note that, there will still be FFS spending for dental services. At present, there is no assumption that the FQHC wrap payments for dental providers will be moved in-plan, which was assumed in the initial decision package.

	SFY 2027	SFY 2028	Change	GR Change
Existing Rite Smiles – Regular	27	28.5	+1.5	+0.6
Existing Rite Smiles – Expansion	2	2.1	+0.1	+0.01
Subtotal Existing Rite Smiles	29	30.6	+1.6	+0.6
New Rite Smiles – Regular	0	10.1	+10.1	+4.3
New Rite Smiles – Expansion	0	5.6	+5.6	+0.6
Total Rite Smiles	29	46.3	+17.3	+5.5
FFS Spending – Managed Care (Core FFS)	1.3	0	(1.3)	(0.6)
FFS Spending – Expansion	2.8	0	(2.8)	(0.3)
FFS Spending – Other Services	3.4	0	(3.4)	(1.5)
Grand Total Dental (excl. FQHC Wrap)	36.5	46.3	+9.8	+3.1
Net New (excl. SFY 2028 rate increase for existing population)			**+8.2**	**+2.7**

5. Managed Care – p. 22: Updated Table III-1

TANF offset was included in the NEMT broker line for current forecasts for FY 2027 and FY 2028 but was separated for FY 2026 Prelim Final and FY 2027 Enacted. Table updated to align reporting.

	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	$ 9,153,638	$0.3 M	$ 9,657,093	$0.5 M
TANF Offset	(500,000)	(500,000)	(500,000)	0.0 M	(500,000)	0.0 M
RIte Share	2,843,727	3,309,561	2,846,284	0.5 M	3,195,219	0.3 M
Premium Assistance Program	30,000	500,000	50,000	0.5 M	500,000	0.5 M
Core FFS	52,217,945	51,292,000	57,399,079	(6.1 M)	58,244,648	0.8 M
CSHCN FFS	2,614,125	2,930,000	2,404,000	0.5 M	2,542,000	0.1 M
Early Intervention FFS	5,205,269	5,203,000	5,533,000	(0.3 M)	5,672,000	0.1 M
NICU	30,067,218	38,300,815	30,610,192	7.7 M	31,660,678	1.1 M
State Only FFS (Non Medicaid)	1,000,000	1,000,000	1,000,000	0.0 M	1,000,000	0.0 M
Rebates	(42,752,476)	(53,913,137)	(43,202,866)	(10.7 M)	(45,728,040)	(2.5 M)
Premium Collection	(50,000)	(50,000)	(50,000)	0.0 M	(50,000)	0.0 M
Tax Intercept	(100,000)	(100,000)	(100,000)	0.0 M	(100,000)	0.0 M
Subtotal - Other Payments	**$ 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**	**$75.4 M**
SFY 2025 accruals - SFY 25/26 risk share change	7,629,966					
Other Adjustments/Rounding	(2,551,372)	0	44,181	(0.0 M)	1,874	(0.0 M)
Total - Managed Care	**$ 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

6. Expansion section – pp. 29-30: Additional context on changes to previously eligible expenditures 6

Deloitte's eligibility system was updated in September 2024 to better identify previously eligible clients (i.e., clients with incomes below 133% FPL but who are on SSI or SSDI) who go through the MAGI-pathway. This resulted in a significant reduction of new clients being "inappropriately" enrolled in Medicaid Expansion and for whom EOHHS made a retroactive reassignment to Regular FMAP as part of its fiscal close activity. The

significant reduction in SFY 2026 represented (a) fewer people being assigned to expansion upon initial enrollment, and (b) people being reassigned at time of renewal.

At present, the adjustments for FY 2027 and FY 2028 reflects the adjustments made at FY 2026 fiscal close. The adjustment shifts expenditures from Expansion FMAP to Regular FMAP. Given current information, we would not reduce this amount.

7. Hospitals – Regular section – p. 32: Updated Table VII-1

For the estimated portion of the Hospital SDP that was for the MCO's tax liability included in original table was referencing the incorrect cell in EOHHS's model. The SDP tax referenced the SFY 2025 SDP not SDY 2026 estimate. There is no change in the total SDP and hospital and tax payments across SFY 2026 through SFY 2028.

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	$0.0 M
Regular	13,760,069	13,843,351	11,644,683	2.2 M	11,644,683	0.0 M
Expansion	4,767,949	4,684,667	4,034,954	0.6 M	4,034,954	0.0 M
Outpatient UPL	8,926,997	8,926,997	10,016,714	(1.1 M)	10,016,714	0.0 M
Regular	6,623,857	6,477,746	7,432,430	(1.0 M)	7,432,430	0.0 M
Expansion	2,303,140	2,449,251	2,584,284	(0.1 M)	2,584,284	0.0 M
SDP - Hospital Payments	324,718,048	324,718,047	324,718,048	(0.0 M)	324,718,048	0.0 M
SDP - MCO Tax	6,626,899	6,626,899	6,626,899	0.0 M	6,626,899	0.0 M
Subtotal - Supplemental Payments	**$ 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*

8. Nursing and Hospice Care – p. 37: Clarification on Table IX-3

The FY 2028 nursing and hospice care trend assumptions are correctly reflected in Table IX-3. The net increase between SFY 2027 and SFY 2028 is greater than the sum of the identified adjustments/assumptions because the SFY 2028 rate increase is effective 10/1/2027 and so there is an increase in spending in SFY 2028 Q1 that is not captured by the SFY 2028 rate increase (i.e., Q1 reflects the rate increase in in the current fiscal year over the prior fiscal year, i.e., SFY 2027 over SFY 2026). The updated table is below:

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
Annualization of SFY 2027 change in Q1	*n/a*	*$9.9 million*	reflects FY27 price change + patient share + utilization change in FY 2028 Q1 that was not included in FY 2027 Q1 given October 1, 2026 rate increase
Total Nursing & Hospice Care		***$32.7 million***	

9. Questions File– p. 2: Addition context on CAA Section 5121 Implementation

Section 5121 of the CAA 2023 requires states to ensure that eligible justice-involved youth receive Targeted Case Management for the 30 days prior to release and at least 30 days following release. States must also ensure eligible youth receive medically necessary screening and diagnostic services during the 30 days prior to release or within one week following release, or as soon as practicable if services cannot be provided before release. It also creates a limited exception to the federal Medicaid inmate exclusion, allowing Medicaid reimbursement for these specified services during the pre-release period. The exclusion remains in effect for other Medicaid-covered services provided during incarceration. Currently, these services are being provided as required by DCYF.

Mechanisms for Medicaid billing, including establishment of the system to support (MMIS build ETA is 12/1/26), are still being finalized; EOHHS' current understanding is that DCYF has not determined if they will bill Medicaid (the services must be provided for compliance absent the billing details). If that moves forward, Medicaid would be drawing down federal match with a nominal decrease in DCYFs budget for these services (same for DOC).

EOHHS' understanding is that at any given time, the average number of youth at the RI Training School is approximately 30. The number of those in the last 30 days is lower, and 1-3 youth are being discharged at any given time. Given the low volume and limited set of services that not all will require, the potential for meaningful savings is low. This represents a rough analysis absent a full budgetary estimate; EOHHS can support completing a more formal estimate in partnership with DCYF.