# Medicaid

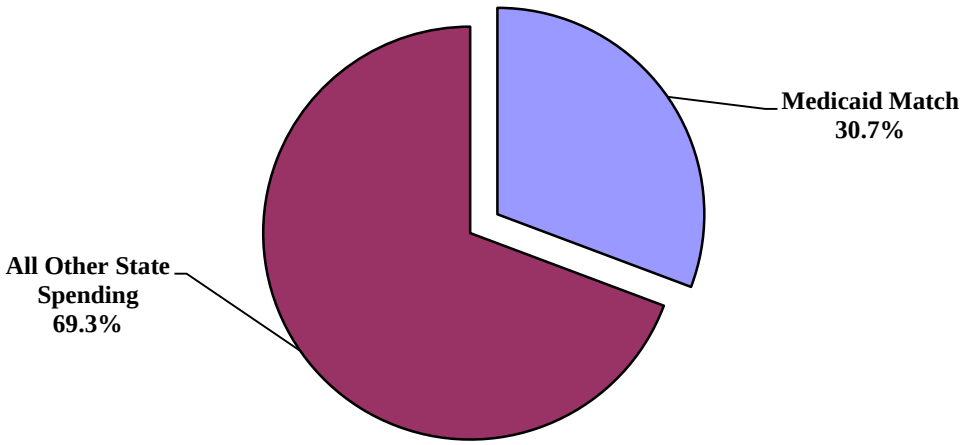
Medicaid is a health insurance program jointly funded by the federal government and the states to provide services to low-income children, pregnant women, parents of dependent children, the elderly, and people with disabilities. The federal government's share of expenditures for most Medicaid services is called the federal medical assistance percentage (FMAP). The remainder is referred to as the nonfederal or state share. With passage of the Patient Protection and Affordable Care Act of 2010, states have the option of expanding coverage to include certain low-income adults with the federal government paying all program costs for the first three years and eventually paying 90 percent of the total cost.

Rhode Island provides medical assistance, residential care, community-based services and case management activities to individuals who meet the eligibility criteria established for the various assistance programs operated by the Executive Office of Health and Human Services and the four departments under its umbrella: Human Services, Behavioral Healthcare, Developmental Disabilities and Hospitals, Children, Youth and Families, and Health. The following table shows Medicaid spending by department, including administrative costs and direct benefits, as well as by percent of the total Medicaid budget.

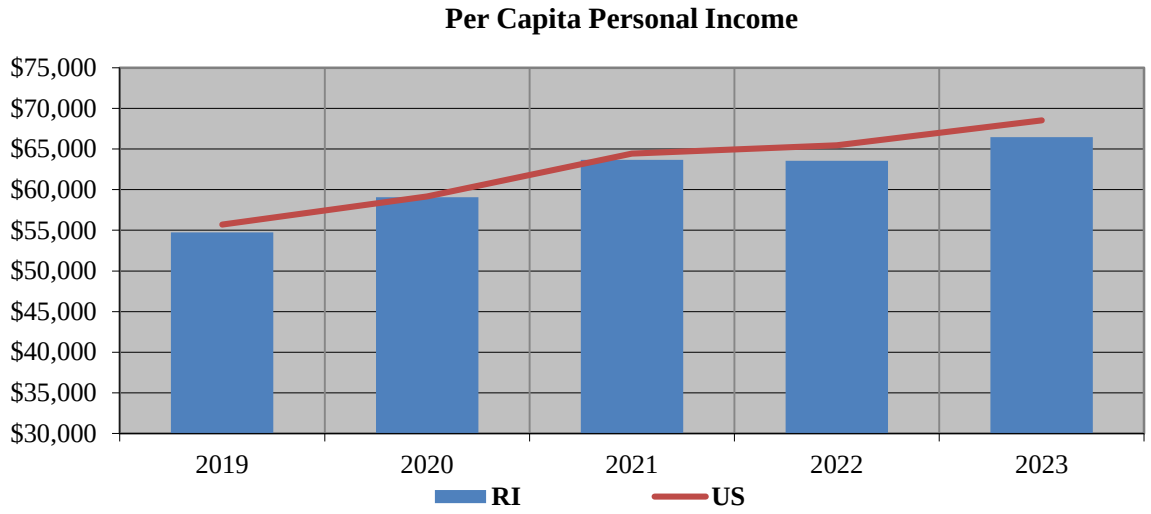
| FY 2026 Recommended | General Revenues | All Funds | % of Medicaid |
|---|---|---|---|
| EOHHS | $ 1,444,247,288 | $ 4,125,745,073 | 84.8% |
| BHDDH | 267,250,168 | 612,337,577 | 12.6% |
| Children, Youth and Families | 35,761,710 | 81,348,084 | 1.7% |
| Human Services | 16,028,568 | 39,929,280 | 0.8% |
| Health | 1,227,459 | 4,026,865 | 0.1% |
| **Total** | **$ 1,764,515,193** | **$ 4,863,386,879** | **100%** |

**Medicaid as a Percent of the State Budget.** Programs supported by Medicaid are 34.2 percent of total spending in the FY 2026 recommended budget and the state match for that requires 30.7 percent of spending from general revenues. The programs and recipients receiving Medicaid funded services are discussed separately in the pages that follow, including the state's mandated coverage for these populations, the number of individuals receiving services and the costs, as well as other optional services provided through the health and human service agencies.

**FY 2026 State Medicaid Match vs All General Revenue Spending**



**Medicaid Rate.** The federal medical assistance percentage, also known as the federal Medicaid matching rate, is a calculation with significant impact on state health and human services spending. Each state has a Medicaid rate. The formula that determines an individual state's Medicaid rate is based on that state's three-year average per capita income relative to national per capita income and represents the portion of medical services delivered under the Medicaid program that the federal government will contribute. States with a higher per capita income level are reimbursed a smaller share of their costs.




By law, the standard Medicaid rate cannot be lower than 50 percent or higher than 83 percent. The federal contribution to any state's administrative costs for Medicaid services is set at 50 percent. The chart above shows the state's per capita income for the previous five calendar years compared to the national average. The FY 2026 rate is based on 2021 through 2023 data. The per capita income data released by the federal Bureau of Economic Analysis is used by the federal government to calculate each state's Medicaid reimbursement rate.

Since the Medicaid rate is published for the federal fiscal year that starts on October 1, the state uses a blended rate for its fiscal year. For example, Rhode Island's FY 2026 rate is based on one quarter of the federal fiscal year 2025 rate and three quarters of the federal fiscal year 2026 rate resulting in the different rate for budgetary purposes.

The following table shows the regular federal fiscal year rate, the regular state fiscal year rate and the enhanced rates related to the pandemic for FY 2021 through FY 2026. As shown, the federal share has remained fairly consistent over the last several years.

| Medicaid Rates | FFY | | SFY | |
|---|---|---|---|---|
| | Regular | Enhanced | Regular | Enhanced |
| 2026 | 57.50% | N/A | 57.20% | N/A |
| 2025 | 56.31% | N/A | 55.99% | N/A |
| 2024 | 55.01% | 55..75% | 54.75% | 55.75% |
| 2023 | 55.01% | 60.16% | 54.19% | 60.09% |
| 2022 | 54.88% | 61.08% | 54.68% | 60.88% |
| 2021 | 54.09% | 60.29% | 53.81% | 60.01% |

**Families First Coronavirus Response Act - Enhanced Medicaid Rate.** On March 18, 2020, President Trump signed into law the Families First Coronavirus Response Act, which temporarily increased a state's Medicaid match rate by 6.2 percent for services provided from January 1, 2020 until the end of the public

health emergency. In exchange, states could not terminate enrollment for those who no longer qualify for benefits.

On December 29, 2022, Congress passed the Consolidated Appropriations Act, 2023 which decoupled the requirement for continued eligibility for Medicaid enrollees and related rate enhancement for the Medicaid match from the public health emergency declaration. The legislation lifted the prohibition on eligibility redeterminations as of March 31, 2023. States had to start the 12-month redetermination process no later than April 1, 2023.

The enhanced Medicaid rate was phased down through the second quarter of FY 2024. The 6.2 percent enhanced rate remained in effect through the third quarter and phased down to 5.0 percent in the fourth quarter. For FY 2024, the enhanced rate was 2.5 percent in the first quarter and 1.5 percent in the second quarter, which marked the end of the rate enhancement. In order for states to receive the enhanced Medicaid rate, they must meet certain conditions. They must have submitted a renewal distribution and system readiness plan by February 1, 2023, if they began the redetermination process in February, or by February 15, 2023, if they began in either March or April. States must also report data related to the unwinding by the eighth day of the month in which the redetermination process starts.

Savings from the enhanced Medicaid rate are partially offset by the state having to maintain enrollment of individuals who may no longer be eligible. The following table shows the gross savings to general revenues from the increased federal share for FY 2020 through the FY 2024 final budget totaling $695.9 million. These savings are offset by the fluctuations in enrollment, which grew by approximately 74,200 individuals from February 2020 through March 2023.

| **Gross General Revenue Match Savings** | |
|---|---|
| FY 2024 Final | $ (39.4) |
| FY 2023 Final | (162.8) |
| FY 2022 Final | (280.0) |
| FY 2021 Final | (135.9) |
| FY 2020 Final | (77.8) |
| **Total** | **$ (695.9)** |

*$ in millions*

**Medicaid - CHIP Enhanced Rate.** The federal medical assistance percentage rate not only determines the state and federal share of Medicaid, the state's largest health and human services program, but also applies to adoption assistance, foster care, and child care. The Medicaid rate is the basis for calculating the enhanced federal medical assistance percentage rate, the federal matching rate for the Children's Health Insurance Program (CHIP). The enhanced Medicaid rate reduces the state share by 30 percent. For example, if a state's Medicaid rate is 52 percent, its state share is 48 percent. That is lowered to 33.6 percent under the enhanced rate of 66.7 percent. A state's Medicaid rate may increase or decrease depending on the adjustment to a state's per capita income, as does the enhanced Medicaid rate.

| **CHIP Rates** | **FFY** | **SFY** |
|---|---|---|
| 2026 | 70.25% | 70.04% |
| 2025 | 69.42% | 69.19% |
| 2024 | 68.51% | 68.33% |
| 2023 | 67.77% | 67.93% |
| 2022 | 68.42% | 68.28% |
| 2021 | 67.86% | 70.54% |

The Affordable Care Act increased the already enhanced rate by another 23 percentage points until FFY 2020 when it was lowered 11.5 extra points to 78.57 percent. The regular enhanced rate returned in FFY 2021 at a rate of 67.86 percent and FY 2026 is 70.25 percent.

**The Patient Protection and Affordable Care Act of 2010.** On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010, commonly referred to as the Affordable Care Act, which provided for national health care reform. That was immediately followed by him signing a package of amendments called the Health Care and Education Reconciliation Act of 2010.

The act required most citizens and legal residents to have health insurance by January 1, 2014, or pay a tax penalty, and expanded Medicaid coverage to individuals and families up to 138 percent of the federal poverty level; the threshold is 133 percent, but the act included a 5 percent disregard, essentially making the Medicaid eligibility threshold 138 percent. The Tax Cuts and Jobs Act of 2017 eliminated the individual mandate penalty to purchase health insurance, but did not make any changes to the expansion program.

The Affordable Care Act also provides for premium credits and cost-sharing subsidies for individuals and families between 139 percent and 400 percent of poverty; this also remains unchanged in the Tax Cuts and Jobs Act. The act requires most employers offer medical coverage, includes small business tax credits for employers with no more than 25 employees and provides for a temporary reinsurance program for employers providing health insurance coverage to individuals over 55 years of age but who are not eligible for Medicare. This provision remains in current law.

The Affordable Care Act allows young adults to remain on a parent's or guardian's health plan until age 26; this provision became effective September 23, 2010. Regulations state that young adults are eligible for this coverage regardless of any of the following factors: financial dependency, residency with parent, student status, employment or marital status. The law does not require that a plan or issuer offer dependent coverage, but that if coverage is offered, it must be extended to young adults up to age 26. Rhode Island requires insurance plans that cover dependent children to cover unmarried dependent children until age 19, or until age 25 if a student. If the dependent child is mentally or physically impaired, the plan must continue coverage after the specified age. This provision remains in current law.

Medicaid Expansion. Title II of the act expands eligibility to lower income persons and assumes federal responsibility for much of the cost of this expansion. Beginning on January 1, 2014, all children, parents and adults without dependent children who are not entitled to Medicare and who have family incomes up to 138 percent of poverty became eligible. The 2013 Assembly expanded coverage to this population.

States were required to maintain the same income eligibility levels through December 31, 2013 for all adults, and this requirement was extended through September 30, 2019, or FY 2020, for children currently on Medicaid. It was extended again until September 30, 2023 with the passage of the Healthy Kids Act that extended the Children's Health Insurance Program. For Rhode Island, this requirement applies to RIte Care eligibility for parents who are at or below 175 percent of poverty and children who are at or below 250 percent. The 2013 Assembly lowered the parent's threshold to 133 percent of poverty and included funding to assist in the transition to coverage through the health benefits exchange. The eligibility threshold for the parent was increased to 138 percent to match the threshold for the expansion program.

Between 2014 and 2016, the federal government paid 100 percent of the cost of covering newly-eligible individuals. On January 1, 2017, the Medicaid rate decreased to 95 percent. The rate was 94 percent for calendar year 2018; it dropped to 93 percent in 2019 and 90 percent on January 1, 2020, for all subsequent years, requiring a 10 percent state match.

The following table shows total program expenses and the state match for FY 2020 through the FY 2026 Governor's recommended budget and projected through FY 2030. Expenditures from FY 2021 through

FY 2024 reflect caseload growth partially attributable to the prohibition on redeterminations during the public health emergency. Redeterminations began April 1, 2023, and the state match for this program remains at 10 percent; the delay in redeterminations did affect total state costs, which more than doubled.

| Medicaid Expansion | | |
|---|---|---|
| FY | General Revenues | All Funds |
| 2030 | $ 91.4 | $ 843.7 |
| 2029 | $ 87.7 | $ 809.5 |
| 2028 | $ 84.1 | $ 776.8 |
| 2027 | $ 80.7 | $ 745.4 |
| 2026 | $ 78.4 | $ 723.5 |
| 2025 | $ 74.6 | $ 688.1 |
| 2024 | $ 76.4 | $ 702.8 |
| 2023 | $ 83.6 | $ 784.5 |
| 2022 | $ 77.6 | $ 722.7 |
| 2021 | $ 68.8 | $ 643.8 |
| 2020 | $ 42.9 | $ 487.3 |

*$ in millions*

HealthSource RI. In September 2011, Governor Chafee issued an executive order to establish the Rhode Island Health Benefits Exchange, renamed HealthSource RI, the marketplace for purchasing health insurance. The 2015 Assembly enacted Article 18 of 2015-H 5900, Substitute A, as amended, to establish the Exchange in general law as a division within the Department of Administration. It authorized HealthSource RI to operate a state-based exchange to meet the minimum requirements of the federal act. It also authorized an assessment be charged by the Department not to exceed revenues raised through the federally facilitated marketplace upon those insurers offering products on the Exchange. The assessment is anticipated to generate $11.1 million for FY 2026.

The 2019 Assembly also included Article 11 of 2019-H 5151, Substitute A, as amended, to address federal changes decreasing the assessment from 3.5 percent to 3.0 percent. The article decoupled the state's premium assessment from the rate charged for federally facilitated marketplaces. It established a fee of 3.5 percent in statute, effective January 1, 2020. The FY Governor's 2026 recommended budget includes $1.9 million from general revenues to be used in conjunction with these revenues for the operations of HealthSource RI.

HealthSource RI offers in-person assistance from professional health benefits navigators and online tools to assist Rhode Island residents and small businesses with shopping for and purchasing health insurance. All plans offered through HealthSource RI meet minimum coverage requirements set by the federal government, including essential health benefits such as preventive care and annual physicals, doctor sick visits, hospitalizations, maternity care, emergency room visits, and prescription coverage.

Tools offered can be used by those who do not have coverage either through an individual plan or through an employer plan, are under-insured by their individual or employer plan, and those who are comparison shopping between their current plan and plans offered through the Exchange. Small employers with fewer than 50 full-time employees may also use HealthSource RI to offer coverage options to their employees.

The Assembly required religious employers that purchase plans on the exchange to offer their employees a full-choice option. The employers would not be responsible for any additional costs of a plan selected by an employee. It also required that if an employer elects the religious exemption variation, it must provide written notice to enrollees that the plan excludes coverage for abortion services.

HealthSource RI began accepting applications on October 1, 2013. Health plans offered through the marketplace are categorized into tiers based on the level of benefits and cost sharing requirements. Individuals in households with incomes below 400 percent of poverty and who are not Medicaid eligible will receive federal subsidies to reduce the cost of commercial health plans purchased through the Exchange.

The 2013 Assembly lowered the state's threshold criteria for RIte Care parents to 133 percent of poverty and created a premium assistance program to aid in the transition to coverage through the Exchange. The state pays 50 percent of the cost of commercial coverage after subtracting what the parents are currently paying for RIte Care coverage and any federal tax credits or subsidies that are available.

**Reinsurance Program.** The 2019 Assembly concurred with Governor Raimondo's proposal to establish a reinsurance program, which was envisioned to provide stability in the individual insurance market; legislation is contained in Article 11 of 2019-H 5151, Substitute A, as amended. It imposes a shared responsibility payment penalty for individuals who do not have health insurance coverage, with certain exemptions and became effective on January 1, 2020. For federal tax year 2017, the penalty per household was $695 per adult and $347.50 per child under 18 or 2.5 percent of the household's income; however, the penalty was capped at the national average premium for bronze level plans. It mirrors the federal penalty, with the exception of capping the penalty at the statewide average premium for bronze level plans offered on the state's health benefits exchange.

The penalty is collected by the tax administrator and deposited into a restricted account titled the Health Insurance Market Integrity Fund. The funds are used to provide reinsurance or payments to health insurance carriers as a means of ensuring that premiums do not increase drastically, and administrative costs. Remaining funds from the penalty can be used for preventative health care programs in consultation with the Executive Office of Health and Human Services. The legislation prohibits the use of general revenues for reinsurance payments. The 2023 Assembly included Section 4 of Article 4 of 2023-H 5200, Substitute A, as amended, to exempt any person on Medicaid during calendar year 2023 from the current penalty assessed for not having health insurance.

The FY 2026 recommended budget includes $16.5 million, which includes $10.8 million from federal funds and $5.7 million in revenue from the Shared Responsibility Payment penalty for individuals without health insurance coverage, with certain exemptions. This includes $15.8 million for reinsurance payments to health insurance carriers and $0.6 million for program administration.

**Unified Health Infrastructure Project.** The state received approval from the Centers for Medicare and Medicaid Services in April 2015 to implement a nine-year, $230.8 million project, including $162.6 million from federal funds including Medicaid, matched by $50.6 million from general revenues. The project is a joint venture among the Executive Office of Health and Human Services, Department of Human Services, and HealthSource RI.

That initial plan was subsequently increased to $363.7 million, including $79.0 million for the state match, and would be a fully integrated system, RI Bridges, instead of two separate systems for its human services eligibility and application and worker accessibility activities in the affected agencies as originally planned. In September 2016, the old system was shut down and the new system became operational. The following table includes FY 2016 spending through the FY 2026 recommended budget, which shifts $18.9 million, including $10.9 million from general revenues, of contracted expenses from the Department of Human Services and HealthSource RI to the Executive Office of Health and Human Services.

| Unified Health Infrastructure Project/Contact Center | General Revenues | Federal Funds | Deloitte Settlement Funds | Other Restricted & HealthSource RI | Total |
|---|---|---|---|---|---|
| **FY 2016 to FY 2024** | **$ 135,144,207** | **$ 468,529,678** | **$ 49,783,569** | **$ 25,734,587** | **$ 682,955,805** |
| **FY 2025 Enacted** | | | | | |
| EOHHS | $ 15,094,971 | $ 52,400,438 | $ - | $ - | $ 67,495,409 |
| DHS | 12,722,083 | 16,076,881 | 520,708 | - | 29,319,672 |
| HealthSource RI/Contact Center | 1,497,552 | - | - | 5,013,568 | 6,511,120 |
| **Total** | **$ 29,314,606** | **$ 68,477,319** | **$ 520,708** | **$ 5,013,568** | **$ 103,326,201** |
| **FY 2025 Governor Revised** | | | | | |
| EOHHS | $ 12,275,221 | $ 45,636,147 | $ 216,431 | $ - | $ 58,127,799 |
| DHS | 13,536,335 | 18,488,540 | 520,708 | - | 32,545,583 |
| HealthSource RI/Contact Center | 1,500,038 | - | - | 5,295,917 | 6,795,955 |
| **Total** | **$ 27,311,594** | **$ 64,124,687** | **$ 737,139** | **$ 5,295,917** | **$ 97,469,337** |
| **FY 2026 Recommendation** | | | | | |
| EOHHS | $ 21,665,055 | $ 53,744,893 | $ 520,708 | $ - | $ 75,930,656 |
| DHS | 3,618,132 | 9,140,548 | - | - | 12,758,680 |
| HealthSource RI/Contact Center | - | - | - | 5,793,588 | 5,793,588 |
| **Total** | **$ 25,283,187** | **$ 62,885,441** | **$ 520,708** | **$ 5,793,588** | **$ 94,482,924** |
| **FY 2016 through FY 2026 Recommended** | **$ 187,738,988** | **$ 595,539,806** | **$ 51,041,416** | **$ 36,824,092** | **$ 874,908,066** |

**Health System Transformation Program.** The Assembly enacted Section 10 of Article 5 of 2015-H 5900, Substitute A, as amended, to authorize the Secretary of Health and Human Services to seek the federal authority required to implement a program to provide participating hospitals and nursing facilities the ability to obtain certain payments for achieving performance goals established by the Secretary.

The Assembly included Section 9 of Article 7 of 2016-H 7545, Substitute A, as amended, to seek federal authority to fund the Rhode Island Health System Transformation with a Medicaid match through a health workforce development partnership with the University of Rhode Island, Rhode Island College and the Community College of Rhode Island. A restricted receipt account was established so the activities can receive the federal Medicaid match.

The state received approval on October 20, 2016, for a five-year grant totaling $129.7 million for the Health System Transformation Project, which was later extended through FY 2024. Aggregate program and administrative expenses from FY 2017 through the FY 2026 recommended budget total $226.9 million.

As part of the project, the state developed shared savings agreements between the managed care health plans and the certified affordable entities. The shared savings incentive programs are the Hospital and Nursing Home Incentive Program and the Accountable Entity Incentive Arrangement.

The second phase expanded opportunities through the Accountable Entities Incentive Arrangement. Payments made to the separate entities through the shared savings agreement averaged approximately $18 million annually for FY 2018 through FY 2024.

Total recommended spending for FY 2025 expenses is $11.5 million and the remaining funding of $2.4 million is eligible for FY 2026. The FY 2026 recommended budget includes $1.3 million for contracted services, $0.6 million for administrative expenses, and $1.6 million for a behavioral health infrastructure project. The following table shows the progression of the grant and examples of the investments made for FY 2017 through FY 2026 in addition to the accountable entities arrangement.

| Fiscal Year | Investment | |
|---|---|---|
| 2026 | Staff support, data and financial analysis, information technology projects, and behavioral heatlh infrastructure project. | $ 3.4 |
| 2025 | | |
| 2024 | Workforce Transformation Initiative & Care Transformation Collaborative through DOH. | 3.2 |
| 2023 | Dept. of Health's Care Transformation Collaborative for Practice Facilitation Services & Collaboration with URI/RIC & CCRI. | 17.6 |
| 2022 | Real Jobs Healthcare Workforce Initiative with URI, RIC, CCRI & DLT. Continued program support for the Commission on the Deaf and Hard of Hearing. Staff support and contracted services. | 19.7 |
| 2021 | Workforce Transformation Initiative and Care Transformation Collaborative through the Dept. of BHDDH. Staff support and contracted services. | 17.0 |
| 2020 | Workforce Transformation Initiative and program support for the Commission on the Deaf and Hard of Hearing. | 15.2 |
| 2019 | Healthcare Workforce Transformation Initiative with URI, CCRI & RIC and administrative services. | 9.7 |
| 2018 | | |
| 2017 | | |
| **Total** | | **$ 85.8** |

*$ in millions*

## Poverty Guidelines

The federal poverty guidelines are thresholds used for the purpose of determining financial eligibility for certain state and federal programs, including several programs in state agencies under the Executive Office. They are based on the calculations made for the poverty threshold used by the United States Census Bureau mainly for statistical purposes, for instance, preparing the estimates of the number of Americans in poverty for each year's report. They are issued each year, generally in the winter, in the Federal Register by the United States Department of Health and Human Services and adjusted for families of different sizes.

Both the thresholds and the guidelines are updated annually for price changes using the Consumer Price Index for All Urban Consumers (CPI-U). The poverty guidelines are sometimes loosely referred to as the "federal poverty level" or "poverty line." The 2026 guidelines are shown in the following table.

| Percent of Federal Poverty Level Based on Annual Income | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Family Size** | **100%** | **138%** | **175%** | **185%** | **200%** | **225%** | **250%** | **261%** |
| 1 | $15,650 | $21,597 | $27,388 | $28,953 | $31,300 | $35,213 | $39,125 | $40,847 |
| 2 | 21,150 | 29,187 | 37,013 | 39,128 | 42,300 | 47,588 | 52,875 | 55,202 |
| 3 | 26,650 | 36,777 | 46,638 | 49,303 | 53,300 | 59,963 | 66,625 | 69,557 |
| 4 | 32,150 | 44,367 | 56,263 | 59,478 | 64,300 | 72,338 | 80,375 | 83,912 |
| 5 | 37,650 | 51,957 | 65,888 | 69,653 | 75,300 | 84,713 | 94,125 | 98,267 |
| 6 | 43,150 | 59,547 | 75,513 | 79,828 | 86,300 | 97,088 | 107,875 | 112,622 |
| 7 | 48,650 | 67,137 | 85,138 | 90,003 | 97,300 | 109,463 | 121,625 | 126,977 |
| 8 | 54,150 | 74,727 | 94,763 | 100,178 | 108,300 | 121,838 | 135,375 | 141,332 |

*For families with more than 8 members, add $6,880 for each additional member for the 100 percent calculation.*

**Rhode Island Consumer Choice Global Compact Waiver.** The Rhode Island Consumer Choice Global Compact Waiver, or Medicaid Global Waiver, was approved by the Centers for Medicare and Medicaid Services on January 16, 2009. The Global Waiver established a new federal-state agreement that provides

Rhode Island with the flexibility to provide services in the least restrictive, most cost-effective way to meet the needs of its citizens. It was in effect until December 31, 2013, at which time the state applied for and received an extension until December 31, 2018, renaming it the 1115 Research and Demonstration Waiver. The state received approval to extend the waiver until December 31, 2023.

The next renewal period was to begin January 1, 2024, and the state submitted its renewal application in December 2022. The Centers for Medicare and Medicaid Services notified the state that it was impossible to approve the waiver because of staff capacity at the federal agency.

Rhode Island initially received an extension until December 1, 2024, which has now been extended through June 30, 2025. The extension does not affect current programs but does delay implementation of programs that have Assembly approval such as adult dental services being provided by the managed care plans. Other programs the state has applied for but not yet requested Assembly approval for, such as housing and nutrition support.

Programs under the waiver include RIte Care, Rhody Health Partners, Rhody Health Options, home and community-based services to elderly residents, residential and community support programs to adults with behavioral health and developmental disabilities, and breast and cervical cancer treatments. It also allows the state to leverage Medicaid for services that were previously state-only in the Departments of Human Services, Behavioral Healthcare, Developmental Disabilities and Hospitals, and Children, Youth and Families.

**Waiver Proposals Approved and Part of the Budget**

| *Program* | *Explanation* |
|---|---|
| Covering Family Home Visiting Program | • Able to receive federal matching funds for evidence-based home visiting services for Medicaid eligible pregnant women and children up to age four who are at-risk for adverse health, behavioral, and educational outcomes<br>• Aimed at improving maternal and child health outcomes, encouraging positive parenting, and promoting child development and school readiness |

The next table shows proposals that have been approved in the waiver that impact youth and families.

**Waiver Proposals Approved and Not Funded as Part of the Budget**

| *Programs for Youth and Families* | *Explanation* |
|---|---|
| Facilitating Medicaid Eligibility for Children with Special Needs | • Eligibility category established for children who meet the SSI disability criteria, but whose household income and assets exceed the SSI resource limits, and who need care in a psychiatric residential treatment facility<br>• Allows children who meet the SSI disability criteria and require care in a residential treatment facility to become Medicaid eligible and receive residential care without parents needing to voluntarily relinquish custody to the Department of Children, Youth and Families |
| Enhancing Peer Support Services for Parents & Youth | • Able to receive federal matching funds for peer mentoring services to children, youth, and young adults, and their families, who have complex behavioral health needs and are at risk of removal from their home due to child welfare or juvenile justice involvement, or who may need extended residential psychiatric treatment |

The next table shows proposals affecting adults that have been approved but are not included in any budgets.

| Waiver Proposals Approved and Not Funded as Part of the Budget | |
|---|---|
| *Programs for Adults* | *Explanation* |
| Supporting Home- and Community-Based Therapeutic Services for the Adult Population | • Expansion of current in-home/community-based skill building and therapeutic/clinical services offered to children and adults<br>• Services may include but are not limited to: home-based specialized treatment; home-based treatment support; individual specific orientation; transitional services; lead therapy; life skill building; specialized treatment consultation by a behavioral health clinician; and treatment coordination |
| Access to Care for Homebound Individuals | • Cover home-based primary care services only for Medicaid eligible individuals who are homebound, have functional limitations that make it difficult to access primary care, or for whom routine office based primary care is not effective because of complex medical, social, and/or behavioral health conditions |
| Waive the Institutions of Mental Disease (IMD) Exclusion | • Waiver of the IMD exclusion to allow Medicaid coverage for residential treatment services in a facility with 16 or more beds for individuals who have substance use disorders<br>**• CMS has approved a waiver of the IMD exclusion for substance abuse disorders only, not mental health** |

One aspect changed was the process that the state has to adhere to in order to amend the waiver. Previously, the process was dictated by the nature of the change and identified as either a Category I, II or III change. The following table shows each separate category, gives brief explanations and examples, and identifies whether or not Assembly approval is required.

| Category | Assembly Approval | Global Waiver Change | Examples of Waiver Changes |
|---|---|---|---|
| I | No | Any administrative change that does not affect eligibility, benefits, healthcare delivery, payment methods or cost sharing | General operating procedures, instruments to determine level of care and prior authorization procedures |
| II | Yes | State plan amendment change that does not change the special terms and conditions of the global waiver or expenditure authority | Benefit packages, payment methods, and cost sharing levels that do not affect eligibility |
| III | Yes | Requires modifying the current waiver or expenditure authority | All eligibility changes, changes to spend down levels, aggregate changes to cost sharing that exceed current limit |

As part of the state's 2018 waiver extension, the Centers for Medicare and Medicaid Services notified the state that the way to approve requested waiver changes would be streamlined and the separate categories eliminated for its 2018 through 2023 waiver. There is now one process to make formal amendment changes that were previously considered Category III. The Assembly included Section 9 of Article 13 of 2019-H 5151, Substitute A, as amended, to retain the requirement for Assembly approval for previous Category II and III changes which will now be identified as formal amendments and state plan changes, respectively.

## Medicaid Recipients

The following table shows the populations to which a state must provide medical benefits and the eligibility criteria established in Rhode Island. This is followed by descriptions of the populations served.

| Populations | |
|---|---|
| **Mandatory** | **Optional** |
| Low-income Medicare beneficiaries up to 135% of poverty | Low-income elderly or adults with disabilities and individuals eligible for home and community care waiver services |
| Children up to age 1 at or below 185% of poverty; Parents and children age 1 to 19 at or below 133% of poverty | Children up to 250% of poverty |
| Supplemental Security Income or Social Security Disability Insurance recipients | Non-disabled adults, without dependent children, ages 19 through 64 with income at or below 138% of poverty |
| | Individuals who are medically needy<br>Women eligible for breast and cervical cancer treatment services |
| Children in adoption assistance or who live in foster care under a Title IV-E program | Children under 18 who would otherwise need institutional care |

**Citizenship.** To be eligible to receive Medicaid funded services, an individual must be a state resident and generally either be a citizen or legal resident for at least five years. There are exceptions.

**Children and Parents.** Medical services are provided to children whose family income is at or below 250 percent of poverty and parents if the income is at or below 138 percent of poverty through the RIte Care and RIte Share programs. Medical services are also provided to children who are placed in foster care or adopted through the Department of Children, Youth and Families.

**Children with Special Health Care Needs.** Medical services are provided to children with special health care needs, including children who are in foster care or adopted through the Department of Children, Youth and Families.

**Pregnant and Post-Partum Women.** Medical services are provided to pregnant women whose annual income is at or below 250 percent of the poverty level. States are federally required to provide services to women at or below 133 percent of poverty. Women who are not otherwise eligible for Medicaid lose coverage after 60 days post-partum. Previously, the state offered a limited Medicaid benefit to post-partum women up to 250 percent of poverty for up to 24 months. The American Rescue Plan Act created a new state Medicaid option to extend full Medicaid coverage for women who are 12 months post-partum and the Assembly enacted Section 7 of Article 12 of 2022-H 7123, Substitute A, as amended, to extend full coverage to approximately 1,000 women. It also expanded full coverage to the population not eligible for Medicaid because of immigration status assuming about 500 participants would receive benefits. The FY 2023 enacted budget included $5.2 million, including $3.5 million from general revenues.

**Coverage for Children Regardless of Immigration Status.** The FY 2023 enacted budget extended medical benefits coverage, funded solely from state sources, to children whose family income is at or below 250 percent of poverty regardless of immigration status and included $1.3 million for the benefit. The legislative change was included in Section 6 of Article 12 of 2022-H 7123, Substitute A, as amended.

Program expenses were $4.7 million for FY 2023 and $9.4 million for FY 2024. The Governor's budget includes $10.3 million for FY 2025 and $10.8 million for FY 2026, consistent with caseload estimates.

**Low Income Elderly.** Individuals age 65 and older are eligible for medical benefits based on income and resources. They are eligible for community and/or long-term care services if they meet income guidelines and the level of care requirements for the state's programs.

**Medicaid Eligible Disabled Non-Elderly Adults.** The state provides medical and cash assistance benefits to an adult, under the age of 65, if that individual meets the Social Security Administration definition of disabled. Individuals are considered disabled if they have a physical or mental disability, expected to last longer than six months and result in their death. There are two programs that provide a monthly cash assistance benefit to a disabled individual, Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI).

An individual determined to be disabled, who has a work history of 40 quarters, may first be eligible for Social Security Disability Insurance, which is not considered a public assistance program. This is a federal program where the individual receives a monthly payment.

The second program available is the federal Supplemental Security Income program for individuals with limited income and resources. Individuals may be eligible for both programs if they meet the income eligibility requirements. States have the option of providing a state payment in addition to the federal payment. Rhode Island began making this supplemental payment in 1987.

**Non-Disabled Adults without Dependent Children.** The 2013 Assembly expanded Medicaid coverage to non-disabled adults without dependent children between the ages of 19 and 64 at or below 138 percent of federal poverty, consistent with the changes under the Affordable Care Act.

**Breast and Cervical Cancer Treatment.** The state provides breast and cervical cancer treatment services through the Medicaid global waiver. A woman must first be screened through the Department of Health's women's cancer screening program before she can receive Medicaid-covered treatment services and must be at or below 250 percent of poverty.

## Mandatory and Optional Benefits

States must provide mandatory benefits to certain populations. States can also choose to cover additional populations and provide additional benefits beyond what is mandated by the federal government. If a state chooses to extend coverage to additional populations, it must provide the same mandatory services it gives to its mandatory populations.

The most recently produced Executive Office of Health and Human Services' Rhode Island Annual Medicaid Expenditure Report was submitted in October 2024 and included Medicaid spending by population and cost per person for FY 2023 as shown in the following table.

**FY 2023 Medicaid Annual Report**

| Populations | # of Persons | % of Population | Total Cost* | % of Cost | Annual Cost/Person |
|---|---|---|---|---|---|
| Children/Parents | 183,193 | 50.0% | $ 789 | 23.3% | $ 4,308 |
| Expansion | 112,745 | 30.8% | $ 759 | 22.4% | $ 6,732 |
| Elderly | 27,535 | 7.5% | $ 728 | 21.5% | $ 26,436 |
| Disabled - Children | 12,344 | 3.4% | $ 261 | 7.7% | $ 21,120 |
| Disabled - Adults | 30,265 | 8.3% | $ 855 | 25.2% | $ 28,260 |
| **Total** | **366,082** | **100%** | **$ 3,392** | **100%** | |

**in millions*

The 2024 annual report includes Medicaid expenditures that total $3,930.2 million from federal and state funds on direct benefits and administrative expenses. Of this amount, $3,392.0 million, or 86 percent of the expenses, is for benefits for full enrollees' covered services. There is another $319.8 million, or seven percent of expenses, for partial enrollees, uncompensated care payments made to hospitals, payments to local education agencies, Medicare premium payments the state makes on behalf of eligible individuals,

and costs not otherwise matchable expenses. The report also includes $209.2 million, or five percent of program costs, on administrative expenses. Of the total spent on Medicaid benefits, $1,289.0 million, or 38.0 percent, was spent on mandatory services for mandatory populations.

| FY 2023 Medicaid Annual Report | | All Funds | % of Total |
|---|---|---|---|
| Mandatory Populations | Mandatory Services | $ 1,289.0 | 38.0% |
| | Optional Services | 576.6 | 17.0% |
| | **Subtotal - Mandatory Populations** | **$ 1,865.6** | **55.0%** |
| Optional Populations | Mandatory Services | $ 1,051.5 | 31.0% |
| | Optional Services | 474.9 | 14.0% |
| | **Subtotal - Optional Populations** | **$ 1,526.4** | **45.0%** |
| **Total Expenses** | | **$ 3,392.0** | **100%** |

*$ in millions*

The requirements to submit the annual report are contained in Rhode Island General Law, Section 42-7.2-5 and, starting in 2020, the report must include: expenditures, including administrative expenses, outcomes and utilization rates by population and sub-population served (e.g. families with children, persons with disabilities, children in foster care, children receiving adoption assistance, adults ages 19 to 64, and the elderly); expenditures, outcomes and utilization rates by each state department or other municipal or public entity receiving federal reimbursement under Medicaid; and expenditures, outcomes and utilization rates by type of service and/or service provider.

The annual report, due by September 15, is also required to show separate reporting of expenditures by mandatory and optional populations receiving mandatory and optional services for each state agency receiving Medicaid funds.

The following table shows both the mandatory and optional benefits provided through the state's Medicaid program for acute care services. Acute care services are direct medical benefits provided to eligible individuals, including doctor visits, hospital services, rehabilitation, and prescription coverage.

| Acute Care Benefits | |
|---|---|
| **Mandatory** | **Optional** |
| Physician services | Prescriptions |
| Lab and X-ray | Rehabilitation and other therapies |
| In/outpatient hospital services | Clinical services |
| Early, Periodic, Screening Diagnostic and Treatment (EPSDT) services | Dental, dentures, prosthetic devices and eyeglasses |
| Family planning services and supplies | Case management |
| Federally qualified health centers and rural health clinic services | Durable medical equipment |
| Nurse midwife as state law permits | Tuberculosis-related services |
| Certified pediatric and family nurse practitioner services | Medical remedial care provided by other licensed professionals |

In addition, the next table includes both the mandatory and optional benefits provided through the state's Medicaid program for long term care and home and community care services.

| Long Term Care Benefits | |
|---|---|
| **Mandatory** | **Optional** |
| **Institutional** | |
| Nursing facility services for those 21 or older needing that level of care | Intermediate Care Facility for the Developmentally Disabled (ICF/DD) |
| | Individuals 65 or older in an institute of mental disease |
| | Inpatient psychiatric hospital service for those under 21 |
| **Home and Community Care Services** | |
| Home health care services for those entitled to nursing home care | Home- and community-based care/other home health care |
| | Targeted case management |
| | Hospice/personal care |
| | Respiratory care services for ventilator dependent individuals |
| | PACE Program |

## Programs and Services

The state provides medical benefits, long-term care services, residential services and other programs to qualified individuals. These programs are described in the sections that follow.

### *Medical Benefits*

**RIte Care/RIte Share.** The RIte Care program provides medical benefits to eligible children and their parents, with federal mandates ensuring coverage for specific low-income populations. Rhode Island extends benefits to children from families earning up to 250 percent of the poverty level (for example, a family of four with an income that does not exceed $80,375) and to parents if the family income is at or below 138 percent of poverty (for that same family of four, an income that is not above $44,367). The state also implemented an income verification method under the Affordable Care Act, which slightly increased the income threshold for children to 261 percent of poverty while keeping the parent's threshold the same.

RIte Share participants can receive RIte Care while having access to employer-sponsored insurance, where the state covers certain costs. Legislation enacted by the 2019 Assembly requires a plan to identify Medicaid-eligible individuals with employer insurance to boost enrollment, which declined after the launch of the Unified Health Infrastructure Project. The most recent figures indicate enrollment levels significantly lower than the pre-implementation numbers. Additionally, there are new reporting requirements for evaluating employer-sponsored plans for cost-effectiveness in RIte Share, discussed in the next section.

The FY 2025 enacted budget included two new positions and converted three contractors for a total of five positions to increase enrollment in the premium assistance program. The budget assumes savings of $1.3 million, including $0.6 million from general revenues, and projected an increase of 1,500 individuals enrolled in the program. The November Caseload Estimating Conference estimate assumes savings of $0.6 million for FY 2025 and $4.1 million for FY 2026 based on updated timeline to implement the proposal. The November 2024 caseload testimony reported enrollment of about 1,600 for FY 2025 and 2,800 for FY 2026.

**RIte Share Outreach and Reporting.** Prior to the September 2016 launch of the Unified Health Infrastructure Project (UHIP), about 8,400 individuals were covered through RIte Share, which declined to 2,000 by November 2020. Following a proposal from Governor Raimondo concerning a new fee for large

employers with Medicaid-covered workers, testimonies revealed employers were often unaware of their employees' RIte Care status.

In 2019, the Assembly required the Executive Office to present a plan by October 1, 2019, aimed at revisiting the RIte Share program and enhancing enrollment. This led to ongoing monthly reports beginning January 2020 detailing access to third-party insurance and RIte Share enrollment. Under current law, enrollment in RIte Share is mandatory for anyone over 19, and failure to enroll can result in the termination of Medicaid eligibility for adults, although children retain their RIte Care coverage.

Governor Raimondo's FY 2021 budget suggested significant operational changes to RIte Share, including penalties for employers not providing employee-specific information on Medicaid eligibility. However, the Assembly did not adopt this proposal due to the impact of COVID-19 on employment and delays in budget enactment.

Governor McKee proposed similar changes in FY 2022 with anticipated savings, but the Assembly only required reports on cost-effective employer-sponsored plans. The January 2025 report indicated 403 employers with 100-299 employees, of which 93 participated, and 143 employers with 300 or more employees, of which only 66 participated as of November 2023. Notably, the report lacked specific details on which employer-sponsored health plans met cost-effectiveness criteria, focusing instead on aggregated data.

**RIte Share Cost Sharing Requirement.** RIte Share recipients with annual incomes above 150 percent of federal poverty pay a monthly cost sharing requirement that is no more than five percent of their annual income. The following chart shows the three separate payments based on a family's annual income, approximately three percent.

| RIte Share Co-Pays | |
|---|---|
| **Poverty Level** | **Current Payments** |
| 150% up to 185% | $61 |
| 185% up to 200% | $77 |
| 200% up to 250% | $92 |

The 2013 Assembly eliminated the monthly cost sharing requirement for families whose children receive coverage through RIte Care so that a family receiving coverage through the Exchange will not have two monthly premiums: one for the child(ren) in RIte Care and the monthly cost for commercial health coverage.

**Extended Family Planning.** The state provides extended family planning services to post-partum women with an income at or below 250 percent of poverty for up to 24 months if the mother loses RIte Care coverage within 60 days after having a child.

**Foster Care.** The state provides RIte Care benefits to a child in a foster care placement. The state does not provide benefits to the biological parent or the foster parent. The child is also covered by Medicaid if determined to be eligible for disability through the Supplemental Security Income program.

**Adoptive Assistance.** The state provides RIte Care benefits to a child in adoptive assistance. The child is also covered by Medicaid if determined to be eligible for disability through the Supplemental Security Income program.

**Children with Special Health Care Needs - Katie Beckett Option.** The state chooses to provide home care and other services to children under the age of 18 who would require an institutional level of care. The income eligibility is based on the child's income and not the family's income. States can also choose to

provide this service as a waiver, which would include a limited number of placements, or as an option under the Medicaid state plan, which is not limited. Rhode Island provides the services under the state plan option allowing for an unlimited number of program participants.

**Early Intervention.** The state provides services to children from birth to age three who have presented with a disability through the early intervention program. The services include physical, speech and occupational therapies.

**Rhody Health Partners.** For adults who are disabled but not receiving Medicare, the state provides medical benefits through Rhody Health Partners. This is a managed care system with plans through either Neighborhood Health Plan of Rhode Island, UnitedHealthcare or Tufts.

**Rhody Health Options.** For adults who are eligible for both Medicare and Medicaid, the state contracts with Neighborhood Health Plan of Rhode Island to manage the acute care and long-term care services for these individuals through its Integrity program.

**Fee-for-Service System.** Individuals who are eligible for both Medicare and Medicaid, known as dual eligibles, receive medical benefits through the traditional fee-for-service system.

**Telemedicine Services.** The Centers for Medicare and Medicaid Services permit states broad flexibility to cover telehealth services through the Medicaid program such as telephonic, video technology commonly available on smart phones and other devices. As a result, a state does not need federal approval to reimburse providers for telehealth services in the same way or pay at the same rate that it pays for face-to-face services.

Governor Raimondo signed an Executive Order that allowed health care providers to be reimbursed by health insurers for telemedicine services during the public health emergency. For services delivered by in-network providers, the rates paid can be no lower than if the services had been delivered through traditional (in-person) methods. This action suspended the prohibition for this activity included in Rhode Island General Law, Section 27-81-4(b). The Assembly enacted 2021-H 6032, Substitute A, as amended, signed by the Governor on July 6, 2021, to require coverage for telemedicine services in certain circumstances for commercial insurers and the Medicaid program at the same rates as face-to-face visits. The Office of the Health Insurance Commissioner promulgated the necessary rules and regulations.

### *Long-Term Care Services*

**Nursing Homes.** The state reimburses nursing homes that provide long-term residential care to elderly and disabled individuals who require a nursing home level of care.

**Hospice Services.** Hospice services are provided to the terminally ill if there is a medical prognosis that life expectancy is six months or less. Services are provided in either the home setting, a nursing home, or other institutional setting.

**Assisted Living Facilities.** The state provides eligible residents access to assisted living facilities, a less expensive alternative to residing in a nursing home. Individuals can access this option, available through the Medicaid Waiver.

**Home and Community Care Services.** Through the Medicaid Waiver, the state provides home care and community care services to allow individuals to remain in their home instead of moving into a nursing home.

**Eleanor Slater Hospital.** Eleanor Slater Hospital provides long-term care for individuals with disabilities and psychiatric patients. The hospital, comprising the Zambarano and Cranston campuses, faced

compliance issues with Medicaid billing, particularly in how psychiatric and forensic patients were categorized. As of October 25, 2022, the Benton facility for forensic patients became a separate entity called the Rhode Island State Psychiatric Facility.

Key issues included non-compliance with federal rules about the patient mix (which led to the designation as an Institute of Mental Disease) and improper billing for forensic patients. Following guidance from the Centers for Medicare and Medicaid Services, the state amended its Medicaid billing practices. Over the years, these compliance issues resulted in significant revenue losses totaling over $200 million due to the need to utilize general revenues in place of the loss of Medicaid funding.

Governor Raimondo and later Governor McKee proposed budgets to address facility needs, including a $64.9 million proposal for a new nursing facility, which the Assembly did not approve. For FY 2023, Governor McKee included funding for a new 110-bed long-term care facility and finalized the separation of the Benton facility into its own fully funded psychiatric facility. The Governor's FY 2026 recommendation for the new facility includes $197.1 million, which is $90.0 million or 84.0 percent more than the approved plan. It assumes that the Assembly will eventually approve the newly proposed debt to supplement current pay-go allocations. However, the Governor's budget does not contain the debt approval for Assembly consideration; it is unclear how the project can proceed as scheduled without an approved plan for updated costs.

### *Residential Services and Other Programs*

**Foster Care.** The state provides foster care services to children in its custody.

**Group Homes.** The state provides placement in group home settings to children in its custody.

**Bradley Hospital Psychiatric Hospitalization.** The state provides short-term treatment and crisis stabilization for children in acute distress, comprehensive evaluations, and long-term treatment. The state pays for psychiatric hospitalization services for Medicaid-eligible children and children who are uninsured at the Emma Pendleton Bradley Hospital in East Providence.

**Bradley Hospital Group Homes.** There are five group homes that are run by Bradley Hospital for children ages 4 to 21, located in East Providence (Rumford House and Swan House), East Greenwich (Greenwich House), North Providence (Hill House), and Warwick (Heritage House).

**HIV Treatment Services.** The state provides treatment and supportive services to HIV positive individuals who are uninsured and with income up to 400 percent of poverty. As of January 1, 2014, individuals are either eligible for the Medicaid expansion program or benefits through the Exchange. Benefits will still be provided using the Ryan White federal grant and any rebate funding the state receives from drug purchases through that grant.

**Mental Health Treatment Services.** The state provides mental health treatment services through the Medicaid waiver. For Medicaid-funded services, managed care organizations must adhere to the requirement of the Mental Health Parity and Addiction Equity Act of 2008, which was later amended by the Affordable Care Act.

**Substance Abuse Treatment Services.** As an option under Medicaid, states can also choose to provide substance abuse treatment services to Medicaid-eligible individuals. For Medicaid-funded services, managed care organizations must adhere to the requirement of the Mental Health Parity and Addiction Equity Act of 2008, which was later amended by the Affordable Care Act.

**Conflict-Free Case Management Services.** Federal changes require that person-centered planning and

conflict-free case management services be provided independently from the agency providing the direct service. This includes Medicaid beneficiaries who receive long-term services and supports in a home- or community-based setting. Currently, direct services are determined by community-based agencies through a case management process, which may result in those services being provided by the same agency. Individuals affected by this include the elderly and disabled in the Executive Office of Health and Human Services and the Department of Human Services' Office of Healthy Aging. Case management services provided through the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals' Division of Developmental Disabilities must also be conflict-free.

The Assembly adopted Section 7 of Article 9 of 2023-H 5200, Substitute A, as amended, to direct the Executive Office of Health and Human Services to establish a conflict-free case management system by January 1, 2024, for individuals receiving home and community-based services through the Medicaid program. This is required to comply with federal regulations that require that person-centered planning and case management services be provided independently from the agency providing the direct service to avoid a conflict of interest.

Funding was initially included in the FY 2024 budget to cover the cost for half a year assuming the January 1, 2024 start date. The Executive Office reported at the May 2024 Caseload Estimating Conference that it delayed the planned implementation and instead would have a phased approach starting in April 2024 with full enrollment assumed in early FY 2026. At the November 2024 Caseload Estimating Conference, adopted funding for medical benefits for FY 2025 includes $6.4 million, of which $2.8 million is from general revenues and $20.3 million, including $8.7 million from general revenues for FY 2026.

**Certified Community Behavioral Health Clinics.** The Assembly authorized the Executive Office of Health and Human Services to submit a state Medicaid plan amendment to establish certified community behavioral health clinics in accordance with the federal model. There is also a $30.0 million appropriation from State Fiscal Recovery funds to support the infrastructure needed to expand the number of clinics and assist with the rate reimbursement structure tied to the federal model. The Executive Office spent $21.8 million in FY 2023 and FY 2024. The Governor's budget includes $7.0 million for FY 2025 and $0.2 million for FY 2026. The total expenses are $29.0 million for the clinics, with the Governor shifting $1.0 million to another project in the Department of Human Services.

The Assembly enacted Section 4 of Article 12 of 2022-H 7123, Substitute A, as amended, to authorize the change to the state Medicaid plan, and the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals defined additional criteria for certification and services provided. During FY 2023, there were requirements to use the appropriate purchasing process for any organizations wanting to participate in the program and to submit cost reports developed by the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to the Executive Office. The reports must include the cost of providing the required services. The Department and Executive Office had to prepare an analysis of the proposals, determine how many organizations could be certified, and the cost for each one. Finally, the Executive Office had to apply for the federal Certified Community Behavioral Health Clinics Demonstration Program if another round of funding becomes available. There was another round of funding, which the state applied for and received approval.

The 2023 Assembly approved legislation delaying implementation from July 1, 2023, to February 1, 2024. It also repealed the deadlines for organizations to submit their cost reports and the state agencies to complete the required analyses for the number and cost for each clinic.

| Certified Community Behavioral Health Clinics - Federal Model | | | |
|---|---|---|---|
| Benchmark | Date | Action Completed | Section 8 |
| Engage with the Division of Purchases to determine the appropriate process for organizations that want to participate | August 1, 2022 | Yes | Retains the deadline |
| Organizations will submit cost reports developed by the Dept. of BHDDH to EOHHS that includes costs for required services | November 1, 2022 | No | Repeals the deadlines |
| BHDDH, with EOHHS, will prepare an analysis of the proposals and determine how many organizations can be certified with the cost for each one | January 15, 2023 | No | |

The FY 2024 final budget included $0.6 million, including $0.3 million from general revenues, for one new position and three contractors to support the initiative. The Governor proposed legislation in his budget to extend the February 1, 2024 start date to July 1, 2024, and again to October 1, 2024, or FY 2025. Even though the Assembly did not change the start date in the current law, the program started on October 1. The November Caseload Estimating Conference estimated $122.8 million for FY 2025 and $193.5 million for FY 2026.

As noted, the state applied for and was awarded a four-year Medicaid demonstration grant through the Centers for Medicare and Medicaid Service and the Substance Abuse and Mental Health Services Administration, effective October 1, 2024, that provides enhanced Medicaid rates for services provided through the initiative. For FY 2025 and FY 2026, the general revenue savings total $12.7 million and $19.8 million, respectively.

**Adults with Developmental Disabilities.** States are mandated to provide Medicaid-funded medical benefits to developmentally disabled adults who require a nursing home level of care and to those who are Supplemental Security Income recipients. The state operates a state-run system for about 100 adults with developmental disabilities and the remaining 3,800 individuals receive residential and community-based services through private developmental disability organizations.

Services provided under the Medicaid Waiver are optional with mandated medical benefits being paid for through the Executive Office of Health and Human Services' budget. The federal regulations governing the waiver mandate that in order to receive services a person must meet three eligibility criteria: diagnostic, functional and financial.

Medicaid-funded services, provided through the waiver, for this eligible population include residential care, day programming and supportive services. The Assembly adopted Section 7 of 2018-H 7200, Substitute A, as amended, to update the Medicaid waiver to reflect its current practice for services to developmentally disabled adults.

For an individual to meet the *diagnostic* criteria, he or she must have mental retardation, defined as an intelligence quotient that is 70 or less, or another type of developmental disability. States have the ability to define developmental disabilities differently using a more expansive definition and consequently serve different populations. Rhode Island uses an expanded developmental disability definition. Section 40.1-21-4.3 of the Rhode Island General Laws defines a developmentally disabled adult as someone who is 18 years of age or older, not under the jurisdiction of the Department of Children, Youth and Families, and who is either a developmentally disabled adult or is a person with a severe, chronic disability.

*Financial* eligibility requires a person to be income eligible for services. In most cases, the only source of income for individuals with developmental disabilities is the $954 monthly Supplemental Security Income check, which places them below the 135 percent of the federal poverty level required for the program.

*Functional* eligibility requires an individual to have a substantial functional limitation in three or more of the following life activities: self-care, receptive and expressive language learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency.

The following table shows the tiers and description of options and supports.

| DD/ID Needs-Based Service Tier Classifications and Options | | |
|---|---|---|
| **Tier** | **Service Options** | **Available Supports** |
| **Tier D and E (Highest): *Extraordinary Needs*** | • Living with Family/Caregiver<br>• Independent Living<br>• Shared Living<br>• Community Support Residence<br>• Group Home/Specialized Group Home | • Community Residential Support or Access to Overnight Support Services<br>• Integrated Employment Supports<br>• Integrated Community and/or Day Supports<br>• Transportation |
| **Tier C (Highest): *Significant Needs*** | • Living with Family/Caregiver<br>• Independent Living<br>• Shared Living<br>• Community Support Residence<br>• Group Home | • Community Residential Support or Access to Overnight Support Services<br>• Integrated Employment Supports<br>• Integrated Community and/or Day Supports<br>• Transportation |
| **Tier B (High): *Moderate Needs*** **Tier A (High): *Mild Needs*** | • Living with Family/Caregiver<br>• Independent Living<br>• Community Support Residence<br>• Shared Living**<br>• Group Home* | • Access to Overnight Support Services<br>• Integrated Employment Supports<br>• Integrated Community and/or Day Supports<br>• Transportation |

**Tier A or B individuals will have access to residential services in a group home if they meet at least one defined exception*
***Tier A will have access to shared living services if they meet at least one defined exception*

Recent Changes. The Assembly adopted Section 10 of 2023-H 5200, Substitute A, as amended, for the Executive Office of Health and Human Services to seek federal approval to allow individuals with developmental disabilities who enter an acute care facility, such as a hospital, to still have access to their personal care attendants. That section also includes the necessary language to seek federal approval to allow parents and other relatives to be paid to provide services for individuals with developmental disabilities receiving services through the community-based system. This makes permanent the opportunity allowed during the pandemic for this payment, also referred to as Appendix K. The Department is required to report the number of participants and expenses in its monthly caseload report. As noted, approval of the waiver has been delayed, which affects this change.

## Department of Justice Consent Decree

On January 14, 2014, Rhode Island entered into an interim settlement with the federal government and on April 8, 2014, signed a consent decree to settle United States v. State of Rhode Island and City of Providence, which addressed the statewide day activity service system for individuals with intellectual and developmental disabilities. State agency parties to the agreement are: Department of Behavioral Healthcare, Developmental Disabilities and Hospitals, Department of Human Services, Department of Elementary and Secondary Education, and the Office of the Attorney General. The Department of Justice finding applies to those who meet the state's definition of an individual with a disability pursuant to the Rhode Island General Laws. This was a ten-year consent decree with the state exiting it on June 30, 2024, if in compliance with all requirements. On October 2, 2023, Judge McConnell issued a court order for additional oversight until June 30, 2026 and noted that he would not be holding periodic public hearings but is available if needed by the court monitor.

A court monitor, initially Charles Moseley and later Dr. A. Anthony Antosh, oversees compliance, including training and outreach programs, and investigates the state's adherence to the decree. The state

established an $800,000 Workshop Conversion Trust Fund to support agencies transitioning to supported employment, involving nine participating agencies.

Additionally, an employment-first task force was created to ensure funding is available for integrated services instead of segregated programs. Court orders from Judge McConnell, starting in February 2020, mandated ongoing reviews and the development of a three-year budget to address workforce issues, align with federal Medicaid standards, and enhance individualized service plans.

Governor McKee also proposed legislation in Sections 5 and 6 of Article 3 of 2021-H 6122 to add expenses for the community-based system for adults with developmental disabilities to the semi-annual medical assistance and public assistance caseload conference, effective on July 1, 2022. The Assembly included Sections 6 and 8 of Article 3 of 2021-H 6122, Substitute A, as amended, to make the change and added that the Executive Office of Health and Human Services provide direct assistance to the Department of Behavioral Healthcare, Developmental Disabilities and Hospitals to facilitate compliance with reporting requirements and preparation for the caseload conferences. The November 2021 Caseload Estimating Conference was the first one that included the Department.

The state's "Action Plan" that addressed compliance with the consent decree, which included increasing the reimbursement rates for direct support professionals to an average of $20 an hour is shown in the following table.

| Action Plan | Description | Status |
|---|---|---|
| Rate Review | Completed by 12/2022 & recommended changes in the FY 2024 budget | Review Done & Funded in FY 2024 |
| DSP Wages | FY 2023: $18/hour<br>FY 2024: $20/hour<br>Both years: Overnight & supervisor wages will increase proportionally | Funded in FY 2023 and FY 2024 |
| Transformation Fund | $12.0 million to be used for integrated day activities and supported employment services | Funded |
| Technology | $2.0 million for technology purchases (example, iPads) | |

Pandemic Impact. The public health emergency limited the ability of the agencies to provide community-based services to individuals outside of their residences. Individuals living either in a 24-hour group home, shared living, or an apartment or home with family, have stayed home. This meant that the providers could not be reimbursed for day activities. The state took several actions to address the effect on providers. For FY 2020, the Department provided a temporary ten percent rate increase totaling $3.0 million and retainer payments totaling $15.6 million. The FY 2021 budget included $13.0 million for one-time payments to 40 agencies to be passed through to direct support staff who make less than $20 an hour and to supplement the response to the public health emergency by addressing any business interruptions, including loss of revenue.

Conflict-Free Case Management. The Assembly concurred with the Governor's requested amendment to add 18 positions and $1.9 million, including $1.0 million from general revenues for FY 2025, to serve as independent facilitators in the interim until the Executive Office has fully implemented conflict-free case management services, which includes this population.

## Human Service Agencies

The Executive Office of Health and Human Services is the umbrella agency for the four health and human service agencies, each analyzed separately in the *House Fiscal Advisory Staff Budget Analysis FY 2026*. The table shows services provided by population and agency responsible for the expenses.

| Programs | EOHHS | DHS | BHDDH | DCYF | DOH |
|---|---|---|---|---|---|
| **Medical Benefits** | | | | | |
| Children and parents | X | | | | |
| Elderly | X | | | | |
| Disabled and adults, without dependent children | X | | | | |
| **Residential and Other Services** | | | | | |
| Nursing and hospice services | X | | | | |
| Assisted living; home- & community-based services to the elderly | X | X | | | |
| Foster care and group home placements | | | | X | |
| Community-based services - developmentally disabled | | | X | | |
| Mental health and substance abuse treatment services | X | | | X | |
| Eleanor Slater Hospital | | | X | | |
| HIV surveillance and treatment services | X | | | | X |

Medical benefits are those primarily provided through the managed care plans, Neighborhood Health Plan of Rhode Island, UnitedHealthcare or Tufts Health Plan. Benefits include: doctor's office visits, prescriptions, lab tests, hospital and emergency care, drug and alcohol treatment, mental health services and referrals to specialists, funded through the Executive Office. The plans also pay for short-term and long-term residential treatment services for those with behavioral health issues and/or substance use disorders.

Residential and other community-based services are those provided outside medical benefits through the department's budgets.