# November 2025
# CASELOAD ESTIMATING CONFERENCE

Medical Assistance Testimony

OCTOBER 27, 2025

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# I. General Considerations

| Medical Benefits | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $3,321,048,695 | $1,220,192,908 |
| **FY 2025** | Revised Enacted | $3,617,238,872 | $1,339,773,272 |
| | Final | **$3,586,804,177** | **$1,322,446,504** |
| | *Surplus over Revised Enacted* | *$30,434,695* | *$17,326,768* |
| **FY 2026** | Enacted | $3,941,048,697 | $1,426,413,116 |
| | Current | **$3,903,200,000** | **$1,413,753,590** |
| | *Surplus over Enacted* | *$37,848,697* | *$12,659,526* |
| **FY 2027** | Current | **$3,980,400,000** | **$1,441,700,962** |

For FY 2026, Medicaid anticipates benefits expenditures of **$3.903 billion**, including **$1.414 billion in General Revenue (GR)**, among the Caseload Estimating Conference budget lines. This is a **$38.0 million (1.0%) surplus**, including a **$12.7 million GR (0.8%) surplus**, compared to the Enacted.

For FY 2027, Medicaid projects expenditures to increase by $77.2 million, or 2.0%, to **$3.980 billion**, including **$1.442 billion GR**.

**Table I-1** compares Medicaid's all funds closing position for FY 2025 and the revised forecasts for FY 2026 and FY 2027. The FY 2024 field in tables throughout the testimony represent the audited close. Based on the primarily fiscal close, Medicaid ended the prior fiscal year with a $17.3 million GR surplus, 1.3% of the FY 2025 Revised Enacted Budget.

**Table I-2** compares these estimates by fund source.

***Attachments 1a and 1b*** summarize Medicaid's current forecast by budget program/category and funding source and include a comparison against FY 2025 Final.

**Table I-3** shows Medicaid's revised FY 2026, average enrollment; a decrease of beneficiaries with Full Medical Assistance Benefits from **311,301** to **302,455**. This is a decline of 8,846 beneficiaries (2.8%), including 8,911 enrolled in managed care. The average monthly enrollment in FY 2027 is expected to decrease by an additional 8,383 beneficiaries, or 2.8%, to **294,072**.

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

Details of Medicaid's revised caseload forecast for FY 2026 and FY 2027 are included in ***Attachments 5b and 5c,*** respectively. Also included are historical caseload metrics in **Attachment 5a** and a new summary of month-end actuals in **Attachment 5d**. Trend assumptions are included in **Major Developments***.*

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **CEC Budget Line** | | | | | | | |
| Managed Care | $ 1,044,283,333 | ($697.4 M) | $ 1,117,462,318 | $ 1,106,800,000 | $10.7 M | $ 1,165,300,000 | $58.5 M |
| Rhody Health Partners | 301,555,968 | (273.9 M) | 341,201,948 | 336,700,000 | 4.5 M | 348,900,000 | 12.2 M |
| Rhody Health Options | 215,486,871 | 209.5 M | 220,353,823 | 242,700,000 | (22.3 M) | 247,800,000 | 5.1 M |
| Expansion | 717,473,870 | (468.9 M) | 730,790,208 | 741,500,000 | (10.7 M) | 701,600,000 | (39.9 M) |
| Hospitals - Regular | 341,190,603 | 696.4 M | 408,226,193 | 405,800,000 | 2.4 M | 402,700,000 | (3.1 M) |
| Hospitals - DSH | 27,646,654 | 283.8 M | 13,900,000 | 13,900,000 | 0.0 M | 13,900,000 | 0.0 M |
| Nursing and Hospice Care | 402,946,046 | (190.5 M) | 477,321,981 | 452,600,000 | 24.7 M | 477,500,000 | 24.9 M |
| Home and Community Care | 237,449,962 | 467.7 M | 293,779,386 | 284,600,000 | 9.2 M | 291,500,000 | 6.9 M |
| Pharmacy | 731,624 | 2.0 M | 7,800,000 | 1,500,000 | 6.3 M | 1,300,000 | (0.2 M) |
| Clawback | 92,702,111 | (0.5 M) | 96,400,000 | 94,600,000 | 1.8 M | 98,100,000 | 3.5 M |
| Other Services | 205,337,135 | 2.4 M | 233,812,840 | 222,500,000 | 11.3 M | 231,800,000 | 9.3 M |
| **Subtotal - CEC Benefits** | **$ 3,586,804,177** | **$30.4 M** | **$ 3,941,048,697** | **$ 3,903,200,000** | **$37.8 M** | **$ 3,980,400,000** | **$77.2 M** |
| Health System Transformation Project | 6,493,295 | (1.2 M) | 1,615,734 | 0 | 1.6 M | 0 | 0.0 M |
| Special Education | 33,201,305 | (3.8 M) | 29,450,000 | 45,400,000 | (16.0 M) | 45,400,000 | 0.0 M |
| ARPA HCBS Investments | 64,430 | (4.9 M) | 5,217,695 | 2,056,214 | 3.2 M | 0 | (2.1 M) |
| **Total - Benefits** | **$ 3,626,563,207** | **$20.5 M** | **$ 3,977,332,126** | **$ 3,950,656,214** | **$26.7 M** | **$ 4,025,800,000** | **$75.1 M** |

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Funding Source** | | | | | | | |
| General Revenue | $ 1,322,446,504 | $17.3 M | $ 1,426,413,116 | $ 1,413,753,590 | $12.7 M | $ 1,441,700,962 | $27.9 M |
| Federal Funds | 2,292,498,578 | 4.7 M | 2,539,897,062 | 2,527,481,410 | 12.4 M | 2,576,734,038 | 49.3 M |
| Restricted Receipts | 11,618,125 | (1.5 M) | 11,021,948 | 9,421,214 | 1.6 M | 7,365,000 | (2.1 M) |
| **Total - Benefits** | **$ 3,626,563,207** | **$20.5 M** | **$ 3,977,332,126** | **$ 3,950,656,214** | **$26.7 M** | **$ 4,025,800,000** | **$75.1 M** |

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Enrolled - Full Benefits:** | | | | | | | |
| Rite Care Core | 160,140 | -519 | 159,850 | 152,340 | -7,510 | 151,004 | -1,336 |
| Rite Care CSHCN | 9,739 | -7 | 9,906 | 9,686 | -220 | 9,853 | 167 |
| Expansion | 79,972 | 102 | 77,020 | 76,407 | -613 | 68,602 | -7,805 |
| Rhody Health Partners | 12,739 | -53 | 12,772 | 12,757 | -15 | 12,761 | 4 |
| Rhody Health Options (Phase II) | 11,422 | 17 | 11,269 | 11,788 | 519 | 11,377 | -411 |
| PACE | 432 | 3 | 459 | 465 | 6 | 486 | 21 |
| Rite Share | 1,395 | -5 | 2,049 | 1,971 | -78 | 2,474 | 503 |
| **Subtotal Enrolled** | **275,839** | **-462** | **273,325** | **265,414** | **-7,911** | **256,557** | **-8,857** |
| **Remaining in FFS - Full Benefits:** | | | | | | | |
| Children and Families | 2,643 | 69 | 2,009 | 1,946 | -63 | 1,587 | -359 |
| Children with Special Healthcare Needs | 1,503 | -38 | 1,556 | 1,378 | -178 | 1,418 | 40 |
| Expansion | 4,333 | -38 | 4,552 | 4,238 | -314 | 4,264 | 26 |
| Aged, Blind, and Disabled | 28,531 | -424 | 29,859 | 29,479 | -380 | 30,246 | 767 |
| **Subtotal Fee-for-Service** | **37,010** | **-431** | **37,976** | **37,041** | **-935** | **37,515** | **474** |
| **Grand Total - Full Benefits:** | **312,849** | **-893** | **311,301** | **302,455** | **-8,846** | **294,072** | **-8,383** |
| ***Composite PMPM*** | *$955* | *-$5* | *$1,055* | *$1,075* | *$20* | *$1,128* | *$120* |

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Other Capitated Arrangements:** | | | | | | | |
| Rite Smiles | 135,393 | -76 | 138,870 | 132,290 | -6,580 | 134,628 | 2,338 |
| Rite Care EFP | 2,090 | -8 | 2,155 | 1,577 | -578 | 980 | -597 |
| SOBRA | 4,319 | 105 | 4,207 | 4,679 | 472 | 5,082 | 403 |
| Transportation Broker | 310,279 | -1,665 | 309,941 | 299,979 | -9,962 | 289,924 | -10,055 |
| **Medicare Premium Payments:** | | | | | | | |
| Part A (Hospital) | 3,469 | 69 | 3,601 | 3,629 | 28 | 3,733 | 104 |
| Part B (Professional Services) | 40,636 | -45 | 41,502 | 41,375 | -127 | 41,642 | 267 |
| Part D (Prescription Drugs) | 38,947 | 588 | 39,203 | 38,501 | -702 | 38,664 | 163 |

# II. Major Developments

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

## A. Summary of FY 2025 Fiscal Close

Table II-1. Comparison of Revised and Fiscal Close, FY 2025 – by budget line

| | SFY 2025 | | |
|---|---|---|---|
| | Revised | Final | Surplus/ (Deficit) |
| **CEC Budget Line** | | | |
| Managed Care | $ 1,037,600,000 | $ 1,044,283,333 | ($6.7 M) |
| Rhody Health Partners | 311,400,000 | 301,555,968 | 9.8 M |
| Rhody Health Options | 212,400,000 | 215,486,871 | (3.1 M) |
| Expansion | 705,100,000 | 717,473,870 | (12.4 M) |
| Hospitals - Regular | 346,900,000 | 341,190,603 | 5.7 M |
| Hospitals - DSH | 27,638,872 | 27,646,654 | (0.0 M) |
| Nursing and Hospice Care | 425,000,000 | 402,946,046 | 22.1 M |
| Home and Community Care | 248,600,000 | 237,449,962 | 11.2 M |
| Pharmacy | 2,700,000 | 731,624 | 2.0 M |
| Clawback | 92,200,000 | 92,702,111 | (0.5 M) |
| Other Services | 207,700,000 | 205,337,135 | 2.4 M |
| **Subtotal - CEC Benefits** | **$ 3,617,238,872** | **$ 3,586,804,177** | **$30.4 M** |
| Health System Transformation Project | 5,274,773 | 6,493,295 | (1.2 M) |
| Special Education | 29,450,000 | 33,201,305 | (3.8 M) |
| ARPA HCBS Investments | (4,866,340) | 64,430 | (4.9 M) |
| **Total - Benefits** | **$ 3,647,097,305** | **$ 3,626,563,207** | **$20.5 M** |

Table II-2. Comparison of Revised and Fiscal Close, FY 2025, FY 2025 – by fund source

| | Revised | Final | Surplus/ (Deficit) |
|---|---|---|---|
| **Funding Source** | | | |
| General Revenue | $ 1,339,773,272 | $ 1,322,446,504 | $17.3 M |
| Federal Funds | 2,297,224,887 | 2,292,498,578 | 4.7 M |
| Restricted Receipts | 10,099,146 | 11,618,125 | (1.5 M) |
| **Total - Benefits** | **$ 3,647,097,305** | **$ 3,626,563,207** | **$20.5 M** |

Medicaid ended FY 2025 with a surplus of $20.5 million -approximately 0.6% of Medicaid's $3.647 billion benefits' budget. This included a GR surplus of $17.3 million (1.3%) against a budget of $1.340 billion.

The major offsetting drivers of the modest surplus as reflected in the FY 2025 preliminary closing are summarized in **Table II-3**, below, grouped by favorable and (unfavorable) variances. Positive amounts indicate a surplus and therefore final expenditures that are lower than included in the FY 2025 Revised. Negative amounts indicate a deficit and spend higher than funded amounts. The single largest source of variance to FY 2025 Revised is EOHHS' estimate of fee for service activity, which in FY 2026 is also overstated and contributing factor to Medicaid's surplus; however, in reviewing FY 2024 accruals, it appears the FY 2025 surplus in nursing homes is more due to an overstatement of the prior year's accrual and not EOHHS overestimating FY 2025 expenditures. Drug rebates also exceeded estimates by a meaningful amount, although some of the variance appears attributed to prior period collections that are not fully captured in the Medicaid's methodology for forecasting rebates. Similarly, the SOBRA deficit is exclusively attributed to an unusual lag in claims submission for births at the end of FY 2024 that were neither fully captured in Medicaid's original accrual or subsequent adjustment in December.

Table II-3. Summary of major drivers of variances between Revised and Fiscal Close, FY 2025 (excludes non-CEC)

| | FY 2026: | | |
|---|---|---|---|
| | Enacted | Current | Surplus/(Deficit) |
| **Favorable Variances** | | | |
| Rite Care | $944.0 M | $918.9 M | $25.1 M |
| Nursing Home & Hospice FFS | $477.3 M | $452.6 M | $24.8 M |
| HCBS FFS | $266.0 M | $256.8 M | $9.2 M |
| Other FFS (Excl. NH/HCBS/NICU) | $343.2 M | $306.4 M | $36.8 M |
| RHP | $373.8 M | $369.0 M | $4.9 M |
| Medicare Premium Payments | $214.3 M | $214.1 M | $0.2 M |
| Drug Rebates | ($155.0 M) | ($156.1 M) | $1.0 M |
| PACE/Rite Smiles/NEMT/Rite Share | $102.3 M | $99.0 M | $3.2 M |
| **Subtotal Favorable** | **$2,566.0 M** | **$2,460.7 M** | **$105.2 M** |
| **Unfavorable Variance** | | | |
| RHO II | $217.5 M | $239.7 M | ($22.2 M) |
| Expansion | $696.2 M | $710.1 M | ($14.0 M) |
| Risk Share | $0.0 M | $10.4 M | ($10.4 M) |
| SOBRA | $88.7 M | $97.3 M | ($8.6 M) |
| Supplemental Hospital Payments | $363.8 M | $366.1 M | ($2.2 M) |
| NICU FFS | $32.1 M | $33.0 M | ($0.9 M) |
| Other/Miscellaneous | ($23.2 M) | ($14.2 M) | ($9.0 M) |
| **Subtotal Unfavorable** | **$1,375.1 M** | **$1,442.3 M** | **($67.2 M)** |
| **Total** | **$3,941.0 M** | **$3,903.0 M** | **$38.0 M** |
| **By Funding Source:** | | | |
| General Revenue | $1,426.4 M | $1,413.7 M | $12.7 M |
| Federal Funds | $2,507.3 M | $2,482.0 M | $25.3 M |
| Restricted Receipts | $7.4 M | $7.4 M | ($0.0 M) |
| **Total** | **$3,941.0 M** | **$3,903.0 M** | **$38.0 M** |

***Potential Adjustments to FY 2025 Preliminary Close***

In preparing for its November caseload, EOHHS identified potential adjustments that it will submit to the RI Auditor General for consideration as part of their prior year adjustments. The first includes an adjustment that should not have an overall impact on federal funds and general revenues; but would change specific budget line positions. Specifically, certain transactions associated with one of the quarterly payments for the Hospital State Directed Payments (SDP) were incorrectly posted to the line sequences of the managed care products to whom the original payments were made—i.e., **Managed Care**, **Expansion**, and **Rhody Health Partners**—instead of the SDP lines sequences included in **Hospitals – Regular** and need to be properly reversed and accounted for in the correct line sequences. The net result is an understatement of about $11.0 million in **Hospitals – Regular** and corresponding overstatement across the other budget lines.

A second adjustment is for the reclassification of certain Expansion-eligible beneficiaries as previously eligible for Medicaid under non-MAGI rules. Such beneficiaries are ineligible for 90 percent federal participation and instead should be claimed at the regular FMAP. EOHHS generally completes a year-end journal entry to change the relevant matching rate; but did not complete this in June 2025. This will have a negative marginal impact on the current GR surplus for FY 2025, reducing but not eliminating the surplus.

In each of the following sections, EOHHS establishes the FY 2025 baseline expenditures by subcategories that is reflective of the activities that incurred within the fiscal year. These baselines use the latest data available to EOHHS and therefore reflect the adjustments noted above. The FY 2025 incurred financial transactions are reflected in each of the budget line sections by separating out prior period activities and updates and/or errors in EOHHS' accruals that may impact the preliminary final. These estimates are intended to offer a basis for a reasonable comparison for EOHHS' revised estimates for FY 2025. As necessary, EOHHS offers additional commentary to support each of the summary tables.

## B. Medicaid's Revised Forecast Compared to FY 2026 Enacted

Medicaid's revised fiscal estimate for FY 2026 is generally consistent with Enacted. Despite the overall favorable variance of 1.1%, there are significant offsetting fiscal changes that are outlined below. **Table II-4** summarizes the

FY 2026 variances. The major drivers of changes between revised FY 2026 and FY 2027 are summarized in **Figure II-1**. Finally, **Table II-5** summarizes the overall composite price-volume variance of Medicaid's revised estimate for FY 2026 compared to the May CEC and FY 2027 estimates over FY 2026.

***Overall reduction in managed care enrollment and premium payments***

Managed care enrollment is down compared to assumed enrollment reflected in Enacted: 273,325 as forecasted in May CEC compared to revised forecast of 265,314. In general, this caseload-driven decline in expenditure is captured in **Table II-4** and the summary calculation of a $119.2 million decrease in volume-related expenditures. This value represents the overall change in caseload between Enacted and current multiplied by overall composite PMPM for the entire Medicaid benefits' program as previously calculated in Enacted (i.e., (Enacted Member Months - Current Member Months) × Enacted PMPM)

Over 90 percent of the net decrease reflects a 7,510 decline in average monthly beneficiaries enrolled in Rite Care Core. Even with a composite rate increase of 6.2% for Rite Care Core and 12.9% for Rite Care CSHCN in FY 2026 (when compared to the revised FY 2025 rates effective October 2024), total non-SOBRA managed care payments for Rite Care remain $29.0 million below budget. This decrease in overall enrollment, in general, and Rite Care enrollment, specifically, carries over to total spending paid to UnitedHealthcare for Rite Smiles and MTM for non-emergency transportation broker services, where actual PMPMs remain unchanged from assumptions for these FY 2026 contracts as included in Enacted.

Premium payments are also $5.2 million lower than budgeted in Rhody Health Partners. But this largely attributed to a change in the enrollment mix rather than the net 15 beneficiary reduction in average monthly enrollment.

In contrast, while enrollment in the Expansion product is down modestly compared to Enacted, with average monthly enrollment down 613 (0.8%), total premiums are up by $11.7 million (1.7%) because current rates reflect price increases exceeding the 5.0% price factor previously assumed.

***Inclusion of Risk Share***

Although the rates are actuarially sound and a recent review of the health plans emerging experience by the State and its certifying actuary did not necessitate any adjustment to the FY 2026 rates, Medicaid believes that uncertainty over plan performance and national trends supports the inclusion of a potential liability for FY 2026. As such, Medicaid has included risk share payments totaling $10.5 million across the managed care products, equivalent to 0.5% of total premium payments. No provision for risk share is included in Rhody Health Options and this liability is included for the current fiscal year only.

***Reduced FFS spending***

Overall fee for service spending is below Enacted and Medicaid's prior estimate in its May 2025 testimony.

The $24.8 million reduction in nursing home and hospice spending follows a similar surplus against these budget items in FY 2025. The lower spending level is maintained in FY 2026 by the decision to reduce the utilization factor applied to this category of service–replacing the previously assumed 2.5% growth factor with a more modest 1.5% growth factor. With over 1,750 Rhode Islanders being admitted or re-admitted to a nursing home every month, there is some risk with this reduction, but the change in assumption is consistent with the general stability among nursing home authorizations. This stability is also a result of the continued investments by the State into home and community-based services, that have seen significant growth in terms of utilization and overall spending.

Additional information on LTSS spending is provided in the **Nursing and Hospice Care** and **Home and Community Care** sections.

In general, the "Other FFS (excl. NH/HCBS/NICU)" is difficult to forecast as it, in large part, reflects cost incurred on behalf of Medicaid beneficiaries prior to their enrollment into managed care. Further, $9.1 million of this $36.5 million surplus is attributed to spending on Certified Community Behavioral Health Centers (CCBHC) that will be moved in-plan for Dual-eligible beneficiaries enrolled in the new Medicare Medicaid plan beginning January 2025. Previously, these costs were carved out of the CMS Demonstration and were budgeted to Other Services.

Table II-4. Summary of major drivers of variances between Nov CEC and Enacted, FY 2026 (excludes non-CEC)

| | FY 2026: Enacted | Current | Surplus/(Deficit) |
|---|---|---|---|
| **Favorable Variances** | | | |
| Rite Care | $944.0 M | $918.9 M | $25.1 M |
| Nursing Home & Hospice FFS | $477.3 M | $452.6 M | $24.8 M |
| HCBS FFS | $266.0 M | $256.8 M | $9.2 M |
| Other FFS (Excl. NH/HCBS/NICU) | $343.2 M | $306.4 M | $36.8 M |
| RHP | $373.8 M | $369.0 M | $4.9 M |
| Medicare Premium Payments | $214.3 M | $212.4 M | $2.0 M |
| Drug Rebates | ($155.0 M) | ($156.1 M) | $1.0 M |
| PACE/Rite Smiles/NEMT/Rite Share | $102.3 M | $99.0 M | $3.2 M |
| **Subtotal Favorable** | **$2,566.0 M** | **$2,459.0 M** | **$107.0 M** |
| **Unfavorable Variance** | | | |
| RHO II | $217.5 M | $239.7 M | ($22.2 M) |
| Expansion | $696.2 M | $710.1 M | ($14.0 M) |
| Risk Share | $0.0 M | $10.4 M | ($10.4 M) |
| SOBRA | $88.7 M | $97.3 M | ($8.6 M) |
| Supplemental Hospital Payments | $363.8 M | $366.1 M | ($2.2 M) |
| NICU FFS | $32.1 M | $33.0 M | ($0.9 M) |
| Other/Miscellaneous | ($23.2 M) | ($14.3 M) | ($8.9 M) |
| **Subtotal Unfavorable** | **$1,375.1 M** | **$1,442.2 M** | **($67.2 M)** |
| **Total** | **$3,941.0 M** | **$3,901.2 M** | **$39.8 M** |
| **By Funding Source:** | | | |
| General Revenue | $1,426.4 M | $1,414.7 M | $11.7 M |
| Federal Funds | $2,507.3 M | $2,479.2 M | $28.1 M |
| Restricted Receipts | $7.4 M | $7.4 M | ($0.0 M) |
| **Total** | **$3,941.0 M** | **$3,901.2 M** | **$39.8 M** |

Figure II-1. Major drivers of change between FY 2026 Nov CEC and FY 2027 Nov CEC

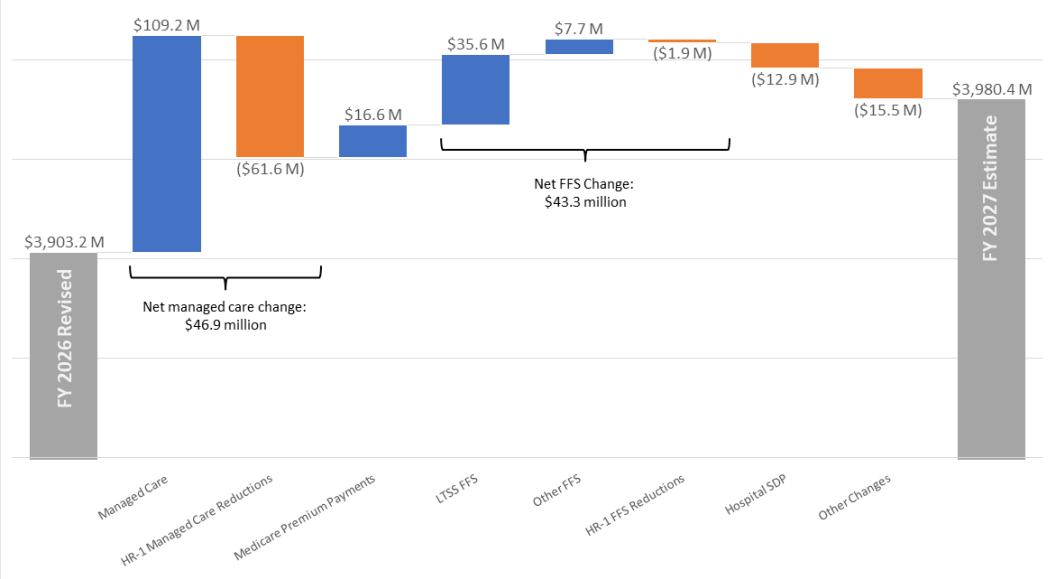



Table II-5 Summary of price-volume analysis, All Funds

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | ($20.1 M)<br>-0.6% | ($10.3 M)<br>-0.3% | ($30.4 M)<br>-0.8% |
| FY 2026 over FY 2025 | $435.6 M<br>12.6% | ($119.2 M)<br>-3.3% | $316.4 M<br>8.8% |
| FY 2026: Current over Enacted | $74.1 M<br>1.9% | ($112.0 M)<br>-2.8% | ($37.8 M)<br>-1.0% |
| FY 2027 over FY 2026 | $185.4 M<br>4.9% | ($108.2 M)<br>-2.8% | $77.2 M<br>2.0% |

## C. Caseload Growth and Trend Development

Rhode Island reached a peak enrollment of 373,325 beneficiaries with full Medicaid benefits in May 2023. The first closures associated with the State's Return to Normal Operations (RTNO) and resumption of redetermination took effect in April 2024. The data breach in December 2024 temporarily reversed the decline, but overall Medicaid enrollment continued to decline once the renewal activities were resumed and as of September 2025 was 302,927, 70,398 below the post-Covid peak.

Of significant note, caseload was below Medicaid's forecast in the last quarter of FY 2026. In May, Medicaid assumed that only 75% of the unanticipated growth between December 2024 and April 2025 (due to Rhode Island pausing renewals and post eligibility verification processes) would ultimately close. The volume of closures ultimately exceeded this estimate. Compared to Medicaid's prior forecast of 316,904, Rhode Island ended FY 2025 with total enrollment of 314,166. And among those enrolled across the managed care products, Medicaid's prior forecast overstated the June 2025 actuals by 1,442; the actual month-end snapshot was 276,142.

***Underlying Trend Factor***

Given the depressed baseline relative to prior estimate, Medicaid's prospective forecast assumes an underlying growth rate of 1.0% for FY 2026 and 1.5% throughout FY 2026. This is a modest decline from prior forecasts that have assumed growth rates between 1.5% and 2.5%, with variance by population – typically assuming a marginally higher growth rate among the MAGI-based eligibility groups compared the SSI- and LTSS-related eligibility groups. The current forecast applies the growth linearly across all eligibility groups and managed care products.

Ther rationale for this assumption is the recent negative trends experienced. While the resumption of renewals and post eligibility verification processes following the cyberattack in December 2024 led to an anticipated decline in enrollment, the decline was greater than anticipated, with enrollment as of September 2025 below the level seen in November 2024 (i.e., prior to the impact of the cyberattack and temporary increase in enrollment).

In general, this depressed caseload implies either the resiliency of Rhode Island's economy or the stability of Medicaid enrollment or both. Although, Medicaid does not presume the continuation of this negative trend from the perspective of its underlying caseload factor, overall enrollment is still anticipated to decline significantly in FY 2026 compared to FY 2025 and again in FY 2027 compared to FY 2026, albeit for two distinct reasons.

***Offsets to Underlying Trend***

The major reasons for Medicaid's prospective caseload decline are as follows:

- Enhanced Income Verification: An additional 5,491 beneficiaries—totaling 30,217 member months in FY 2026 and 32,964 member months in FY 2027—who will lose eligibility because of enhanced income verification checks. These closures are assumed to reflect a marginal increase in income-related closures beyond the status quo volume of closure activities that has long been associated with the existing use of State Wage Information Collection Agency (SWICA) data.
    - These additional reductions are spread out across the fiscal year, but from a modeling perspective are assumed to be effectively captured by the underlying trends that are now lower than they would otherwise be absent the use to the additional sources for income verification.
- Federal Changes in the House Reconciliation Bill Passed in July, H.R.-1: In FY 2027, a total of 30,917 current beneficiaries—accounting for a total 126,741 member months in FY 2027—are expected to lose eligibility due to federal regulatory changes related to immigration status or new community engagement requirements. See **Section H** below in the **Major Developments** for additional information on these federally mandated changes to eligibility.

**Figure II-2** puts Medicaid's current enrollment snapshot (as of September 2025) in context but comparing it to Rhode Island's pre- and post-Public Health Emergency Medicaid enrollment as well to the current fiscal year end snapshot and post HR-1 eligibility changes as of end of FY 2027.

**Figure II-3** shows the increase in enrollment and costs for the Cover All Kids program since its implementation in FY 2023.

**Figure II-4** compares Medicaid's current enrollment forecast to the Medicaid's prior forecast assumed in May as that served as basis for FY 2026 Enacted.

Medicaid's projections are in **Attachment 5b** and **Attachment 5c**. These reflect full-time equivalent beneficiaries and not distinct beneficiaries as they have been adjusted for partial month enrollment.

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

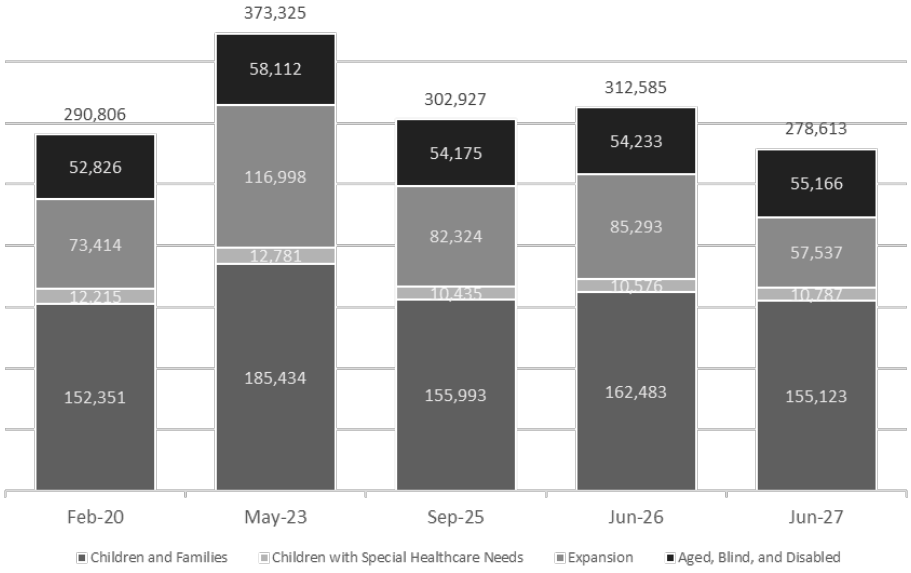



Figure II-3. Cover All Kids Eligibility and State Only Costs (Capitation and FFS Activity)

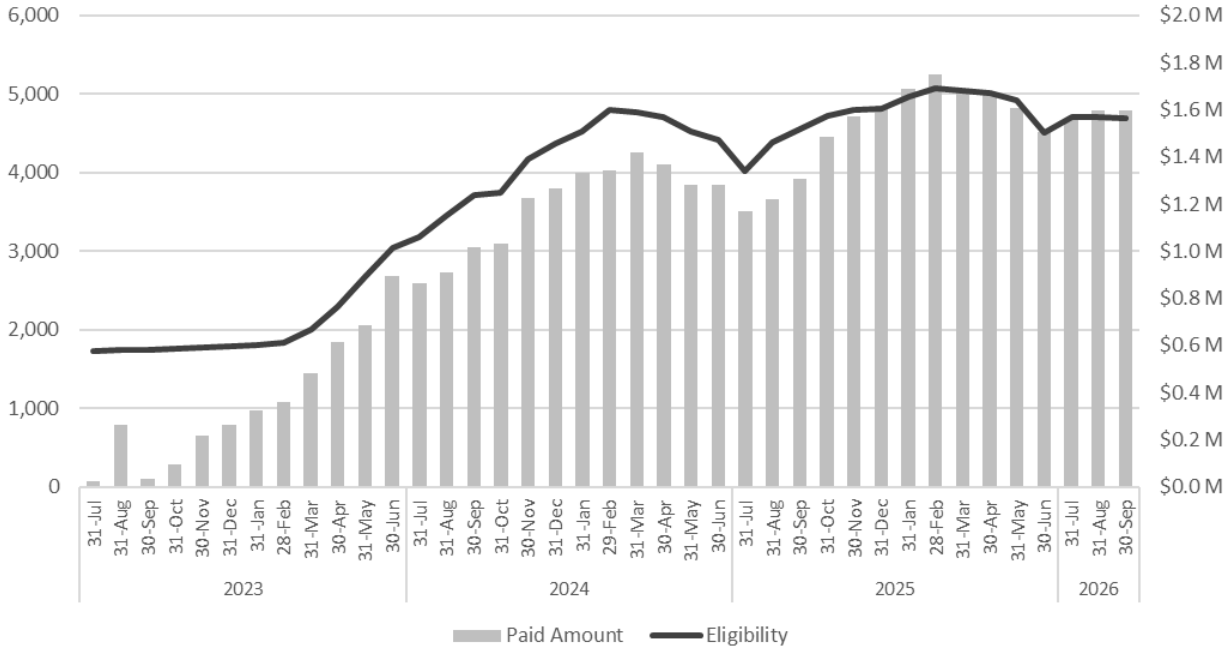
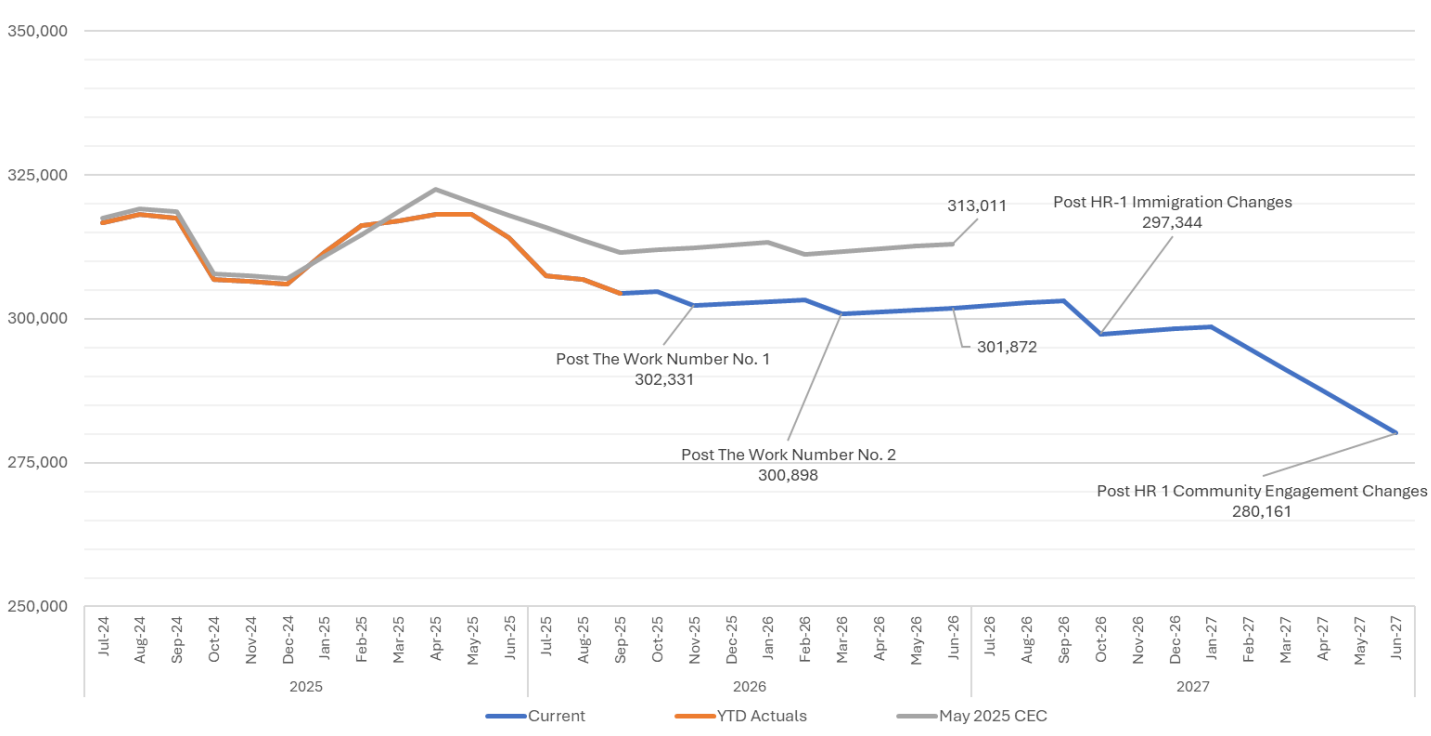


Figure II-4. Current Full Medicaid Forecast Compared to May 2025 CEC[1]




***National Forecasts of Medicaid Enrollment/Expenditures***

The Congressional Budget Office (CBO) has not released an updated baseline projections report since June 2024. However, since the CBO's last release of baseline projections for Medicaid in June 2024, the U.S federal government passed House Resolution 1 - H.R. 1. The CBO has released an analysis on the distributional effects of H.R. 1 on the Medicaid system. CBO estimated that by 2034, the total number of people without health insurance nationally would increase by 2.1 million. This forecast reflects CBO estimates of the annual changes in the number of people without health insurance under H.R. 1 from 2026 through 2034 based on each specific provision. CBO projects that with the combined impact of the act, there will be a total annual change in the number of uninsured of 1.3% that increases each year of its projection, capping at a 10% increase in 2034.

While there is significant uncertainly around enrollment and expenditures pending guidance on recent changes, other independent analyses of national Medicaid forecasts project significant enrollment reductions in the coming years. For example, Manatt Health projects approximately 12% overall reductions in enrollment for non-expansion states.[2]

***Forecasting the Overall Price Factors***

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

Medicaid's managed care estimate includes updated rates for FY 2026 and estimated rates for FY 2027. The FY 2027 budget reflects a composite increase of 5.0% across all product lines.

The composite rates in **Table II-6** reflect composite price changes given changes in the underlying enrollment mix.

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

[2] https://shvs.org/resource/senate-passed-h-r-1-updated-estimates-on-impact-to-state-medicaid-coverage-and-expenditures-hospital-expenditures-including-impacts-by-congressional-district/

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

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

Table II-6. FY 2025 through FY 2027: Caseload and Composite PMPM with Trends

| | Caseload: | | | Price: | | | Caseload Trend | | Price Trend | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2025 | 2026 | 2027 | 2025 | 2026 | 2027 | FY25 → FY26 | 2027 | FY26 → FY27 | FY25 → FY26 | FY26 → FY27 |
| **Full Benefits:** | | | | | | | | | | | |
| Rite Care Core | 160,140 | 152,340 | 151,004 | $368 | $395 | $412 | -4.9% | $412 | -0.9% | 7.4% | 4.3% |
| Rite Care CSHCN | 9,739 | 9,686 | 9,853 | $1,433 | $1,644 | $1,728 | -0.5% | $1,728 | 1.7% | 14.7% | 5.1% |
| Expansion | 79,972 | 76,407 | 68,602 | $695 | $773 | $813 | -4.5% | $813 | -10.2% | 11.2% | 5.2% |
| Rhody Health Partners | 12,739 | 12,757 | 12,761 | $2,231 | $2,408 | $2,529 | 0.1% | $2,529 | 0.0% | 7.9% | 5.0% |
| CMS Demonstration | 11,422 | 11,788 | 11,377 | $1,540 | $1,692 | $1,784 | 3.2% | $1,784 | -3.5% | 9.9% | 5.4% |
| PACE | 432 | 465 | 486 | $5,493 | $5,805 | $6,125 | 7.6% | $6,125 | 4.5% | 5.7% | 5.5% |
| RIte Share [1] | 1,395 | 1,871 | 2,016 | $130 | $139 | $153 | 34.1% | $153 | 7.7% | 6.8% | 10.0% |
| **Subtotal** | 275,839 | 265,314 | 256,099 | $642 | $712 | $745 | -3.8% | $67,916 | -3.5% | 10.9% | 4.8% |
| **Other Capitated Arrangements:** | | | | | | | | | | | |
| Rite Smiles | 135,393 | 132,290 | 134,628 | $18 | $18 | $19 | -2.3% | $19 | 1.8% | 1.9% | 4.9% |
| Rite Care EFP | 2,090 | 1,577 | 980 | $14 | $27 | $29 | -24.5% | $29 | -37.9% | 96.8% | 5.0% |
| SOBRA Payment | 360 | 390 | 424 | $18,858 | $20,789 | $21,829 | 8.3% | $21,829 | 8.7% | 10.2% | 5.0% |
| Non-Emergency Transportation [2] | 310,279 | 299,979 | 289,924 | $9 | $10 | $10 | -3.3% | $10 | -3.4% | 12.0% | 5.7% |

## D. H.R.-1 Federal Changes Impacting FY 2026 and 2027

The reconciliation bill passed by Congress in July 2025 – H.R.-1 – has changes that are effective in FYs 2026 and 2027. Only two items have explicit adjustments reflective in EOHHS' testimony, changes to who is considered a "qualified alien" for purposes of eligibility and imposition of community engagement requirements. Estimates for these items are not indicative of final policy decisions nor do they account for federal guidance that is not yet available. CMS has not promulgated any regulations related to any H.R.-1 sections as of October 2025 and has offered limited preliminary guidance.

***FY 2026***

- **Section 71116** of H.R.-1 caps the total SDP payment value at 100% of Medicare for expansion states. Previously approved payments, as defined by CMS, are "grandfathered in" and subject to a yearly phasedown of 10% until the new threshold is met.

  CMS released a "Section 71116 SDP Letter" on September 9, 2025[3] to "aid state planning efforts until a final rule is promulgated… this information is preliminary in nature and final policies will depend on the contents of the final rule." This letter says that as part of the rulemaking effort, CMS is considering changes to the total payment rate limit for SDPs for other services beyond the four services mandated by section 71116 (inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center).

  The FY 2026 hospital separate payment term SDP, paid at a percentage of the average commercial rate, is currently under CMS review. The state is awaiting a CMS decision on its "grandfathered in" status. Based on the "Section 71116 SDP Letter," it is the agency's opinion that both the FY 2025 and FY 2026 hospital separate payment term SDP are "grandfathered in," meaning the FY 2026 value of $325 million will be allowable until the FY 2029 rating period when a 10% annual reduction will be applicable until it reaches Medicare levels. This opinion is based on the applicable rating period beginning within 180 days of enactment of section 71116 and the submission meets preprint status criteria #5, that a completed preprint was submitted to CMS prior to July 4, 2025.

  When asked if CMS agreed with the state's conclusion, CMS indicated they will include language in their standard adjudication letter (preprint approval provided to states upon review completion) to provide preliminary feedback on CMS's initial assessment of the impact of section 71116, including whether a preprint is likely eligible for the grandfathering period. They also indicated that final implementation and decision will depend on the contents of a final rule, meaning the state may not have a final approval on the FY 2026 preprint value for some time. This puts the current year $44 million payment increase over FY

[3] https://www.medicaid.gov/medicaid/managed-care/downloads/sdp-ltr-09092025.pdf

2025 at risk, or at minimum, at risk of a delay. These payments are made quarterly, and Medicaid waits for approval prior to payment.

In short, if the FY 2026 payment is "grandfathered in," the 2026 preprint value will be the maximum payment allowed through FY 2029 when a phase down is required at 10% per year until the payment reaches 100% of Medicare. If the FY 2026 payment is not "grandfathered in," the FY 2025 preprint value will be the maximum payment allowed through FY 2029 when the phase down is effective. The FY 2025 payment is $44 million lower (All Funds) than the FY 2026 payment.

- **Section 71113** prohibits federal match for services provided by certain abortion providers for the one-year period following enactment. This change impacts Planned Parenthood of Southern New England (PPSNE). The current managed care rates include approximately $750,000 All Funds, including $200,000 GR for PPSNE non-abortion services. The managed care organizations will not make any payments for the services and Medicaid is awaiting CMS guidance on any next steps regarding rating.

  This provision is effective for the one-year period following date of enactment of this legislation and therefore remains in the FY 2027 base.

***FY 2027***

- **Section 71109** says that regardless of any provisions to the contrary in the applicable section of law, only "aliens lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country," certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants. The change means that many "qualified" individuals, - such as refugees, asylees, humanitarian parolees, victims of trafficking, individuals subject to battery and other cruelty, conditional entrants, etc. will need to adjust their status to lawfully permanent resident (LPR) (i.e., obtain a green card) before they will be eligible for full Medicaid. The changes will prevent the state from enrolling individuals who meet the definition currently but will not be considered "qualified" as of October 2026. Refugees, humanitarian parolees, asylum grantees, certain abused spouses and children, trafficking victims, and certain other non-citizens would no longer be considered qualified aliens for purposes of Medicaid and CHIP eligibility.

  CMS has not released any guidance for this change. Absent CMS guidance, there are several areas of uncertainty. One area is whether qualified aliens who are currently exempt from the five-year bar will need to wait five years from when they obtain LPR status before regaining eligibility. It is also unclear whether LPRs who have been exempt from the five-year bar will become subject to the five-year bar under H.R.-1. The option to cover lawfully present children and pregnant/postpartum individuals is also understood to remain in place. Pending clarification from CMS, the impact analysis assumes that all such individuals will become subject to the five-year bar and that children and pregnant/postpartum individuals will not be impacted.

  The Federal Verification Hub (FVH) is used to verify citizenship and immigration status for Medicaid applicants. It utilizes the Systematic Alien Verification of Entitlements (SAVE) program to check naturalized and derived U.S. citizenship. Using a limited dataset from the FVH as of September 2025, Medicaid estimates this will impact approximately 9,000 individuals who currently have full or limited Medicaid benefits, through managed care or fee-for-service, in Rhode Island. This includes 6,255 enrolled in managed care and 1,750 remaining in FFS with full Medicaid benefits and 995 with limited benefits. The required closure of these beneficiaries will result in lower Medicaid payments estimated to be $61.8 million, including $21.7 million in state funding.

  Medicaid assumes these estimates will change once formal federal guidance is issued and once the FVH dataset is updated by the federal government; until then, this should be interpreted cautiously. Currently, there is significant missing data for individuals who are currently considered qualified and other areas of

uncertainty as noted above. This estimate assumes 75% of potential closures – those with missing data and therefore cannot determine their status as of Oct 1, 2026 – will ultimately close.

Providers and especially hospitals will be impacted fiscally because of the increase in uncompensated care, although those who lose coverage would still be eligible for Emergency Medicaid in applicable situations.

See **Table II-7** below for program level impact and an estimate of the FY 2027 reductions attributed to this federal requirement.

- **Section 71119** imposes "community engagement" requirements, effective January 1, 2026, that require some Medicaid beneficiaries and applicants to work, participate in a work program, and/or participate in community service for at least 80 hours a month, or be in school at least half time. People can also comply based on having income levels consistent with 80+ hours per month of work at minimum wage. The requirement generally applies to those enrolled via Adult Expansion or an expansion-like waiver category. In Rhode Island, this accounts for both Expansion and the parent/caretaker population with income over 121% FPL (lower-income parent/caretakers are a mandatory state plan population and not affected). Approximately 90,000 individuals are in these eligibility groups.

  There is a set of exemptions in H.R.-1. For the purposes of a preliminary fiscal estimate, Medicaid used claims data as a proxy to estimate the number of beneficiaries who may meet one of the exemption criteria. Based on the total number of people enrolled in Expansion and the 121% FPL+ parent/caretaker group, how many people are estimated to be exempt, and how many people are estimated to be compliant based on Medicaid's proxy analysis, EOHHS anticipates that 32,000 individuals will be subject to the requirements and 75% of those (approximately 24,600, nearly all from the expansion population group) will be at risk for disenrollment due to this requirement. The 75% assumption is based on the experience of two states who implemented requirements.[4] For the purposes of this budget estimate, Medicaid identified individuals with income above 50% of the FPL and as SNAP/TANF eligible (and therefore meeting more restrictive work requirements) as proxies for compliance.

  The FY 2027 estimate assumes individuals are assessed for compliance at their redetermination date, which would be spread evenly across the last six months of FY 2027, meaning not all 24,600 would be impacted for all 6 months of implementation in FY 2027. The total expenditure reduction for FY 2027 is $49.7 million, including $5.0 million GR. See **Table II-8** for number of beneficiaries impacted and resulting reduction in member months and premium payments in the second half of FY 2027.

- **Section 77107** requires redeterminations every 6 months for Expansion adults. Due to existing post eligibility verification processes that are performed quarterly, which effectively assesses whether or not a beneficiary maintains their income-based eligibility, and because changes in household income is the primary reasons why an expansion beneficiary would fail to renew during their annual renewal, no additional closures are assumed.

[4] https://medicaiddirectors.org/wp-content/uploads/2025/07/RWJ-Work-Requirement.pdf

Table II-7. HR 1 – Change to definition of qualifying non-citizen: Caseload and capitation adjustments assumed in Medicaid's estimate – by program

| | SFY 2027: | | |
|---|---|---|---|
| | Clients Impacted | Member Months [1] | Expenditures |
| **Capitation Payments** | | | |
| Rite Care | 2,860 | 25,740 | $ 14,516,918 |
| Expansion | 2,380 | 21,420 | 17,322,020 |
| Rhody Health Partners | 227 | 2,043 | 5,150,192 |
| Rhody Health Options | 770 | 6,930 | 11,625,915 |
| PACE | 17 | 153 | 992,760 |
| Medicare Savings Program [2] | 990 | 8,910 | 4,279,742 |
| **Subtotal** | **6,457** | **65,196** | **$ 53,887,547** |
| **Fee-for-Service Activity** | | | |
| Hospitals | | | 5,238,794 |
| Offset: Hospitals (Emergency Medicaid) | | | (6,295,313) |
| Nursing Homes | | | 1,820,026 |
| Home and Community Based Care | | | 3,987,503 |
| Other Services | | | 2,991,792 |
| **Subtotal** | | | **$ 7,742,803** |
| **Grand Total** | | | **$ 61,630,350** |

Note 1. Impacted clients are expected to lose eligibility effective October 1, 2026.
Note 2. Medicare Savings Program includes Part B and Part D (Clawback) premium payments. Impacted clients include 787 full benefit Duals and 213 limited benefit Duals.

Table II-8. HR 1 – Closures due to new community engagement requirement among Expansion and certain adults with children 13 years or older

| | SFY 2027: | | |
|---|---|---|---|
| | Clients Impacted | Member Months [1] | Expenditures |
| **Capitation Payments** | | | |
| Rite Care | 170 | 435 | $ 241,394 |
| Expansion | 24,460 | 61,110 | 49,459,519 |
| **Subtotal** | **24,460** | **61,545** | **$ 49,700,914** |

Note 1. Impacted clients are assumed to lose eligibility during renewals (that are shifting to a 6-month cadence) with total closures being evenly distributed over 6 moonths between February 2027 through July 2027.

## E. FY 2026 Budget Initiative Implementation

Status updates on FY 2026 (and select prior year) initiatives are detailed below.

- Primary Care Rate Increase. *In process*. EOHHS and Gainwell are in the final stages for system updates necessary to implement this project. For managed care, the MCOs will have 90-days post signature of their respective amended contracts to effectuate this change, where claims will be mass updated retrospectively back to October 1, 2025. The state plan amendment for this primary care initiative is currently in public comment through October 29, 2025, and will be submitted to CMS thereafter.
- FQHC Rate Increase. *In process*. The enacted budget includes $10.5 million from all sources, including $4.0 million from general revenues to increase reimbursement rates to FQHCs. With the additional funding, FQHCs received a total increase of 12.67% over FY 2025 reimbursement rates for medical/behavioral services. Absent the additional funds, FQHCs would have received only a 3.4% inflationary increase over FY 2025 rates. The rates are updated in FFS and funding included in the managed care contract amendments. There is no SPA for this initiative.
- Interprofessional Consultations. *In process*. Systems project is currently being processed by Gainwell for both fee-for-service and managed care interprofessional consultation rates. The state plan amendment

for interprofessional consultations is in public comment until October 30th and will be submitted to CMS thereafter with an effective date of October 1, 2025.

- Long Term Behavioral Health Beds. *In process.* An amendment to the state plan was posted for public comment on September 10, 2025, and closed 30 days later, on October 10. EOHHS is preparing the submission package for CMS review. EOHHS is also working with Gainwell to identify, plan, and implement system changes needed for the creation of a new provider type and reimbursement rate. The FY 2026 estimate includes $4.1 million from all sources of funds in the Hospital program assuming implementation in January. The FY 2027 estimate includes $11.3 million from all sources for a full year of funding.
- The Work Number. *Implemented.* The Equifax data sources were first used in income verifications associated with post eligibility verification batch process in September 2025 with resulting closures notices sent for October 31, 2025. Savings associated with these closures will be realized in terms of reduced November premium payments. Equifax is also being used for income verifications associated with both new applications and renewal activities. After the initial savings reflected in November 2025 and March 2026 in FY 2026, Medicaid assumes any ongoing savings will be achieved through cost avoidance that depress month-over-month growth. This is reflected in Medicaid's forecast with the application of a reduced caseload growth factors of 1.0% in FY 2026 and 1.5% in FY 2027.
- Rite Share. *Implemented.* FY 2025 savings were adjusted downward due to delays resulting from the data breach and hiring. Hiring completed in April 2025, and the Rite Share team estimates approximately 800 gross new enrollments in FY 2025. Since the start of FY 2026, enrollments have accelerated, with a gross 512 beneficiaries added from July 1, 2025, to October 15, 2025. The Rite Share program is, however, subject to a significant amount of churn from employment and eligibility shifts, and the net increase in FY 2026 to date is 215 beneficiaries. As of October 15, 2025, total Rite Share enrollment was 1,850 beneficiaries. The average monthly enrollment forecast for FY 2026 is now 1,971, reflecting an annualized growth rate of 25% for the remaining months in the fiscal year. For FY 2027, the growth rate is reduced to 10% resulting in an average monthly membership of 2,474, an increase of 503 net beneficiaries relative to the revised FY 2026 estimate.
- Conflict Free Case Management. *In process*. The revised estimate for FY 2026 totals $8.3 million, $0.8 million less than the May CEC. The revised estimate assumes 12,036 beneficiaries may be eligible for CFCM with 5,154 beneficiaries receiving services by June 2026. The decrease is due to 466 fewer DD beneficiaries, and 5,213 fewer non-DD beneficiaries billing Medicaid by June. The May estimate assumed that nearly all non-DD beneficiaries would be receiving CFCM services by June. This will not materialize due to available case managers. The estimate excludes 576 DD beneficiaries who receive case management through BHDDH staff. The estimate excludes all DD beneficiaries currently receiving services through Independent Facilitators (IFs). Through September 2025, there are 555 beneficiaries receiving services from IFs and this is expected to grow. However, consistent with the May CEC, the estimate assumes these beneficiaries will transition to case managers in the community beginning in February.

  In FY 2027, Medicaid projects $11.8 million and assumes 6,270 beneficiaries will receive CFCM services by June 2027, including 1,899 DD beneficiaries and 4,371 non-DD beneficiaries. The model excludes 576 beneficiaries who are still expected to be managed by BHDDH FTEs.
- Community Health Worker Program. *In process.* An amendment to the Medicaid State Plan was posted on May 9, 2025, with a public hearing having occurred on June 3. The amendment was submitted to CMS and is currently pending approval. The FY 2026 estimate assumes $3.5 million from all sources based on expenses from July 2025 to-date.
- Medicare Savings Program (MSP) Expansion. *Delayed.* This initiative requires changes to eligibility criteria in the RIBridges system. Currently, the required system changes are slated to be deployed in late January 2026. As such, new FPL values will be effective on February 1, 2026. The annual federal FPL inflation adjustment will run eligibility on all MPP individuals in early March 2026 and transition most beneficiaries from SLMB to QMB at that time.

- Primary Care Health Assessment Impact. *In process.* The funding required in the managed care rates for this new assessment will be added to a forthcoming rate amendment, effective January 1, 2026.
- Ticket to Work. *Implemented*. Enrollment in Ticket to Work went live on September 22, 2024. The state's MMIS vendor, Gainwell, is actively working on the required system changes to implement hardship requests. This specific component was 50% completed as of October 1, 2025.
- Mobile Response Stabilization Services (MRSS). *In process*. Planning is underway to ensure the standalone MRSS service begins on October 1, 2026. EOHHS anticipates submitting this SPA to CMS no later than May 2026, due to the ongoing planning and implementation efforts, and SPA requirements set by CMS.
- Pharmacy Review. *In process.* EOHHS is currently obtaining the necessary documentation from various sources and working with the State actuary to support development of a pharmacy delivery system update. The FY 2026 budget included positions; a staff member has been hired to start mid-November 2025. EOHHS is still estimating half a year of savings in SFY 2027 for approximately $4.1 million in GR, $14.6 million all funds. In out years, full year savings will be realized in the amount of $8.4 million in GR, $29.5 million all funds. However, continued implementation delays brought on by challenges in acquiring necessary data and documentation could foreclose on some SFY 2027 savings. Also, the savings is dependent on funding for three unfunded positions to continue to expand pharmacy work in the outyears. EOHHS expects these positions to be funded in the SFY 27 budget.
- Program Integrity. *In process.* Positions were posted to the state's website in September. The postings have closed and EOHHS is actively interviewing. Due to current PAR processing times, the hiring process can take between six to nine months to complete. While EOHHS expects most positions to be filled by January, backfilling any internal (if any) staff will be similarly delayed.

## F. 1115 Waiver Update

In December 2022, Rhode Island submitted an extension request for its Demonstration 1115 Waiver (Demonstration). In July 2023, CMS alerted Medicaid of a delay in its Demonstration and issued a 12-month extension of the State's current 1115 Demonstration Waiver, ensuring maintenance of all authorities during CMS review. Medicaid identified priority items for which the State requested approval on an earlier timeline. In September 2024, Medicaid submitted a Demonstration amendment to allow for the provision of personal care services to HCBS-eligible beneficiaries while they are in an acute inpatient hospital setting, consistent with the directive included in Article 9 of 2024-H5200 Sub A, as amended. CMS approved the Demonstration amendment on March 21, 2024, that includes the state's priority items from the December 2022 submission and the personal care services. The approved priority items are listed below.

1. Delivery of personal care services to recipients in acute hospital settings.
2. Permanent retention of certain "Attachment K" HCBS authorities first granted during the PHE, including for parents/guardians of (adult) self-direction participants to provide services to these participants; to conduct certain personal care and case management services via telehealth; to conduct level of care evaluations, functional assessments, and person-centered planning meetings remotely rather than in-person; and to use electronic signatures for person-centered plans.
3. Authority for a new HCBS service, Remote Monitoring and Support, which was added in relation to the BHDDH Consent Decree.
4. Changes to the education requirement for Home Stabilization providers, to facilitate greater access to the service.
5. Changes to waiver language to reflect the 12-month postpartum continuous eligibility policy established in the Medicaid State Plan.
6. Increase of the income eligibility threshold (from 300% to 400% of the SSI benefit rate) for adults with disabilities who are at risk of needing institutional care to access a limited set of HCBS services.

Medicaid used the time created by the CMS delay to develop an addendum, submitted May 2024, to the original renewal request to maximize the state's opportunities arising from federal guidance that had been provided after

fall 2022. Both the December 2022 request and the May 2024 Addendum also requested technical changes to align with current program operations and enhance transparency.

In November 2024, CMS alerted Medicaid that additional review delays would push the renewal date to late June 2025. CMS issued a formal six-month extension to allow the Demonstration to continue with the authorities that were in place in March 2024, effective through June 2025. CMS paused all direct engagement with Medicaid in December 2024.

CMS re-engaged with the state in March 2025, and soon informed EOHHS that it would not be possible to renew the waiver until December 2025; on June 10, CMS issued a new formal six-month extension to allow the Demonstration to continue through December 31, 2025. Also in spring 2025, CMS formally rescinded its past guidance related to Health-Related Social Needs and stated that all waiver requests related to such services would instead be reviewed on a case-by-case basis. To ensure that December 2025 approval could be achieved, EOHHS formally withdrew several requests from consideration for the renewal. Withdrawn requests were for services/authorities for which state GR had not been appropriated and which had not been previously provided through Medicaid authority, and included: pre-release supports and Medicaid coverage for incarcerated individuals up to 90 days before release; medical respite/recuperative care for homeless individuals; expanded eligibility for existing Home Stabilization services; new housing supports including move-in costs and up to six months of rent payment; nutrition services including medically tailored meals and healthy food prescriptions; and contingency managements, a behavioral intervention for treating SUD. The removal of these requests does not reduce the scope of Medicaid benefits currently being provided to beneficiaries. If directed by a future enacted state budget, EOHHS can submit an amendment request for any or all of the services in the future and CMS will consider such requests at that time.

Throughout summer and early fall 2025, EOHHS has worked closely with CMS on necessary technical updates to the 1115 Special Terms and Conditions and to provide required information for the renewal's budget neutrality analysis. In addition to an array of technical updates to ensure that the 1115 Special Terms and Conditions are aligned with current program operations, there is one remaining substantive authority request that is still outstanding pending the waiver renewal:

1. Managed Dental Benefits for Adults. Inclusion of adult dental benefits into the existing RIte Smiles managed care program. The request is limited to the nature of the delivery system (i.e., managed care rather than FFS) and does not propose to change the scope of adult dental benefits.

## G. Cell and Gene Therapy (CGT) Access Model

Sickle Cell Disease (SCD) is a painful condition that disproportionately affects African Americans more often than others. SCD has limited treatment options, which can result in high healthcare costs. Nationally, Medicaid covers around half of SCD patients. In December 2023, the FDA approved the first cell and gene therapy treatment for SCD.[5] In January 2024, the Biden-Harris Administration announced that SCD would be the first focus of the CGT Access Model, led by CMS.[6] The CGT Access Model is a voluntary model for states and manufacturers that tests whether a CMS-led approach to developing and administering outcomes-based agreements for cell and gene therapies improves Medicaid beneficiaries' access to innovative treatment, improves their health outcomes, and reduces health care costs and burdens to state Medicaid programs. Under the program, CMS will negotiate outcome-based agreements with manufacturers, linking pricing to health outcomes, and provide states with an option to access these drugs at a negotiated rate.

In mid-2025, Rhode Island received approval for participation in the CGT Access Model, with a start date of January 1, 2026. The State is working with managed care organizations and community-based organizations for implementation of the CGT Access Model. Medicaid is actively monitoring plan experience and working with the state's actuary regarding the treatment of these drugs' costs. In FY 2025, EOHHS budgeted $6.6 million for FFS

[5] https://www.fda.gov/news-events/press-announcements/fda-approves-first-gene-therapies-treat-patients-sickle-cell-disease#:~:text=Casgevy%2C%20a%20cell%2Dbased%20gene,type%20of%20genome%20editing%20technology..

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

expenditures associated with SCD treatment; as of FY 2026, these services are included in-plan with the full cost accounted for in MCO rates. Approximately $7.5 million in funding is included in the rates for this purpose.

## H. Cross Budget Line Summaries: Rebates and NEMT

### *Drug Rebates and J-Code Collections*

Rebates on prescriptions provided in a pharmacy (DRE) and in an outpatient setting (J-Code) offset the federal and state costs of most prescription drugs dispensed to Medicaid patients. Medicaid's rebate collections reduce the program's gross pharmacy spend by over 40%. **Table II-9** summarizes Medicaid's DRE and J-Code invoices for FY 2025 through FY 2027 projected. DRE rebates total $147.8 million and J-Codes total $8.3 million in FY 2026. Medicaid projects a total of $148.5 million in DRE rebates and $8.4 million in J-Code rebates for FY 2027. The decline in FY 2026 over FY 2025 was attributed to the unwinding of the PHE and reduction in caseload. Due to general uncertainty in this estimate, no price factor was applied.

Medicaid derived its forecast by dividing the average quarterly rebate amounts invoiced to the drug manufacturers in the four quarters through FY 2026 Q3 by the average managed care enrollment for the same period. The resulting PMPM multiplier, calculated by product line, was applied to Medicaid's enrollment forecast.

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

Table II-9. Summary of Drug Rebate Collections

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **DRE** | | | | | | | |
| Managed Care | $ (44,411,740) | $0.8 M | $ (43,725,427) | $ (44,455,523) | $0.7 M | $ (50,465,663) | ($6.0 M) |
| Rhody Health Partners | (41,457,014) | 7.4 M | (36,004,544) | (37,073,563) | 1.1 M | (43,077,694) | (6.0 M) |
| Expansion | (62,061,665) | 1.8 M | (60,897,976) | (59,256,288) | (1.6 M) | (62,196,014) | (2.9 M) |
| Fee-for-Service | (7,130,724) | 0.5 M | (6,757,008) | (7,030,320) | 0.3 M | (7,537,627) | (0.5 M) |
| **Subtotal DRE** | **$ (155,071,711)** | **$10.6 M** | **$ (147,384,955)** | **$ (147,815,694)** | **$0.4 M** | **$ (163,276,998)** | **($15.5 M)** |
| **J-Code** | | | | | | | |
| Managed Care | (2,531,303) | 0.0 M | (2,468,196) | (2,529,194) | 0.1 M | (2,625,750) | (0.1 M) |
| Rhody Health Partners | (1,331,463) | 0.0 M | (1,088,167) | (1,400,764) | 0.3 M | (1,471,570) | (0.1 M) |
| Expansion | (2,936,581) | 0.2 M | (2,781,953) | (2,943,191) | 0.2 M | (2,774,272) | 0.2 M |
| Fee-for-Service | (1,270,208) | (0.1 M) | (1,315,005) | (1,379,637) | 0.1 M | (1,488,120) | (0.1 M) |
| **Subtotal J-Code** | **$ (8,069,555)** | **$0.2 M** | **$ (7,653,321)** | **$ (8,252,786)** | **$0.6 M** | **$ (8,359,712)** | **($0.1 M)** |
| **Total Rebates** | **$ (163,141,266)** | **$10.8 M** | **$ (155,038,276)** | **$ (156,068,480)** | **$1.0 M** | **$ (171,636,710)** | **($15.6 M)** |
| **QROA** | | | | | | | |
| Managed Care | 1,350,211 | 0.0 M | 1,378,550 | 1,351,601 | 0.0 M | 1,408,565 | $0.1 M |
| Rhody Health Partners | 973,980 | 0.0 M | 996,789 | 870,996 | 0.1 M | 914,790 | 0.0 M |
| Expansion | 459,309 | 0.0 M | 454,009 | 438,547 | 0.0 M | 412,198 | (0.0 M) |
| Fee-for-Service | 313,379 | 0.0 M | 331,254 | 308,239 | 0.0 M | 331,997 | 0.0 M |
| **QROA** | **$ 3,096,879** | **$0.0 M** | **$ 3,160,602** | **$ 2,969,383** | **$0.2 M** | **$ 3,067,550** | **$0.1 M** |

### *Non-Emergency Medical Transportation (NEMT)*

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

The original rates included rates with annual inflationary factors applied, but with the proviso that they remain subject to change in future years based on enrollment and utilization. Medicaid allocates spending for the beneficiaries in its Aged, Blind, and Disabled eligibility groups based on enrollment in Rhody Health Options, Rhody Health Partners, or FFS. After reviewing emerging experience in the second half of FY 2024 and consideration of

the impact of the unwinding on reasonability of the rates, Medicaid determined that no change beyond that stipulated within the contract was warranted for FY 2026.

For FY 2027, the rates reflect an increase of 5.0% across the individual rating categories. This is consistent with the base assumption applied to the other managed care rates.

The NEMT services forecast is in **Table II-10** and average monthly enrollment is in **Table II-11.**

Table II-10. Non-Emergency Transportation - Capitation

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| **Budget Line** | **Final** | **Surplus/ (Deficit)** | **Enacted** | **Current** | **Surplus/ (Deficit)** | **Current** | **FY26 → FY27** |
| Managed Care | $ 9,793,695 | $0.1 M | $ 10,060,738 | $ 9,596,796 | $0.5 M | $ 9,776,542 | $ 179,745 |
| Expansion | 12,251,100 | 0.5 M | 12,200,242 | 12,014,575 | 0.2 M | 11,574,051 | (440,524) |
| Rhody Health Partners | 3,139,876 | (0.0 M) | 3,228,395 | 3,228,437 | (0.0 M) | 3,485,251 | 256,813 |
| Rhody Health Options | 2,809,164 | 0.1 M | 2,850,560 | 2,982,495 | (0.1 M) | 3,107,939 | 125,445 |
| Other Services | 6,582,432 | 0.1 M | 7,431,450 | 7,113,652 | 0.3 M | 7,732,681 | 619,029 |
| **Subtotal** | **$ 34,576,268** | **$0.8 M** | **$ 35,771,385** | **$ 34,935,955** | **$0.8 M** | **$ 35,676,463** | **$ 740,508** |
| TANF Charge Back | (500,000) | 0.0 M | (500,000) | (500,000) | 0.0 M | (500,000) | 0 |
| MTM Liquidated Damages | 0 | 0.0 M | 0 | 0 | 0.0 M | 0 | 0 |
| **Subtotal Medicaid** | **$ 34,076,268** | **$0.8 M** | **$ 35,271,385** | **$ 34,435,955** | **$0.8 M** | **$ 35,176,463** | **$0.7 M** |

Table II-11. Non-Emergency Transportation - Average Monthly Enrollment

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| **Medicaid** | **Final** | **Change** | **Enacted** | **Current** | **Change** | **Current** | **FY26 → FY27** |
| Children and Families | 175,514 | -375 | 175,396 | 167,308 | -8,088 | 165,592 | -1,716 |
| Expansion | 82,800 | -78 | 80,117 | 78,898 | -1,219 | 70,763 | -8,135 |
| Rhody Health Partners | 12,733 | -38 | 12,726 | 12,726 | 0 | 12,722 | -5 |
| Rhody Health Options | 11,392 | 2 | 11,237 | 11,757 | 520 | 11,345 | -412 |
| Other ABD | 26,693 | -1,182 | 29,295 | 28,042 | -1,253 | 28,226 | 184 |
| Subtotal Medicaid | 309,131 | -1,671 | 308,771 | 298,731 | -10,040 | 288,647 | -10,084 |
| *Overall PMPM* | *$9.19* | ($0.04) | *$9.52* | *$9.61* | $0.09 | *$10.16* | $0.55 |
| ***Department of Human Services*** | | | | | | | |
| OHA Co-Pay | 1,147 | 28 | 1,170 | 1,248 | 78 | 1,277 | 29 |
| Elderly Transportation Program | $412.5k per month | | $431.5k per month | $431.5k per month | | $431.5k per month | |

# III. Managed Care

| Managed Care | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $1,007,366,165 | $425,365,444 |
| **FY 2025** | Revised Enacted | $1,037,600,000 | $444,347,574 |
| | Final | **$1,044,283,333** | **$445,914,440** |
| | *Deficit over Revised Enacted* | *($6,683,333)* | *($1,566,866)* |
| **FY 2026** | Enacted | $1,117,462,318 | $464,278,305 |
| | Current | **$1,106,800,000** | **$462,718,463** |
| | *Surplus over Enacted* | *$10,662,318* | *$1,559,842* |
| **FY 2027** | Current | **$1,165,300,000** | **$481,460,624** |

***FY 2026***

The FY 2026 revised all funds forecast of $1.107 billion reflects a surplus of $10.7 million (1.0%), including $1.6 million GR (0.4%), over the Enacted. Medicaid forecasts an average enrollment of 167,320 Rite Care eligible beneficiaries in FY 2026, a decrease of 8,049 compared to the Enacted. This includes 152,340 beneficiaries enrolled in Rite Care Core, 9,686 in Rite Care CSHCN, 1,971 enrolled in Rite Share, and an average of 3,324 remaining in FFS each month.

The current year surplus is primarily attributed to the following forecast changes. Supporting details are included in **Table III-1** through **Table III-3**:

- $26.7 million reduction in net premium payments for Rite Care Core ($24.3 million) and Rite Care CSHCN ($2.4 million) primarily attributable to a forecasted enrollment decrease of 7,510 and 220, respectively.
- $1.0 million reduction in Core FFS.
- $1.3 million reduction in Rite Smiles premium payments.
    - Current projections forecast a decrease in Rite Smiles enrollment by 6,580 beneficiaries compared to enacted, from 138,870 to 132,290.

As illustrated **Table III-4,** the decrease of 8,049 beneficiaries generated $51.3 million in savings, a 4.6% reduction compared to Enacted. However, forecasted price increases in FY 2026 offset these savings by $40.4 million, an increase of 3.8% compared to Enacted.

The savings are partially offset by:

- A $10.3 million increase in SOBRA premium payments attributable to an increase in Rite Care SOBRA births of 551 above the Enacted level.
- The inclusion of a $5.0 million for potential risk share.
    - Although the rates are actuarially sound and a recent review of the health plans' emerging experience by the State and its certifying actuary did not necessitate any adjustment to the rates, uncertainty over certain plan performance over the course of the fiscal year supports the inclusion of a potential liability for FY 2026.
- A $1.5 million state-only increase for Cover All Kids (CAK) program due to increased premium payments despite what appears to a moderation in enrollment growth within the program.
    - Medicaid continues to make year-end adjustments for Rhode Islanders originally assigned to CAK eligibility group but who have their appropriate immigration/citizenship status validated by the FVH. The state-only amount budgeted is net of this adjustment.

***FY 2027***

Medicaid estimates expenditures of $1.165 billion, including $481.1 million GR, in FY 2027. This represents an increase of $57.9 million, or 5.2%, compared to the updated forecast for FY 2026. The drivers behind the changes in spending when comparing to the current fiscal year are summarized **Table III-1** through **Table III-4** below.

- A $41.6 million increase in premium payments for Rite Care (Core and CHSCN) is attributed to a composite PMPM increase of $17 and $84 for Rite Care Core and Rite Care CSHCN, respectively, offset by net decline in the average monthly enrollment in Rite Care Core.
    - Note that despite the assumption of a 1.5% underlying growth rate for Rite Care, the FY 2027 estimate includes the closure of 3,030 beneficiaries, accounting for a total of 26,175 member months in FY 2027, due to eligibility changes related to HR-1, including qualified alien status and community engagement requirements. These closures reduce premium payments by $14.8 million. For additional information see relevant **Section F** in **Major Developments**.
- $11.8 million increase in RIte Care SOBRA premiums payments.
    - Current projections forecast a rise in overall number of RIte Care SOBRA births of 332, noting the updated cost per SOBRA birth increased by $1,039 compared to the updated forecast for FY 2026, from $20,789 to $21,829.
- $4.7 million increase in NICU payments.
    - Current projections forecast increased overall NICU stays by 46 when compared to the forecasted level for FY 2026, as well as an increase to the cost per stay by $3,157, from $63,136 to $66,293.

Year over year increase was partially offset by the items below:

- $5.0 million decrease due to the assumption of no risk share payments given the rebasing of the premiums; and
- $6.1 million increase in Rebates collected (4.2%).

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

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

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

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

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

**Table III-7** and **Table III-8** identify changes to total CHIP and family planning claiming activities that contribute to a slight deficit when compared to the Enacted.

**Table III-9** identifies changes to CCBHC claiming activities that contribute to a slight deficit compared to the Enacted.

Additional month-by-month details are provided in **Attachment 5**.

## Table III-1. Summary of Managed Care Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Payments to Plans** | | | | | | | |
| RIte Care Core | $ 687,394,024 | $2.3 M | $ 728,402,629 | $ 704,080,062 | $24.3 M | $ 732,160,381 | $28.1 M |
| Rite Care Cover-All-Kids | 15,904,570 | 0.2 M | 16,905,000 | 18,397,956 | (1.5 M) | 19,317,854 | 0.9 M |
| RIte Care CSHCN | 166,633,589 | (0.1 M) | 192,719,143 | 190,347,917 | 2.4 M | 203,805,214 | 13.5 M |
| Rite Care EFP | 347,149 | 0.0 M | 370,486 | 515,326 | (0.1 M) | 336,274 | (0.2 M) |
| Rite Care SOBRA | 77,261,667 | (3.0 M) | 81,370,901 | 91,638,705 | (10.3 M) | 103,467,749 | 11.8 M |
| Withhold | 4,369,882 | 0.0 M | 4,635,546 | 4,564,825 | 0.1 M | 4,753,653 | 0.2 M |
| Risk Share | 3,308,487 | (1.8 M) | 0 | 5,005,326 | (5.0 M) | 0 | (5.0 M) |
| Rite Smiles | 26,739,066 | (0.1 M) | 27,943,080 | 26,607,834 | 1.3 M | 28,427,568 | 1.8 M |
| **Subtotal - Payments to Plans** | **$ 981,958,435** | **($2.4 M)** | **$ 1,052,346,785** | **$ 1,041,157,952** | **$11.2 M** | **$ 1,092,268,693** | **$51.1 M** |
| *CCBHC (reflected in "Payments to Plans")* | *22,107,175* | *(0.4 M)* | *30,780,195* | *26,743,182* | *4.0 M* | *29,210,932* | *2.5 M* |
| **Other Payments** | | | | | | | |
| Non-Emergency Transportation | $ 9,793,695 | $0.0 M | $ 10,060,738 | $ 9,602,571 | $0.5 M | $ 9,803,804 | $0.2 M |
| TANF Offset | (500,000) | 0.0 M | (500,000) | (500,000) | 0.0 M | (500,000) | 0.0 M |
| RIte Share | 2,178,067 | (0.1 M) | 3,222,008 | 3,290,315 | (0.1 M) | 4,541,490 | 1.3 M |
| Premium Assistance Program | 46,056 | (0.0 M) | 50,000 | 50,000 | 0.0 M | 50,000 | 0.0 M |
| Core FFS | 54,806,334 | (1.5 M) | 58,294,000 | 57,330,000 | 1.0 M | 58,144,000 | 0.8 M |
| CSHCN FFS | 3,655,687 | (0.8 M) | 2,669,000 | 3,703,000 | (1.0 M) | 3,824,000 | 0.1 M |
| Early Intervention FFS | 4,588,484 | (0.2 M) | 4,586,000 | 5,295,000 | (0.7 M) | 5,374,000 | 0.1 M |
| NICU | 29,704,199 | 0.7 M | 32,077,410 | 32,957,230 | (0.9 M) | 37,654,582 | 4.7 M |
| State Only FFS (Non Medicaid) | 1,057,959 | (0.1 M) | 1,000,000 | 1,000,000 | 0.0 M | 1,000,000 | 0.0 M |
| Rebates | (46,943,043) | 1.7 M | (46,193,623) | (46,984,717) | 0.8 M | (53,091,413) | (6.1 M) |
| Premium Collection | (50,000) | 0.0 M | (50,000) | (50,000) | 0.0 M | (50,000) | 0.0 M |
| Tax Intercept | (105,000) | 0.0 M | (100,000) | (100,000) | 0.0 M | (100,000) | 0.0 M |
| **Subtotal - Other Payments** | **$ 58,232,438** | **($0.2 M)** | **$ 65,115,533** | **$ 65,593,399** | **($0.5 M)** | **$ 66,650,462** | **$1.1 M** |
| **Subtotal - Managed Care** | **$ 1,040,190,873** | **($2.7 M)** | **$ 1,117,462,318** | **$ 1,106,751,350** | **$10.7 M** | **$ 1,158,919,155** | **$52.2 M** |
| Balance to RIFANS/Rounding | 4,092,460 | (4.0 M) | 0 | 48,650 | (0.0 M) | 23,100 | (0.0 M) |
| **Total - Managed Care** | **$ 1,044,283,333** | **($6.7 M)** | **$ 1,117,462,318** | **$ 1,106,800,000** | **$10.7 M** | **$ 1,158,942,255** | **$52.1 M** |
| General Revenue | $445.9 M | $4.4 M | $464.3 M | $462.7 M | $1.6 M | $481.5 M | $18.7 M |
| Federal Funds | $598.4 M | $9.8 M | $653.2 M | $644.1 M | $9.1 M | $683.8 M | $39.8 M |

## Table III-2. Average Managed Care Caseload

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Full Benefits by Delivery System** | | | | | | | |
| Rite Care Core | 160,140 | -519 | 159,850 | 152,340 | -7,510 | 151,004 | -1,336 |
| Rite Care CSHCN | 9,739 | -7 | 9,906 | 9,686 | -220 | 9,853 | 167 |
| Rite Share | 1,395 | -4 | 2,049 | 1,971 | -78 | 2,474 | 503 |
| Remaining in FFS - Core | 2,643 | 70 | 2,009 | 1,946 | -63 | 1,587 | -359 |
| Remaining in FFS - CSHCN | 1,503 | -37 | 1,556 | 1,378 | -178 | 1,418 | 40 |
| ***Total - Full Benefits*** | 175,421 | -498 | 175,370 | 167,320 | -8,049 | 166,335 | -986 |
| *Overall PMPM* | $496 | $5 | $531 | $551 | $20 | $581 | *$29* |
| *% Enrolled in Managed Care* | 96.8% | | 96.8% | 96.8% | | 96.7% | |
| ***Other Caseload Factors*** | | | | | | | |
| EFP Only | 2,090 | -8 | 2,155 | 1,577 | -579 | 980 | -597 |
| Rite Smiles | 135,393 | -76 | 138,870 | 132,290 | -6,580 | 134,628 | 2,338 |
| Non-Emergency Transportation | 175,514 | -375 | 175,396 | 167,409 | -7,988 | 166,054 | -1,355 |

## Table III-3. Medicaid Births and NICU Stays

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **SOBRA Births** | | | | | | | |
| RIte Care | 4,097 | 161 | 3,857 | 4,408 | 551 | 4,740 | 332 |
| Expansion | 222 | -56 | 350 | 271 | -79 | 342 | 71 |
| Total - SOBRA Births | 4,319 | 105 | 4,207 | 4,679 | 472 | 5,082 | 403 |
| *Cost per SOBRA Birth* | *$18,858* | *$0* | *$21,074* | *$20,789* | *-$285* | *$21,829* | *$1,039* |
| NICU Stays | 494 | 59 | 444 | 522 | 78 | 568 | 46 |
| *Cost per NICU Stay* | *$60,130* | *-$12,280* | *$72,246* | *$63,136* | *-$9,110* | *$66,293* | *$3,157* |

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

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | $8.3 M | ($22.5 M) | ($14.2 M) |
| | 0.8% | -2.1% | -1.3% |
| FY 2026 over FY 2025 | $110.7 M | ($48.2 M) | $62.5 M |
| | 11.1% | -4.6% | 6.0% |
| FY 2026: Current over Enacted | $40.6 M | ($51.3 M) | ($10.7 M) |
| | 3.8% | -4.6% | -1.0% |
| FY 2027 over FY 2026 | $58.7 M | ($6.5 M) | $52.1 M |
| | 5.3% | -0.6% | 4.7% |

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

| | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| **RIte Care Core** | | | | | |
| MF < 1 y.o. | $866 | $726 | $763 | -16.1% | 5.0% |
| MF 1-4 y.o. | $303 | $345 | $362 | 13.6% | 5.0% |
| MF 5-14 y.o. | $247 | $265 | $278 | 7.1% | 5.0% |
| M 15-44 y.o. | $307 | $332 | $349 | 8.2% | 5.0% |
| F 15-44 y.o. | $465 | $500 | $525 | 7.5% | 5.0% |
| MF 45+ y.o. | $689 | $748 | $786 | 8.7% | 5.0% |
| Composite | $372 | $395 | $412 | 6.2% | 4.3% |
| *Average Member Months* | 160,140 | 152,340 | 151,004 | -4.9% | -0.9% |
| **RIte Care CSHCN** | | | | | |
| Substitute Care | $1,064 | $1,155 | $1,213 | 8.5% | 5.0% |
| SSI <15 | $2,454 | $2,736 | $2,873 | 11.5% | 5.0% |
| SSI 15-20 | $1,632 | $1,832 | $1,923 | 12.3% | 5.0% |
| Katie Beckett | $4,413 | $4,293 | $4,507 | -2.7% | 5.0% |
| Adoption Subsidy | $812 | $969 | $1,018 | 19.4% | 5.0% |
| Composite | $1,456 | $1,644 | $1,728 | 12.9% | 5.1% |
| *Average Member Months* | 9,739 | 9,686 | 9,853 | -0.5% | 1.7% |
| SOBRA Payment | $18,858 | $20,789 | $21,829 | 10.2% | 5.0% |
| EFP Only | $14 | $27 | $29 | 96.8% | 5.0% |
| Katie Beckett - Care Management | $125 | $94 | $98 | -25.1% | 5.0% |
| Rite Share | $130 | $139 | $153 | 6.8% | 10.0% |

Table III-6. Summary of Rite Smiles Monthly Premiums

| | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| **Rite Smiles** | | | | | |
| MF 0-2 | $4 | $5 | $5 | 3.9% | 5.0% |
| MF 3-5 | $15 | $16 | $17 | 7.7% | 5.0% |
| MF 6-10 | $22 | $23 | $24 | 3.7% | 5.0% |
| MF 11-15 | $25 | $25 | $27 | 1.4% | 5.0% |
| MF 16-19 | $17 | $17 | $18 | -0.1% | 5.0% |
| MF 20+ | $17 | $17 | $18 | -0.1% | 5.0% |
| Composite | $18 | $18 | $19 | 1.8% | 5.0% |
| *Average Enrollment* | 135,393 | 132,290 | 134,628 | -2.3% | 1.8% |

Table III-7. CHIP Offsets

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Nov CEC | Surplus/ (Deficit) | Nov CEC | FY26 → FY27 |
| **CHIP Offset** | **$ 133,375,768** | **($0.0 M)** | **$ 140,036,266** | **$ 136,743,139** | **($3.3 M)** | **$ 136,868,595** | **$0.1 M** |
| *Additional GR Relief* | *$17.6 M* | ($0.1 M) | *$18.0 M* | *$17.6 M* | | *$17.3 M* | ($0.2 M) |
| *CHIP FMAP* | 69.19% | | 70.04% | 70.04% | | 70.46% | |
| *Regular FMAP* | 55.99% | | 57.20% | 57.20% | | 57.80% | |

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

Table III-8. EFP Claiming

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Nov CEC | Surplus/ (Deficit) | Nov CEC | FY26 → FY27 |
| **Family Planning Offset** | **$ 8,700,000** | **($0.6 M)** | **$ 9,300,000** | **$ 8,700,000** | **($0.6 M)** | **$ 8,900,000** | **$0.2 M** |
| *Additional GR Relief* | *$3.0 M* | ($0.2 M) | *$3.1 M* | *$2.9 M* | ($0.2 M) | *$2.9 M* | $0.0 M |
| *Family Planning FMAP* | 90.00% | | 90.00% | 90.00% | | 90.00% | |
| *Regular FMAP* | 55.99% | | 57.20% | 57.20% | | 57.80% | |

Table III-9. CCBHC Claiming

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Nov CEC | Surplus/ (Deficit) | Nov CEC | FY26 → FY27 |
| **CCBHC Offset** | **$ 22,107,175** | **$0.4 M** | **$ 30,780,195** | **$ 26,743,182** | **($4.0 M)** | **$ 29,210,932** | **$2.5 M** |
| *Additional GR Relief* | *$2.9 M* | $0.0 M | *$4.0 M* | *$3.4 M* | ($0.5 M) | *$3.7 M* | $0.3 M |
| *CHIP FMAP* | 69.19% | | 70.04% | 70.04% | | 70.46% | |
| *Regular FMAP* | 55.99% | | 57.20% | 57.20% | | 57.80% | |

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

# IV. Rhody Health Partners

| Rhody Health Partners | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $292,912,685 | $128,710,656 |
| **FY 2025** | Revised Enacted | $311,400,000 | $133,700,651 |
| | Final | **$301,555,968** | **$129,919,387** |
| | *Surplus over Revised Enacted* | *$9,844,032* | *$3,781,264* |
| **FY 2026** | Enacted | $341,201,948 | $140,718,732 |
| | Current | **$336,700,000** | **$140,087,281** |
| | *Surplus over Enacted* | *$4,501,948* | *$631,451* |
| **FY 2027** | Current | **$348,900,000** | **$142,952,526** |

***FY 2026***

For Rhody Health Partners (RHP), Medicaid forecast expenditures of $336.7 million, including $140.1 million GR. This represents a surplus of $4.5 million (1.3%), including $0.6 million (0.5%) GR compared to the Enacted. The surplus is attributed to reduced premium payments associated with a reduction of beneficiaries in more expensive rate cells, i.e. 95 monthly membership reduction in SPMI, while overall enrollment in RHP is largely flat. A $1.4 million increase in rebate collections also contributes to the surplus.

Medicaid forecasts an average fiscal year enrollment of 12,757 in FY 2026, a decrease of 15 beneficiaries per month across all rate cells compared to the Enacted.

***FY 2027***

The RHP forecast of $348.9 million, including $143.0 million GR for FY 2027. This represents an increase of $12.2 million (3.6%), including $2.9 million GR (2.0%), compared to revised estimate for FY 2026. This increase is largely due to a $19.5 million increase in premium payments because of a rate inflation assumption of 5%, partially offset by a $6.1 million increase in pharmacy rebate collections.

Medicaid forecasts an average enrollment of 12,761 beneficiaries in RHP in FY 2027; an increase of just three when compared to revised FY 2026.

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

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

**Table IV-3** summarizes the price and volume variances for FY 2025 through FY 2027.

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

## Table IV-1. Summary of RHP Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Payments to Plans** | | | | | | | |
| Rhody Health Partners | $ 339,326,069 | $1.5 M | $ 372,035,003 | $ 367,124,088 | $4.9 M | $ 386,946,555 | $19.8 M |
| Withhold | 1,705,261 | 0.0 M | 1,813,261 | 1,843,468 | (0.0 M) | 1,936,525 | 0.1 M |
| Risk Share | 0 | 0.8 M | 0 | 1,834,086 | (1.8 M) | 0 | (1.8 M) |
| **Subtotal - Payment to Plans** | **$ 341,031,331** | **$2.3 M** | **$ 373,848,264** | **$ 370,801,642** | **$3.0 M** | **$ 388,883,080** | **$18.1 M** |
| *CCBHC (reflected in "Payments to Plans")* | *32,557,982* | *0.2 M* | *45,674,707* | *38,094,352* | *7.6 M* | *41,058,958* | *3.0 M* |
| **Other Payments** | | | | | | | 0 |
| Non-Emergency Transportation | 3,139,876 | 0.0 M | 3,228,395 | 3,228,437 | (0.0 M) | 3,485,251 | 0.3 M |
| FFS | 993,310 | 0.1 M | 1,218,000 | 1,071,000 | 0.1 M | 1,071,000 | 0.0 M |
| Rebates | (42,788,477) | 6.5 M | (37,092,711) | (38,474,327) | 1.4 M | (44,549,264) | (6.1 M) |
| **Subtotal - Other Payments** | **$ (38,655,291)** | **$6.6 M** | **$ (32,646,316)** | **$ (34,174,890)** | **$1.5 M** | **$ (39,993,013)** | **($5.8 M)** |
| **Subtotal - Rhody Health Partners** | **$ 302,376,040** | **$9.0 M** | **$ 341,201,948** | **$ 336,626,753** | **$4.6 M** | **$ 348,890,066** | **$12.3 M** |
| Balance to RIFANS/Accruals/Rounding | (820,072) | 0.9 M | 0 | 73,247 | (0.1 M) | 9,934 | (0.1 M) |
| **Total - Rhody Health Partners** | **$ 301,555,968** | **$9.8 M** | **$ 341,201,948** | **$ 336,700,000** | **$4.5 M** | **$ 348,900,000** | **$12.2 M** |
| *General Revenue* | *$129.9 M* | *$3.8 M* | *$140.7 M* | *$140.1 M* | *$0.6 M* | *$143.0 M* | *$2.9 M* |
| *Federal Funds* | *$171.6 M* | *$6.1 M* | *$200.5 M* | *$196.6 M* | *$3.9 M* | *$205.9 M* | *$9.3 M* |

## Table IV-2. RHP Average Enrollment

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Rhody Health Partners** | | | | | | | |
| SSI 21-44 | 3,536 | -17 | 3,563 | 3,567 | 4 | 3,564 | -4 |
| SSI 45+ | 6,101 | -22 | 6,089 | 6,085 | -5 | 6,084 | -1 |
| SPMI | 1,994 | -13 | 1,999 | 1,905 | -95 | 1,909 | 5 |
| I/DD | 1,108 | 0 | 1,120 | 1,201 | 81 | 1,204 | 3 |
| ***Total*** | 12,739 | -53 | 12,772 | 12,757 | -15 | 12,761 | 3 |
| *Composite RHP PMPM* | *$2,231* | *-$10* | *$2,439* | *$2,420* | *-$19* | *$2,536* | *$115* |
| *Overall PMPM (incl. of Other Payments)* | *$1,973* | *-$65* | *$2,226* | *$2,197* | *-$29* | *$2,302* | *$105* |
| ***Other Caseload Factors*** | | | | | | | |
| Non-Emergency Transportation | 12,733 | 127 | 12,726 | 12,726 | 0 | 12,722 | -5 |

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

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | ($9.9 M) | $1.8 M | ($8.1 M) |
| | -3.2% | 0.6% | -2.6% |
| FY 2026 over FY 2025 | $34.7 M | $0.4 M | $35.1 M |
| | 11.5% | 0.1% | 11.7% |
| FY 2026: Current over Enacted | ($4.1 M) | ($0.4 M) | ($4.5 M) |
| | -1.2% | -0.1% | -1.3% |
| FY 2027 over FY 2026 | $12.1 M | $0.1 M | $12.2 M |
| | 3.6% | 0.0% | 3.6% |

## Table IV-4. RHP Monthly Premiums

| | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| **Rhody Health Partners** | | | | | |
| SSI 21-44 | $1,638 | $1,756 | $1,844 | 7.2% | 5.0% |
| SSI 45+ | $2,285 | $2,515 | $2,641 | 10.1% | 5.0% |
| SPMI | $3,593 | $3,827 | $4,019 | 6.5% | 5.0% |
| I/DD | $1,373 | $1,550 | $1,627 | 12.9% | 5.0% |
| Composite | $2,231 | $2,408 | $2,529 | 7.9% | 5.0% |
| *Average Member Months* | 12,739 | 12,757 | 12,761 | 0.1% | 0.0% |

# V. Rhody Health Options

| Rhody Health Options | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $176,765,466 | $77,747,428 |
| **FY 2025** | Revised Enacted | $212,400,000 | $94,373,080 |
| | Final | **$215,486,871** | **$94,746,592** |
| | *Deficit over Revised Enacted* | *($3,086,871)* | *($373,512)* |
| **FY 2026** | Enacted | $220,353,823 | $94,258,122 |
| | Current | **$242,700,000** | **$102,582,565** |
| | *Deficit over Enacted* | *($22,346,177)* | *($8,324,443)* |
| **FY 2027** | Current | **$247,800,000** | **$101,920,781** |

***FY 2026***

The Rhody Health Options (RHO) revised forecast of $242.7 million, including $102.6 million GR, represents a deficit of $22.3 million (10.1%), $8.3 million (8.8%) GR, compared to Enacted. Medicaid forecasts an average enrollment of 11,788, an increase of 519 beneficiaries per month, compared to the prior forecast.

Medicaid is actively finalizing its rates for a new Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) contract with Neighborhood Health Plan of Rhode Island (NHPRI) effective January 1, 2026. A FIDE SNP is a type of Medicare Advantage plan that combines Medicare and Medicaid benefits into a single health plan for individuals who qualify for both. It is like the prior CMS arrangement but adheres to different rate setting methodologies that are generally seen as being more favorable to the health plan.

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

Changes in Medicaid's revised forecast for FY 2026 are attributable to the following:

- Increased enrollment due to Medicaid electing to passively enrolling approximately 1,000 beneficiaries in the final quarter of FY 2026 that had previously not been accounted for in Medicaid's May testimony. This passive enrollment offset some of the steady decline in the program and increases Medicaid's revised forecast for FY 2026 by 519 enrollees.
- Increase of approximately 1.5% to the composite rates for the first 6 months of FY 2026 (i.e., the last 6 months of NHPRI's current 18-month contract for the final rating period of the current CMS Demonstration) – this is less than the 5.0% increase assumed.
- The inclusion of CCBHC expenditures into the managed care rates effective January 2026. Previously, for FY 2025 and through the first half of FY 2026, this benefit expense was carved out of the current CMS Demonstration and paid on a fee for service basis.
    - There is an offsetting reduction in CCBHC expenditures in **Other Services** due to this shift of this benefit into the managed care contract.
- An increase in the composite price for the FIDE-SNP effective January 2025 that exceeds the 5.0% rate increased assumed in Enacted. Inclusive of new funding added for the CCBHC program, the composite rate increase effective January 1 is equivalent to approximately 10.0% when compared to the FY 2025 rates.
    - This composite change understates the pricing changes included in the FIDE SNP. This is because rates in the FIDE SNP are highly variable—ranging from $372 for a Community

Well Dual to $9,302 for a beneficiaries residing long term in a nursing facility—and the composite rate increase is also determined by any change in the mix of beneficiaries. The overall composite rate increases between October 2024 rates and January 2026 rates is estimated at 7.3% based on current mix of enrollees. However, the rate increases vary between less than 4% (for Dual – Community LTSS) and greater than 155% (for Dual – SPMI)—with the latter primarily due to inclusion of CCBHC spending.

***FY 2027***

Medicaid forecasts spending in the Rhody Health Options, for the new FIDE-SNP program, to increase by $5.1 million (2.1%) and decrease by $0.7 million GR (-0.6%), in FY 2027 over revised FY 2026 estimate. The attenuated growth is attributed to the following:

- Part of this stability is due to the rates shifting on a CY-basis in lieu of a FY-basis, and so the 5.0% price factor only impacts the second half of FY 2027;
- The cost of the 5.0% price assumption is attenuated by declining enrollment. This decline is the net result of an underlying growth rate of 1.5% discounted by a closure of 770 clients in October 2026 due to the H.R-1 qualified alien changes.
    - The 770 beneficiaries account for 6,930 member months in FY 2027, reducing premiums payments by $11.6 million. For additional information see relevant **H.R.-1 Federal Changes Impacting FY 2026 and 2027** in **Major Developments**.

The improving GR position is due to the accounting of increased enhanced FMAP available for approximately $20.9 million in CCBHC related expenditures now included in Rhody Health Options budget line – more than twice the amount assumed for FY 2026.

**Table VI-1** summarizes RHO expenditures.

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

**Table V-3** calculates the price and volume-related changes between FY 2025 and FY 2027.

The average monthly RHO capitation rates by pay level are summarized in **Table V-4.**

Table V-1. RHO Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Payments to Plans** | | | | | | | |
| CMS Demonstration/FIDE-SNP (RHO II) | $ 203,248,297 | ($3.7 M) | $ 208,609,161 | $ 235,017,807 | ($26.4 M) | $ 244,627,531 | $9.6 M |
| Withhold | 9,403,397 | (1.1 M) | 8,894,102 | 4,642,463 | 4.3 M | 0 | (4.6 M) |
| **Subtotal - Payment to Plans** | **$ 212,651,694** | **($4.7 M)** | **$ 217,503,263** | **$ 239,660,269** | **($22.2 M)** | **$ 244,627,531** | **$5.0 M** |
| **Other Payments** | | | | | | | |
| Non-Emergency Transportation | $ 2,809,164 | ($0.0 M) | $ 2,850,560 | $ 2,982,495 | ($0.1 M) | $ 3,107,939 | $0.1 M |
| Rebates | (10,568) | 0.0 M | 0 | 0 | 0.0 M | 0 | 0.0 M |
| **Subtotal - Other Payments** | **$ 2,798,596** | **$0.0 M** | **$ 2,850,560** | **$ 2,982,495** | **($0.1 M)** | **$ 3,107,939** | **$0.1 M** |
| **Subtotal - Rhody Health Options** | **$ 215,450,290** | **($4.7 M)** | **$ 220,353,823** | **$ 242,642,764** | **($22.3 M)** | **$ 247,735,470** | **$5.1 M** |
| Balance to RIFANS/Accruals/Rounding | 36,581 | 0.0 M | 0 | 57,236 | (0.1 M) | 64,530 | 0.0 M |
| **Total - Rhody Health Options** | **$ 215,486,871** | **($4.7 M)** | **$ 220,353,823** | **$ 242,700,000** | **($22.3 M)** | **$ 247,800,000** | **$5.1 M** |
| *General Revenue* | *$94.7 M* | *($0.4 M)* | *$94.3 M* | *$102.6 M* | *($8.3 M)* | *$101.9 M* | *($0.7 M)* |
| *Federal Funds* | *$120.7 M* | *($2.7 M)* | *$126.1 M* | *$140.1 M* | *($14.0 M)* | *$145.9 M* | *$5.8 M* |

Table V-2. RHO Average Enrollment

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Rhody Health Options** | | | | | | | |
| SPMI | 816 | 0 | 807 | 860 | 53 | 835 | -25 |
| I/DD | 1,260 | -2 | 1,256 | 1,246 | -10 | 1,209 | -37 |
| Community LTSS | 2,305 | 42 | 2,290 | 2,485 | 195 | 2,405 | -80 |
| Institutional LTSS | 609 | -5 | 619 | 602 | -17 | 584 | -18 |
| Community Non-LTSS | 6,432 | -19 | 6,298 | 6,596 | 298 | 6,344 | -251 |
| ***Total*** | 11,422 | 16 | 11,269 | 11,788 | 519 | 11,377 | -411 |
| *Overall PMPM* | *$1,572* | *$55* | *$1,629* | *$1,714* | *$84* | *$1,811* | *$97* |
| ***Other Caseload Factors*** | | | | | | | |
| Non-Emergency Transportation | 11,392 | -360 | 11,237 | 11,757 | 520 | 11,345 | -412 |

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

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | $7.5 M | ($6.6 M) | $0.9 M |
| | 3.6% | -3.1% | 0.4% |
| FY 2026 over FY 2025 | $20.3 M | $6.9 M | $27.2 M |
| | 9.1% | 3.2% | 12.6% |
| FY 2026: Current over Enacted | $12.2 M | $10.2 M | $22.3 M |
| | 5.3% | 4.6% | 10.1% |
| FY 2027 over FY 2026 | $13.6 M | ($8.5 M) | $5.1 M |
| | 5.8% | -3.5% | 2.1% |

Table V-4. Summary of RHO Monthly Premiums

| | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| **Rhody Health Options** | | | | | |
| SPMI | $948 | $1,545 | $2,263 | 63.0% | 46.5% |
| I/DD | $219 | $299 | $377 | 36.4% | 26.2% |
| Community LTSS | $5,078 | $5,210 | $5,198 | 2.6% | -0.2% |
| Institutional LTSS | $5,075 | $5,210 | $5,198 | 2.7% | -0.2% |
| Community Non-LTSS | $272 | $328 | $381 | 20.7% | 16.2% |
| Composite | $1,540 | $1,692 | $1,784 | 9.9% | 5.4% |
| *Average Member Months* | 11,422 | 11,788 | 11,377 | 3.2% | -3.5% |

# VI. Expansion

| Expansion | | All Funds | General Revenue |
|---|---|---|---|
| **FY 2024** | Final | $702,835,229 | $76,369,437 |
| **FY 2025** | Revised Enacted | $705,100,000 | $76,172,839 |
| | Final | **$717,473,870** | **$73,776,800** |
| | *Deficit over Revised Enacted* | *($12,373,870)* | *$2,396,039* |
| **FY 2026** | Enacted | $730,790,208 | $78,747,971 |
| | Current | **$741,500,000** | **$80,528,026** |
| | *Deficit over Enacted* | *($10,709,792)* | *($1,780,055)* |
| **FY 2027** | Current | **$701,600,000** | **$76,623,513** |

***FY 2026***

Medicaid's revised FY 2026 forecast for Expansion is $741.5 million, including $80.5 million GR: a $10.7 million (1.5%) deficit, including $1.8 million deficit GR (2.3%), compared to the Enacted. Average monthly enrollment of 80,663, represents a reduction of 940 eligible beneficiaries compared to Medicaid's prior forecast reflected in the Enacted. Of the revised eligibility figure, 76,407 are enrolled managed care.

The general deficit for Expansion is primarily attributed to:

- Increased capitation payments of $13.8 million, despite lower enrollment compared to Enacted, due to an overall $18 PMPM increase (2.4%).

This increased spending is mitigated by:

- Overall caseload-related savings of $8.4 million. Medicaid forecasts an average monthly enrollment of 80,663 beneficiaries, a decrease of 940 from the Enacted.
- Reduced SOBRA payments of $1.7 million.
- A decrease in fee-for-service spending of $6.2 million.

***FY 2027***

Medicaid projects Expansion expenditures for FY 2027 of $701.6 million, including $76.6 million GR. This represents a decrease of $39.9 million (5.4%), including $3.9 million GR (4.8%) compared to the current fiscal year. Average monthly enrollment for FY 2027 is 68,602, a decrease of 7,805.

This reduced caseload contributes to $71.4 million (9.6%) in reduced spending (holding PMPM constant) below the current year. The decreased enrollment occurs in all rate cells across the Expansion population. Significantly, the most expensive rate cells for adults aged 50-64 years old with a PMPM exceeding $1,000 are projected to decrease by 2,089 beneficiaries.

The decreases are partially mitigated by:

- A 5.0% increase across the managed care rating categories (compared to FY 2026), equivalent to a $40 increase for a composite PMPM of $813 in FY 2027.
- $1.6 million increase to fee-for-service spending and $1.8 million increase in SOBRA payments.

***Previously Eligible Expansion-Eligible Beneficiaries***

FY 2026 and FY 2027 include adjustments for Expansion beneficiaries who would have been previously eligible for Medicaid under criteria in place prior to January 1, 2014 (e.g., individuals who meet specific disability standards

but otherwise meet Expansion eligibility criteria). These beneficiaries are not eligible for the enhanced 90% federal financial participation and Rhode Island must return any enhanced FMAP claimed on behalf of these beneficiaries. Until the eligibility system is properly configured to prospectively identify these beneficiaries, Medicaid must make adjusting entries at the end of each fiscal year. The revised estimate includes $16.3 million in FY 2026 and $15.5 million in FY 2027 that are not eligible for a 90/10 match.

**Table VI-1** summarizes all expenditures by product line to the health plans as well as various FFS payments.

Medicaid's revised average caseload forecast and a comparison to prior estimates is summarized in **Table VI-2** with additional month-by-month detail provided in **Attachment 5**.

**Table VI-3** calculates the price and volume related changes for FY 2025 Final, FY 2026 Enacted and Current, and FY 2027 over FY 2026.

The average monthly Expansion capitation rates, by pay level, are summarized in **Table VI-4**.

Table VI-1. Summary of Medicaid Expansion Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Payments to Plans** | | | | | | | |
| Expansion | $ 647,857,651 | ($0.2 M) | $ 676,838,872 | $ 688,495,850 | ($11.7 M) | $ 651,309,045 | ($37.2 M) |
| Expansion - Previously Eligible | 15,300,000 | 0.0 M | 15,900,000 | 18,108,168 | (2.2 M) | 18,792,904 | 0.7 M |
| RIte Smiles | 1,942,578 | 0.1 M | 2,135,585 | 1,933,044 | 0.2 M | 2,065,247 | 0.1 M |
| SOBRA | 4,186,441 | 1.1 M | 7,286,275 | 5,633,868 | 1.7 M | 7,465,395 | 1.8 M |
| Withhold | 3,332,001 | (0.0 M) | 3,455,162 | 3,541,568 | (0.1 M) | 3,345,658 | (0.2 M) |
| Risk Share | 27,044,632 | (17.9 M) | 0 | 3,552,149 | (3.6 M) | 0 | (3.6 M) |
| **Subtotal - Payments to Plans** | **$ 699,663,304** | **($17.0 M)** | **$ 705,615,895** | **$ 721,264,647** | **($15.6 M)** | **$ 682,978,249** | **($38.3 M)** |
| *CCBHC (reflected in "Payments to Plans")* | *25,882,959* | *(0.1 M)* | *35,445,290* | *31,330,970* | *4.1 M* | *30,821,127* | *(0.5 M)* |
| **Other Payments** | | | | | | | |
| Non-Emergency Transportation | $ 12,251,100 | $0.0 M | $ 12,200,242 | $ 12,014,575 | $0.2 M | $ 11,574,051 | ($0.4 M) |
| Expansion FFS | 69,284,289 | 3.3 M | 76,654,000 | 70,415,000 | 6.2 M | 72,006,000 | 1.6 M |
| Rebates | (64,998,246) | 0.6 M | (63,679,929) | (62,199,479) | (1.5 M) | (64,970,286) | (2.8 M) |
| DRE | (62,061,665) | 0.5 M | (60,897,976) | (59,256,288) | (1.6 M) | (62,196,014) | (2.9 M) |
| J-Code | (2,936,581) | 0.1 M | (2,781,953) | (2,943,191) | 0.2 M | (2,774,272) | 0.2 M |
| **Subtotal - Other Payments** | **$ 16,537,143** | **$3.9 M** | **$ 25,174,313** | **$ 20,230,096** | **$4.9 M** | **$ 18,609,765** | **($1.6 M)** |
| **Subtotal - Expansion** | **$ 716,200,446** | **($13.1 M)** | **$ 730,790,208** | **$ 741,494,742** | **($10.7 M)** | **$ 701,588,014** | **($39.9 M)** |
| Balance to RIFANS/Accruals/Rounding | 1,273,424 | (1.2 M) | 0 | 5,258 | (0.0 M) | 11,986 | 0.0 M |
| **Total - Expansion** | **$ 717,473,870** | **($14.3 M)** | **$ 730,790,208** | **$ 741,500,000** | **($10.7 M)** | **$ 701,600,000** | **($39.9 M)** |
| *General Revenue* | *$73.8 M* | *$2.4 M* | *$78.7 M* | *$80.5 M* | *($1.8 M)* | *$76.6 M* | *($3.9 M)* |
| *Federal Funds* | *$643.7 M* | *($14.8 M)* | *$652.0 M* | *$661.0 M* | *($8.9 M)* | *$625.0 M* | *($36.0 M)* |

Table VI-2. Summary Medicaid Expansion Average Enrollment

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| **Enrolled** | | | | | | | |
| F 19-24 | 7,832 | 35 | 7,505 | 7,477 | -28 | 6,695 | -782 |
| F 25-29 | 4,606 | 17 | 4,392 | 4,422 | 30 | 3,958 | -463 |
| F 30-39 | 5,696 | 14 | 5,515 | 5,624 | 109 | 5,053 | -571 |
| F 40-49 | 4,691 | 9 | 4,520 | 4,632 | 112 | 4,188 | -444 |
| F 50-64 | 12,342 | -36 | 11,913 | 11,497 | -416 | 10,435 | -1,063 |
| M 19-24 | 8,145 | 40 | 7,747 | 7,562 | -185 | 6,759 | -802 |
| M 25-29 | 6,249 | 21 | 5,940 | 5,768 | -171 | 5,115 | -653 |
| M 30-39 | 11,705 | 20 | 11,316 | 11,343 | 27 | 10,103 | -1,240 |
| M 40-49 | 7,604 | 10 | 7,404 | 7,522 | 118 | 6,761 | -761 |
| M 50-64 | 11,103 | -28 | 10,769 | 10,561 | -208 | 9,536 | -1,026 |
| ***Subtotal - Enrolled*** | 79,972 | 102 | 77,020 | 76,407 | -613 | 68,602 | -7,805 |
| Rite Share | 34 | -3 | 32 | 18 | -13 | 31 | 12 |
| Remaining in FFS | 4,333 | -38 | 4,552 | 4,238 | -314 | 4,264 | 26 |
| ***Total - Expansion*** | 84,340 | 61 | 81,603 | 80,663 | -940 | 72,897 | -7,767 |
| *Overall PMPM* | *$709* | *$14* | *$746* | *$764* | *$18* | *$806* | *$41* |
| *% Enrolled in Managed Care* | 94.8% | | 94.4% | 94.7% | | 94.1% | |
| ***Other Caseload Factors*** | | | | | | | |
| Non-Emergency Transportation | 82,800 | -78 | 80,117 | 78,898 | -1,219 | 70,763 | -8,135 |
| SOBRA Births | 222 | -56 | 350 | 271 | -79 | 342 | 71 |

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

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | $13.8 M<br>2.0% | $0.5 M<br>0.1% | $14.3 M<br>2.0% |
| FY 2026 over FY 2025 | $55.3 M<br>8.1% | ($31.3 M)<br>-4.4% | $24.0 M<br>3.3% |
| FY 2026: Current over Enacted | $19.1 M<br>2.6% | ($8.4 M)<br>-1.2% | $10.7 M<br>1.5% |
| FY 2027 over FY 2026 | $31.5 M<br>4.7% | ($71.4 M)<br>-9.6% | ($39.9 M)<br>-5.4% |

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

| | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| **Expansion** | | | | | |
| F 19-24 | $378 | $412 | $432 | 8.9% | 5.0% |
| F 25-29 | $526 | $572 | $600 | 8.6% | 5.0% |
| F 30-39 | $756 | $831 | $873 | 10.0% | 5.0% |
| F 40-49 | $964 | $1,055 | $1,107 | 9.4% | 5.0% |
| F 50-64 | $974 | $1,058 | $1,111 | 8.6% | 5.0% |
| M 19-24 | $236 | $310 | $326 | 31.8% | 5.0% |
| M 25-29 | $416 | $466 | $490 | 12.1% | 5.0% |
| M 30-39 | $619 | $684 | $718 | 10.6% | 5.0% |
| M 40-49 | $872 | $961 | $1,009 | 10.2% | 5.0% |
| M 50-64 | $983 | $1,105 | $1,161 | 12.4% | 5.0% |
| Composite | $695 | $773 | $813 | 11.2% | 5.2% |
| *Average Member Months* | 79,972 | 76,407 | 68,602 | -4.5% | -10.2% |

# VII. Hospitals – Regular

| Hospitals - Regular | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $354,175,364 | $122,826,036 |
| **FY 2025** | Revised Enacted | $346,900,000 | $112,626,926 |
| | Final | **$341,190,603** | **$116,953,804** |
| | *Surplus over Revised Enacted* | *$5,709,397* | *($4,326,878)* |
| **FY 2026** | Enacted | $408,226,193 | $130,443,116 |
| | Current | **$405,800,000** | **$131,269,677** |
| | *Surplus over Enacted* | *$2,426,193* | *($826,561)* |
| **FY 2027** | Current | **$402,700,000** | **$132,742,552** |

***FY 2026***

Medicaid's revised estimate for **Hospital – Regular** totals $405.8 million, including $131.3 million GR, in FY 2026; a $2.4 million (0.6%) All Funds surplus, but a $0.8 million GR (0.6%) deficit compared to the Enacted. The different status of the All Funds position and GR position is due to a marginal decrease in the proportional allocations of supplemental payments—including Upper Payment Limit and State Directed Payments—to the Expansion funding source. Because this allocation is based on actual claims experience, the relatively greater reduction in Expansion beneficiaries compared to non-Expansion beneficiaries, reduces the proportion of these gross supplemental payments that remain eligible for the 90% FMAP.

The gross decline in **Hospital – Regular** expenditures is driven by reduced inpatient ($5.7 million) hospital claims activity, offsetting a $1.0 million increase in outpatient activity, and slightly increased overall supplemental payments ($2.2 million).

Medicaid's methodology for revising its current year estimate included looking at FY25 claims activity, specifically the impact of FY25 Q4, adjusting for an incurred but not reported (IBNR) factor. The FY26 estimate includes the 2.3% rate increase effective July 1, 2025.

***FY 2027***

FY 2027 hospital spending is expected to decrease by $3.1 million to $402.7 million, including $132.7 million GR.

The overall decrease is attributed to a $12.6 million reduction to the Hospital State Directed Payments, despite the amount of GR used to finance the payment remaining constant between FY 2026 and FY 2027. The reduction in federal funds is due to the forecasted reduction in Expansion beneficiaries who are eligible for 90% federal financial participation. They in turn will increase the state share as a proportion of the SDP expenditure, reducing the multiplicative effect of the budgeted GR amount. This is discussed further in the following pages.

Changes in FY 2027 include offsetting impacts related to the qualified alien changes included in H.R.-1:

- Reduction of $5.3 million in hospital spending associated with the reduction in the claims activity among immigrants who will not retain or who no longer become Medicaid eligible because changes in H.R.-1.
- Increase of $6.3 million in hospital spending due to heightened Emergency Medicaid activity associated with those losing coverage relying more heavily on emergency services.

Other notable changes include the annualizing the anticipated placements in the new long term behavioral health unit at St. Joseph/Fatima Hospital that were only partially accounted for in the current fiscal year, increasing this cost from $4.1 million in FY 2026 to $11.3 million in FY 2027.

Overall, as it relates to baseline FFS spending, the estimate assumes a projected annual rate change of 3.3% for inpatient and outpatient services, pursuant to current law, which is estimated at $1.4 million. Medicaid also assumes a 1.5% utilization increase in FY 2026 given the FY 2025 experience.

A summary of the revised estimates for FY 2026 and FY 2027 are shown in **Table VII-1**. A summary of the price changes for FY 2027 are included in **Table VII-2**.

Table VII-1. Summary of Hospital – Regular Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Supplemental Payments** | | | | | | | |
| Inpatient UPL | $ 10,487,197 | $0.0 M | $ 16,829,582 | $ 18,528,018 | ($1.7 M) | $ 18,528,018 | $0.0 M |
| Regular | 7,969,117 | 0.1 M | 12,891,460 | 14,079,257 | (1.2 M) | 14,079,257 | 0.0 M |
| Expansion | 2,518,080 | (0.1 M) | 3,938,122 | 4,448,761 | (0.5 M) | 4,448,761 | 0.0 M |
| Outpatient UPL | 7,846,189 | 0.0 M | 8,396,504 | 8,926,997 | (0.5 M) | 8,926,997 | 0.0 M |
| Regular | 5,527,401 | 0.5 M | 6,431,722 | 6,288,797 | 0.1 M | 6,288,797 | 0.0 M |
| Expansion | 2,318,788 | (0.5 M) | 1,964,782 | 2,638,200 | (0.7 M) | 2,638,200 | 0.0 M |
| SDP - Hospital Payments | 281,032,815 | 0.0 M | 325,279,678 | 324,718,048 | 0.6 M | 312,088,065 | (12.6 M) |
| SDP - MCO Tax | 5,735,364 | (0.0 M) | 6,065,269 | 6,626,899 | (0.6 M) | 6,369,144 | (0.3 M) |
| **Subtotal - Supplemental Payments** | **$ 305,101,565** | **($0.0 M)** | **$ 356,571,033** | **$ 358,799,962** | **($2.2 M)** | **$ 345,912,224** | **($12.9 M)** |
| **FFS Activity** | | | | | | | |
| Inpatient FFS | $ 32,896,673 | ($4.2 M) | $ 43,209,000 | $ 38,030,000 | $5.2 M | $ 47,333,813 | $9.3 M |
| Outpatient FFS | 8,340,176 | (0.6 M) | 8,351,000 | 8,969,000 | (0.6 M) | 9,404,000 | 0.4 M |
| **Subtotal - FFS Activity** | **$ 41,236,849** | **($4.8 M)** | **$ 51,560,000** | **$ 46,999,000** | **$4.6 M** | **$ 56,737,813** | **$9.7 M** |
| **Subtotal - Hospitals - Regular** | **$ 346,338,414** | **($4.8 M)** | **$ 408,131,033** | **$ 405,798,962** | **$2.3 M** | **$ 402,650,037** | **($3.1 M)** |
| Balance to RIFANS/Accruals/Rounding | (5,147,811) | 10.5 M | 95,160 | 1,038 | 0.1 M | 49,964 | 0.0 M |
| **Total - Hospitals - Regular** | **$ 341,190,603** | **$5.7 M** | **$ 408,226,193** | **$ 405,800,000** | **$2.4 M** | **$ 402,700,000** | **($3.1 M)** |
| *General Revenue* | *$117.0 M* | *($4.3 M)* | *$130.4 M* | *$131.3 M* | *($0.8 M)* | *$132.7 M* | *$1.5 M* |
| *Federal Funds* | *$224.2 M* | *$10.0 M* | *$277.8 M* | *$274.5 M* | *$3.3 M* | *$270.0 M* | *($4.6 M)* |

Table VII-2. FY 2027 Hospital Trend Assumptions (Excludes Managed Care and Expansion FFS)

| **Inpatient** | **Percent** | **Dollar Impact** | **Source** |
|---|---|---|---|
| Price | 3.3% | $1.1 million | FFY 26 Inpatient Hospital PPS Market Basket - No Productivity Adjustment |
| Utilization | 1.5% | $0.5 million | Medicaid |
| ***Subtotal Inpatient*** | | ***$1.6 million*** | |
| **Outpatient** | **Percent** | **Dollar Impact** | **Source** |
| Price | 3.3% | $0.3 million | FFY 26 Inpatient Hospital PPS Market Basket - No Productivity Adjustment |
| Utilization | 1.5% | $0.4 million | Medicaid |
| ***Subtotal Outpatient*** | | ***$0.7 million*** | |
| **TOTAL** | | **$2.4 million** | |

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

### *Upper Payment Limit (UPL)*

FY 2026

The FY 2026 estimate is comprised of $18.5 million for inpatient and $8.9 million for outpatient and reflects a deficit over enacted of $2.2 million ($1.7 inpatient, and $0.5 million outpatient). The FY 2026 estimate has been revised for latest cost reports received from participating hospitals. The updated modeling reflects the impact of the FFY 2024 Medicare cost reports. Based on Medicaid's analysis of the proportion of hospital FFS expenditures, approximately 24% of inpatient activity and 27% of outpatient activity is eligible for 90.0% federal financial participation. This allocation is reflected in the state-federal splits for the Hospital budget line.

FY 2027

The FY 2026 revised estimates are held constant for FY 2027, comprised of $18.5 million for inpatient and $8.9 million for outpatient.

***Managed Care State Directed Payment (SDP) to Hospitals***

FY 2026

Medicaid assumes $331.3 million in all funds financing for the managed care hospital SDP, including $99.5 million GR, consistent with the enacted budget. Hospitals expect to receive $324.7 million in total payments, while $6.6 million is allocated to the premium tax paid by the MCOs. The FY 2026 SDP allocation by hospital was forecasted by distributing funds based on the FY 2025 Q4 payment distribution.

This SDP allocation assumes that the pending pre-print submission is approved by CMS and the allocation can be grandfathered in as discussed in the Major Developments section.

FY 2027

Medicaid maintains GR support consistent with the FY 2026 Enacted at $99.5 million, inclusive of the tax liability incurred by the plans. The total SDP was adjusted accordingly based on the FFY 2027 FMAP rates and utilization mix across the different eligibility groups, i.e., Expansion, CHIP, and Regular Medicaid. With current enrollment forecasts, Medicaid estimates $99.5 million GR will support SDPs of $318.5 million, a decrease of $12.9 million compared to the FY 2026 Enacted total. Exclusive of the premium tax, the amount to be received by hospitals is forecasted to decrease by $12.6 million from $324.7 million to $312.1 million. The decline is attributed to the more significant decline in Expansion beneficiaries—whose expenditures are financed with a 90% federal match—compared to the other eligibility groups.

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

Table VII-3. Supplemental Payments by Hospital, FY 2026

| | SFY 2025 | SFY 2026: | | | | | |
|---|---|---|---|---|---|---|---|
| | | | | UPL: | | Total | FY25 → FY26 |
| | Total | SDP [1],[2] | DSH [3] | Inpatient | Outpatient | | |
| Rehab | $ 398,806 | $ 159,642 | $ - | $ 21,525 | $ - | $ 181,167 | $ (217,639) |
| Bradley | 21,130,074 | 24,414,645 | - | - | - | 24,414,645 | $ 3,284,571 |
| Butler | 22,694,664 | 26,222,444 | - | - | - | 26,222,444 | $ 3,527,780 |
| Eleanor Slater | 7,000,000 | - | 12,900,000 | - | - | 12,900,000 | $ 5,900,000 |
| Kent | 22,852,493 | 24,078,724 | 40,473 | 1,467,312 | 647,622 | 26,234,131 | $ 3,381,638 |
| Landmark | 12,823,959 | 14,056,216 | - | 691,432 | 395,337 | 15,142,985 | $ 2,319,026 |
| Miriam | 27,530,509 | 29,461,895 | - | 1,581,584 | 999,541 | 32,043,020 | $ 4,512,511 |
| Newport | 8,419,576 | 9,255,178 | - | 335,734 | 217,121 | 9,808,033 | $ 1,388,457 |
| Rhode Island | 120,388,912 | 125,080,643 | 412,959 | 5,379,808 | 4,989,363 | 135,862,773 | $ 15,473,861 |
| Roger Williams | 17,267,352 | 12,469,574 | 352,256 | 825,564 | 450,456 | 14,097,850 | $ (3,169,502) |
| Our Lady of Fatima | 10,758,013 | 9,325,491 | 122,646 | 974,391 | 299,700 | 10,722,228 | $ (35,785) |
| South County | 4,788,626 | 5,312,370 | - | 100,002 | 155,931 | 5,568,303 | $ 779,677 |
| Westerly | 3,973,346 | 3,249,547 | 71,666 | 62,654 | 79,593 | 3,463,460 | $ (509,886) |
| Women & Infants | 41,078,742 | 41,631,679 | - | 7,088,012 | 692,333 | 49,412,024 | $ 8,333,282 |
| Encompass Rehab [4] | - | - | - | - | - | - | $ - |
| Total | $ 321,105,072 | $ 324,718,048 | $ 13,900,000 | $ 18,528,018 | $ 8,926,997 | $ 366,073,063 | $ 44,967,991 |

Note 1. SDP payment for SFY 2026 will be reconciled and completed in last quarter of CY 2026. Amounts do not include state premium tax included in payment to MCOs.
Note 2. Total SDP payment reflects amount included in SFY 2026 Enacted budget and distributed based on SFY 2025 Q4 payments. Actual distribution may vary.
Note 3. DSH total may change due to allowances under uncompensated care and its interaction with the State Directed Payment. New DSH workbooks are anticipated to be submitted to EOHHS in May 2026
Note 4. New hospital - operations began in August 2024, no supplemental payments received in FY25. Awaiting information to generate FY26 estimated payments

# VIII. Hospitals - DSH

| Hospitals - DSH Payments | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $14,738,872 | $6,714,937 |
| **FY 2025** | Revised Enacted | $27,638,872 | $12,075,423 |
| | Final | **$27,646,654** | **$12,075,423** |
| | *Deficit over Revised Enacted* | *($7,782)* | *$0* |
| **FY 2026** | Enacted | $13,900,000 | $5,794,894 |
| | Current | **$13,900,000** | **$5,907,500** |
| | *Deficit over Enacted* | *$0* | *($112,606)* |
| **FY 2027** | Current | **$13,900,000** | **$5,851,900** |

***FY 2026***

Medicaid estimates a $13.9 million DSH payment in FY 2026, no change from the Enacted from all sources. The GR share of expenses is updated to reflect actual FY 2026 FMAP. This includes a $12.9 million payment to Eleanor Slater hospital, and $1.0 million to the remaining DSH eligible private hospitals. The inclusion of the hospital SDP is expected to make the majority of private hospitals ineligible for a DSH payment.

***FY 2027***

Medicaid has not yet received its preliminary FFY 2027 / SFY 2027 federal allotment. Absent the allotment, Medicaid maintains its FY 2026 estimate, adjusted for the FFY 2027 FMAP.

Table VIII-1. Summary of Hospitals – DSH Expenditures

| | **SFY 2025** | | **SFY 2026** | | | **SFY 2027** | |
|---|---|---|---|---|---|---|---|
| | **Final** | **Surplus/ (Deficit)** | **Enacted** | **Current** | **Surplus/ (Deficit)** | **Current** | **FY26 → FY27** |
| DSH - Private Hospitals | $ 14,738,872 | $0.0 M | $ 1,000,000 | $ 1,000,000 | $0.0 M | $ 1,000,000 | $0.0 M |
| DSH - Eleanor Slater Hospital | 12,900,000 | 0.0 M | 12,900,000 | 12,900,000 | 0.0 M | 12,900,000 | 0.0 M |
| Balance to RIFANS/Accruals/Rounding | 7,782 | (0.0 M) | 0 | 0 | 0.0 M | 0 | (0.0 M) |
| **Total - Hospitals - DSH** | **$ 27,646,654** | **($0.0 M)** | **$ 13,900,000** | **$ 13,900,000** | **$0.0 M** | **$ 13,900,000** | **($0.0 M)** |
| *General Revenue* | *$12.1 M* | *$0.0 M* | *$5.8 M* | *$5.9 M* | *($0.1 M)* | *$5.9 M* | *($0.1 M)* |
| *General Revenue* | *$15.6 M* | *($0.0 M)* | *$8.1 M* | *$8.0 M* | *$0.1 M* | *$8.0 M* | *$0.1 M* |

***FFY 2021 DSH Audit***

The independent audit of Rhode Island's FFY 2021 DSH payments was completed in December 2024. The audit found that Landmark Hospital received a DSH payment that exceeded its total eligible uncompensated care costs (UCC). Estimated UCC are based on prior year data updated for inflation. This prior year data can differ from actual experience and lead to overpayment.

The Medicaid State Plan requires that Medicaid recoup from Landmark the amount by which the DSH payment exceeded eligible UCC and redistribute this amount to the other qualifying hospitals. CMS mandates that the recoupment and redistribution be completed within one year of discovery, which is December 20, 2025. Medicaid entered into a legal agreement with Landmark to recoup the overpayment in nine monthly installments, between February and October 2025. To date, all payments have been received, with only the October 2025 final payment still pending. Once the overpayment is fully recouped, Medicaid will redistribute the funds to the remaining hospitals by the end of calendar year 2025.

Table VIII-2. FFY 2021 DSH Recoupment and Redistribution

| Hospital | Recoupment | Redistribution |
|---|---|---|
| Kent Hospital | $ - | $ 1,428,361 |
| Landmark Hospital | (10,871,201) | - |
| Miriam Hospital | - | 671,917 |
| Newport Hospital | - | 299,647 |
| Rhode Island Hospital | - | 4,527,090 |
| Roger Williams Medicial Center | - | 912,112 |
| Our Lady of Fatima Hospital | - | 644,184 |
| South County Hospital | - | 293,699 |
| Westerly Hospital | - | 367,612 |
| Women & Infants Hospital | $ - | 1,726,579 |
| | $ (10,871,201) | $ 10,871,201 |

***FFY 2022 DSH Audit***

The independent audit of Rhode Island's FFY 2022 DSH payments is currently underway and is expected to be completed in December 2025.

***SFY 2026 DSH Allotment and Reductions***

CMS sent Medicaid its reduced preliminary FFY 2026 DSH allotment in October 2025. The preliminary federal allotment of $40.2 million allows for a maximum DSH payment of $70.0 million. Medicaid maintains the FY 2026 Enacted amount of $13.9 million, with GR and All Funds reflecting FFY 2026 FMAP rates.

**Table VIII-3** summarizes the FY 2026 DSH amounts.

Table **VIII-3**. FFY 2026 / SFY 2026 DSH Summary

| SFY 26 | Federal Funds | General Revenue | Total DSH | General Revenue vs. Enacted | Total DSH vs. Enacted | Effective FMAP |
|---|---|---|---|---|---|---|
| Enacted | $ 8,105,106 | $ 5,794,894 | $ 13,900,000 | $ - | $ - | 58.31% |
| Nov. Testimony | 7,992,500 | 5,907,500 | 13,900,000 | - | - | 57.50% |
| Max DSH with Reduction | $ 40,226,072 | $ 29,732,314 | $ 69,958,386 | $ 23,937,420 | $ 56,058,386 | 57.50% |

***SFY 2027 DSH Allotment and Reductions***

The Full-Year Continuing Appropriations and Extension Act, 2025 (enacted on March 15, 2025) eliminated the FFY 2025 DSH allotment reductions required under section 1923(f)(7)(A) of the Social Security Act (the Act). Currently, the DSH allotment reductions required under section 1923(f)(7)(A) of the Act are in effect for FFY 2026 through FFY 2028, at $8 billion for each fiscal year. The first of these reductions is reflected in the FFY 2026 table above. Medicaid has not yet received its preliminary FFY 2027 federal allotment or anticipated reduction. Absent the allotment, Medicaid maintains the amount of $13.9 million, with GR and All Funds splits updated to reflect FFY 2027 FMAP rates.

Table **VIII**-4. FFY 2027 / SFY 2027 DSH Summary

| SFY 27 | Federal Funds | General Revenue | Total DSH | General Revenue vs. Enacted | Total DSH vs. Enacted | Effective FMAP |
|---|---|---|---|---|---|---|
| FFY 2026 / SFY 2026 Payment | 7,992,500 | 5,907,500 | 13,900,000 | | | 57.50% |
| FFY 2027 / SFY 2027 Payment | 8,035,590 | 5,864,410 | 13,900,000 | | | 57.81% |
| Max DSH with Reduction | 40,226,072 | 29,357,170 | 69,583,242 | 23,449,670 | 55,683,242 | 57.81% |

# IX. Nursing and Hospice Care

| Nursing and Hospice Care | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $354,530,496 | $157,303,755 |
| **FY 2025** | Revised Enacted | $425,000,000 | $187,042,500 |
| | Final | **$402,946,046** | **$177,274,058** |
| | *Surplus over Revised Enacted* | *$22,053,954* | *$9,768,442* |
| **FY 2026** | Enacted | $477,321,981 | $204,266,507 |
| | Current | **$452,600,000** | **$193,712,800** |
| | *Surplus over Enacted* | *$24,721,981* | *$10,553,707* |
| **FY 2027** | Current | **$477,500,000** | **$201,505,000** |

***FY 2026***

The FY 2026 revised estimate for the nursing and hospice budget line totals $452.6 million, including $193.7 million GR. This represents a $24.7 million (5.2%), including $10.6 million GR, surplus compared to the Enacted. This surplus reflects reduced utilization.

Medicaid implemented a 5.3% rate increase effective October 1, 2025. This follows upon last year's 14.5% increase that was the result of a cost-based rebasing of the facility per diem. After reduction in patient share as a proportion of total nursing facility revenues considerations (i.e., patient contributions are not expected to increase by 5.3% as well) and so the effective increase in direct Medicaid costs is estimated to be 6.2%.

The revised estimate includes actual expenses paid from October 2024 through June 2025, reflecting the rebasing of nursing home per diem effective October 1, 2024. For FY 2026, Medicaid lowered its prior (i.e., as reflected in its May CEC testimony) utilization factor from 2.5% to 0.0%.

As seen in **Table IX-4**, the total nursing facility authorizations are stable-to-declining within FFS (a lag in authorizations understates the actual authorizations anticipated for the second half of FY 2025); however, given uncertainty around (a) how the shift from RUG-IV to PDPM that begins this month may impact average acuity, and (b) the reality of persistent growth since what the low point of authorizations in Summer 2020, assuming a negative utilization factor is imprudent. Additional information on the shift from RUG-IV to PDPM is outlined below; however, it should be noted that although the shift is intended to be budget neutral, changes in coding patterns could have unintended consequences in terms of gross revenues if average acuity increases as a result of this change.

***FY 2027***

The FY 2027 estimate totals $477.5 million, including $201.5 million GR. This reflects an increase of $24.9 million (5.5%), including $7.8 million GR (5.4%) over the current fiscal year.

This estimate reflects price trend factor of 3.2% after the application of a 0.7% productivity adjustment factor, as derived from CMS Skilled Nursing Facility PPS market basket update for FFY 2026. After patient share, this increases to an effective change of 3.8%.

With respect to utilization, a 1.5% factor is applied; however, this non-price factor can be interpreted to represent a change in either average acuity or average daily census.

A below-the-line reduction of $1.8 million is assumed within the FY 2027 estimate to reflect LTSS beneficiaries losing coverage who will no longer meet eligibility requirements following implementation of H.R.-1 requirements for qualified aliens. During the nine months following the implementation of the new federal regulations, this is equivalent to 21 beneficiaries per day.

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

**Table IX-2** shows the average nursing facility per diem before and after patient share. Noteworthy, between 2020 and 2025, net patient revenue from Medicaid beneficiaries at nursing facilities in Rhode Island has cumulatively increased 44.6%, an average of 7.7% per year. This is nearly twice the cumulative inflation in the United States that between 2020 and 2025 (estimate) was 25.2%, equivalent to 4.6% per year.[7]

Average patient share, which is projected to be 14.7% of total patient revenue for FY 2026, is estimated to remain at $49 per day. This stability in total patient share is assumed despite likelihood of social security payments increases because offsetting reductions to other assets such as annuities and equities may lessen other the total asset pool available for a beneficiary's contribution to the cost of care.

Rate and utilization assumptions used are presented in **Table IX-3**. Additional information on paid days is presented in **Attachment 4**.

**Figure IX-1** summarizes the increase in overall spending on nursing facilities and the average monthly Medicaid census at Rhode Island nursing facilities across all payers and funding sources. Please note that this data is not completed for missing data or IBNR and so the apparent decline in the last quarter of available data is likely overstated. **Table IX-4** provides some additional details on the nature of the stays by budget line and payer.

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **FFS Activity** | | | | | | | |
| Hospice | $ 33,491,103 | $0.1 M | $ 37,791,000 | $ 38,477,000 | ($0.7 M) | $ 40,752,000 | $2.3 M |
| Nursing Home | 376,451,905 | 18.6 M | 439,530,981 | 414,074,000 | 25.5 M | 436,727,974 | 22.7 M |
| **Subtotal FFS** | **$ 409,943,008** | **$18.7 M** | **$ 477,321,981** | **$ 452,551,000** | **$24.8 M** | **$ 477,479,974** | **$24.9 M** |
| Balance to RIFANS/Rounding | (6,996,962) | 3.3 M | 0 | 49,000 | (0.0 M) | 20,026 | (0.0 M) |
| **Total - Nursing and Hospice Care** | **$ 402,946,046** | **$22.1 M** | **$ 477,321,981** | **$ 452,600,000** | **$24.7 M** | **$ 477,500,000** | **$24.9 M** |
| *General Revenue* | *$177.3 M* | *$8.0 M* | *$204.3 M* | *$193.7 M* | *$10.6 M* | *$201.5 M* | *$7.8 M* |
| *Federal Funds* | *$225.7 M* | *$10.0 M* | *$273.1 M* | *$258.9 M* | *$14.2 M* | *$276.0 M* | *$17.1 M* |

Table IX-2. Average Nursing Home Medicaid per diem

| Effective Date [1] | Average Nursing Facility per Diem | Medicaid Cost per Day | Patient Share per Day [2] | Patient Share % |
|---|---|---|---|---|
| October 1, 2020 | $240 | $200 | $40 | 16.7% |
| October 1, 2021 | $249 | $207 | $42 | 16.9% |
| October 1, 2022 | $261 | $216 | $45 | 17.2% |
| October 1, 2023 | $282 | $235 | $47 | 16.7% |
| October 1, 2024 | $329 | $280 | $49 | 14.9% |
| October 1, 2025 est. | $346 | $295 | $51 | 14.7% |
| October 1, 2026 est. | $357 | $304 | $53 | 14.8% |

Note 1. Average of the 12-months following effective date. October 2025 and October 2026 estimates.
Note 2. For October 2025 and October 2026, average patient share estimated to increase by $2 per day due to COLA increases for Social Security and/or SSI – consistent with average over prior 4 years.

Table IX-3. FY 2027 Nursing and Hospice Care Trend Assumption (Excludes Managed Care and Expansion Lines)

| Nursing and Hospice | Percent | Dollar Impact[1,2] | Source |
|---|---|---|---|
| Price Factor | 3.2% | $11.0 million | FFY 26 Actual Skilled Nursing Facility PPS Market Basket - No Productivity Adjustment |
| Utilization | 1.5% | $7.1 million | Medicaid |
| Patient Share | 0.56% | $1.9 million | Medicaid |
| ***Subtotal Nursing & Hospice Care*** | | ***$20.0 million*** | |
| Annualization of prior Oct 1 increase | | $4.9 million | Annualization of FY 2026 5.3% |
| **Total Nursing & Hospice Care** | | **$24.9 million** | |

Note 1. The value of the rate change pertains to the Nursing and Hospice Care baseline only. Additional nursing home spending is in Expansion, Managed Care, and included in each of the managed care products.

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

Note 2. The "Price Factor" illustrates the impact of the annual rate increase to the State and not the full value of the rate increase received by the nursing facility. All else equal, the component of the rate paid by Medicaid (i.e., not paid by the resident) will increase by a larger percentage than the rate increase seen by the facility, as patient share collections do not necessarily increase by the same percentage as the nursing home rate increase each year.

Figure IX-1. Average daily nursing home census and paid amount by month, all payers, Jan-20 through Jun-25

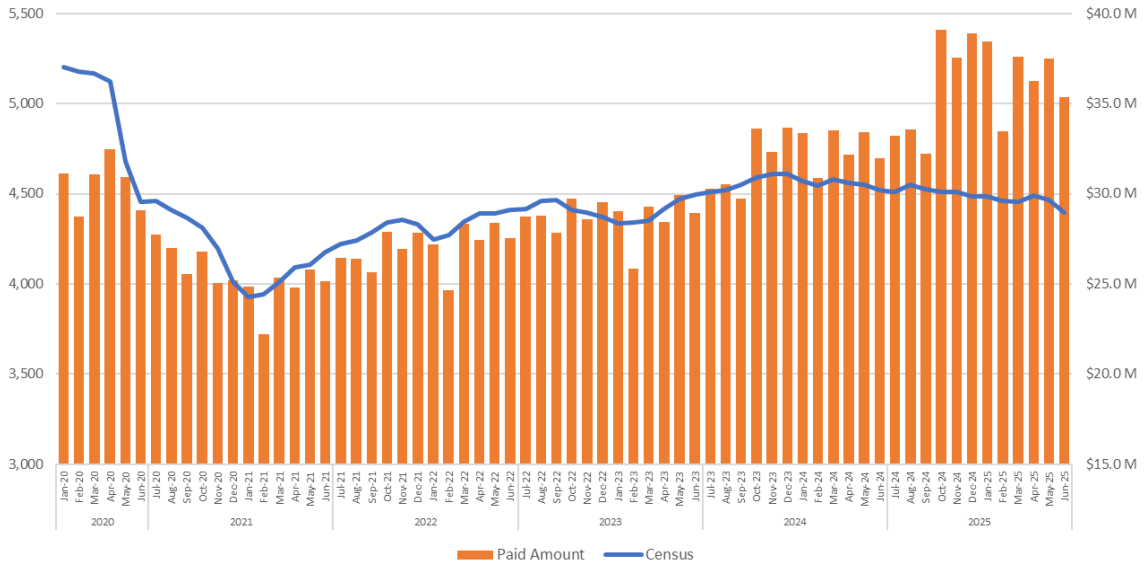



Table IX-4. Average daily nursing facility census, by fiscal year

| | SFY 2020 | SFY 2021 | SFY 2022 | SFY 2023 | SFY 2024 | SFY 2025 |
|---|---|---|---|---|---|---|
| Regular FFS - Medicaid Days | 4,459 | 3,672 | 3,725 | 3,616 | 3,822 | 3,824 |
| Expansion FFS | 73 | 73 | 87 | 75 | 87 | 89 |
| Rhody Health Options | 503 | 375 | 458 | 669 | 606 | 530 |
| Other Managed Care | 63 | 48 | 49 | 50 | 43 | 44 |
| Total | 5,099 | 4,168 | 4,320 | 4,411 | 4,559 | 4,486 |

***Update on transition to PDPM pricing***

The FY 2025 Enacted Budget authorized the Medicaid program to transition from a Resource Utilization Group (RUG-IV) based nursing facility payment methodology to a Patient Driven Payment Model (PDPM) payment classification system, effective October 1, 2025. CMS implemented PDPM to focus on an individual's unique clinical and functional needs, rather than the volume of services provided. Since its inception, October 1, 2019, RI nursing facilities have been using the Optional State Assessments (OSAs), provided as a transitional assessment, to continue a RUG based payment. As of October 1, 2025, CMS is no longer supporting the OSAs.

Medicaid's goal in moving to PDPM for nursing facility reimbursement, is to efficiently provide an equitable payment structure using an acuity-based service for beneficiary needs, with continued system and data support from CMS. PDPM maintains the overall nursing facility reimbursement structure (defined in the Nursing Facility Principles of Reimbursement in Section 4.19-D of the Medicaid State Plan). PDPM only modifies the patient acuity factor by using the nursing facility Case Mix Indices posted in the 2025 Federal Register (except for ventilator-related acuity categories that continue to be customized by EOHHS to reflect the additional resources necessary in ventilator-related cases). The nursing component of the PDPM payment calculation is used by most New England states, aligns best to the services provided in RI facilities, and minimizes operational complexities by utilizing a similar number of rates (25), as compared to RUG-IV (48). It was successfully implemented on October 1, 2025. The next nursing facility payment date is scheduled for November 14, 2025.

# X. Home and Community Care

| Home and Community Care | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $164,738,168 | $73,123,087 |
| **FY 2025** | Revised Enacted | $248,600,000 | $109,408,860 |
| | Final | **$237,449,962** | **$104,082,796** |
| | *Surplus over Revised Enacted* | *$11,150,038* | *$5,326,064* |
| **FY 2026** | Enacted | $293,779,386 | $125,703,952 |
| | Current | **$284,600,000** | **$121,808,800** |
| | *Surplus over Enacted* | *$9,179,386* | *$3,895,152* |
| **FY 2027** | Current | **$291,500,000** | **$123,013,000** |

***FY 2026***

Medicaid's revised forecast for home and community care is of $284.6 million, including $121.8 million GR; a $9.2 million, including $3.9 million GR surplus compared to the Enacted budget. This surplus is driven by a lower utilization factor than had been assumed in the May CEC estimate for personal care, less spending for self-directed than expected and fewer beneficiaries receiving CFCM, offset by projected deficits in other HCBS services.

The revised FY 2026 estimate is based on actual FY 2025 claims experience with equal emphasis on the monthly median average and last quarter to establish a monthly base estimate, which is then adjusted for any utilization changes. EOHHS assumes a 2.5% utilization increase for all HCBS services over FY 2025 actual experience in the revised estimate; meanwhile, the May estimate assumed a 5.0% utilization increase for personal care and 2.5% for all other HCBS services.

The increase is partially offset by $0.8 million in savings due to less spending by PACE members, despite six more beneficiaries than assumed in the enacted budget. This is discussed on the next page.

Regarding conflict free case management, Medicaid projects FFS expenditures totaling $8.3 million based on current utilization and certification of additional providers expected by January 2026. This includes $1.9 million for DD beneficiaries and $6.4 million for non-I/DD beneficiaries. In addition to new providers, the estimate also assumes transition of DD beneficiaries currently receiving services from Independent Facilitators (IFs) to community case managers. Expenditures are included in the Other HCBS line item shown in **Table X-1,** which summarizes Home and Community Care Expenditures from FY 2025 through FY 2027.

**Figure X-1** and **Table X-3** highlight the increase by home care agencies since pre-Covid. **Table X-2** summarizes changes in HCBS authorizations; however, the count of beneficiaries authorized for HCBS is not equivalent to the number of beneficiaries utilizing LTSS services. Medicaid derives its FFS estimates from actual utilization as reflected in MMIS' claims with prospective adjustments for any anticipated changes in price and/or utilization. This approach is unlike the PMPM basis that Medicaid uses for its managed care estimates.

***FY 2027***

The FY 2027 forecast totals $291.5 million, including $123.0 million GR. This is a $6.9 million (2.4%), including $1.2 million GR (1.0%) increase above the current fiscal year estimate. The increase is driven by an assumed 2.5% utilization increase over the FY 2026 revised estimate as claims data continue to show year-over-year increases and there is no expectation this will slow. Consistent with the enacted budget, the estimate for home care no longer includes an annual inflationary index as relevant rates are subject to the biennial OHIC rate review process.

Select home delivered meals codes are eligible for an annual rate increase on July 1 of each year. Medicaid uses the March release of the New England CPI-U for Food at Home. As this data is not yet available, Medicaid used the

September 2025 release, which showed a 1.99% increase. When applied to the blended trend and utilization assumed for HCBS services, the projected inflationary increase is equivalent to $17,785.

The increase is partially offset by a $1.6 million reduction in conflict free case management expenditures compared to the FY 2026 enacted. Total FFS expenditures are expected to be $11.8 million in FY 2027 vs. the $13.5 million that was included in May CEC estimate for FY 2026. Compared to the revised FY 2026 estimate, the FY 2027 estimate is $3.5 million greater, primarily reflecting the annualization of new providers coming on-line in FY 2026 and transition of DD beneficiaries from IFs to community case management providers.

**Figure X-1** provides additional detail on Home Care spending and utilization by fiscal year, between 2019 and 2024 and compares spending in first quarter of FY 2025 (prior to OHIC-mandated rate increases) and the last quarter of FY 2025. Inclusive of all home care spending (i.e., including managed care spending), average monthly spending has increased by more than 300% since before Covid (i.e., FY 2019), with the increase driven by the near doubling of the reimbursement rate paid to home care agencies per hour as well as their provision of 67% more hours of care per beneficiary per month. Comparatively, the average number of users per month has increased less than 10% over the same period. Further, just over the last fiscal year total reimbursements have increased by 65% per month, largely driven by the 50% rate increase required of OHIC.

**Table X-3** provides additional detail on Home Care spending and utilization by year through FY 2025.

### *Program of All Inclusive Care for the Elderly (PACE)*

FY 2026

Medicaid's FY 2026 forecast totals $32.4 million, a surplus of $0.8 million compared to the enacted budget due to lower spending.

FY 2027

Medicaid's FY 2027 forecast totals $35.7 million, an increase of $3.3 million compared to the enacted budget due to increased enrollment ($1.5 million) and spending ($1.9 million).

Medicaid submitted a PACE SPA to CMS on March 25th to update the rating methodology, aligning with the direction set forth in the FY 2025 Enacted Budget. In years without a full rebase, Medicaid will apply price and utilization trend adjustments to the amount that would otherwise be paid (AWOP) at the service category level to account for Medicaid program changes, fee schedule updates, and changes in service mix. Under this updated methodology, FY 2025 was the first rebasing year, followed by trend adjustments in FY 2026 and FY 2027.

**Table X-4** summarizes PACE monthly caseload and premiums. **Table X-5** summarizes the price-volume comparison for PACE expenditures between FY 2025 and FY 2027.

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| PACE | $ 28,482,891 | ($0.2 M) | $ 33,153,687 | $ 32,383,051 | $0.8 M | $ 35,723,545 | $3.3 M |
| *Enrollment* | *432* | *3* | *459* | *465* | *6* | *486* | *21* |
| **FFS Activity** | | | | | | | |
| Self-Directed | $ 28,610,546 | $2.1 M | $ 33,024,000 | $ 30,453,000 | $2.6 M | $ 31,183,000 | $0.7 M |
| Adult Day | 6,527,689 | 0.1 M | 7,021,000 | 7,413,000 | (0.4 M) | 7,598,000 | 0.2 M |
| Home Care | 138,295,724 | 3.9 M | 171,654,627 | 165,935,000 | 5.7 M | 166,127,497 | 0.2 M |
| Shared Living | 10,563,925 | (0.6 M) | 10,838,000 | 11,812,000 | (1.0 M) | 12,107,000 | 0.3 M |
| Assisted Living | 25,625,830 | 0.4 M | 27,910,000 | 28,022,000 | (0.1 M) | 28,722,000 | 0.7 M |
| Other HCBS | 6,191,696 | (1.4 M) | 10,178,072 | 8,560,403 | 1.6 M | 9,976,894 | 1.4 M |
| **Subtotal FFS** | **$ 215,815,411** | **$4.4 M** | **$ 260,625,699** | **$ 252,195,403** | **$8.4 M** | **$ 255,714,391** | **$3.5 M** |
| **Subtotal - Home and Community Care** | **$ 244,298,302** | **$4.2 M** | **$ 293,779,386** | **$ 284,578,454** | **$9.2 M** | **$ 291,437,936** | **$6.9 M** |
| Balance to RIFANS/Rounding | (6,848,340) | 6.9 M | 0 | 21,546 | (0.0 M) | 62,064 | 0.0 M |
| **Total - Home and Community Care** | **$ 237,449,962** | **$11.1 M** | **$ 293,779,386** | **$ 284,600,000** | **$9.2 M** | **$ 291,500,000** | **$6.9 M** |
| *General Revenue* | *$104.1 M* | *$5.3 M* | *$125.7 M* | *$121.8 M* | *$3.9 M* | *$123.0 M* | *$1.2 M* |
| *Federal Funds* | *$133.4 M* | *$5.8 M* | *$168.1 M* | *$162.8 M* | *$5.3 M* | *$168.5 M* | *$5.7 M* |

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

| | SFY 2025 | SFY 2026 | Current: Sep-25 | FY25 → FY26 |
|---|---|---|---|---|
| PACE | 432 | 465 | 453 | 7.6% |
| **HCBS Authorization in FFS** | | | | |
| Assisted Living | 758 | 888 | 881 | 17.2% |
| Shared Living | 352 | 424 | 420 | 20.5% |
| Self-Directed | 725 | 833 | 827 | 14.9% |
| Home Care | 3,340 | 3,754 | 3,727 | 12.4% |
| ***Subtotal HCBS*** | 5,175 | 5,899 | 5,855 | 14.0% |
| | | | | |
| ***HCBS Enrolled in RHO*** | 2,702 | 2,804 | 2,804 | 3.8% |
| ***% of HCBS (excl. PACE) in RHO*** | *34.3%* | *32.2%* | *32.4%* | |

Figure X-1. Average monthly home care spending, by FY through 2024 and by select quarters in FY 2025

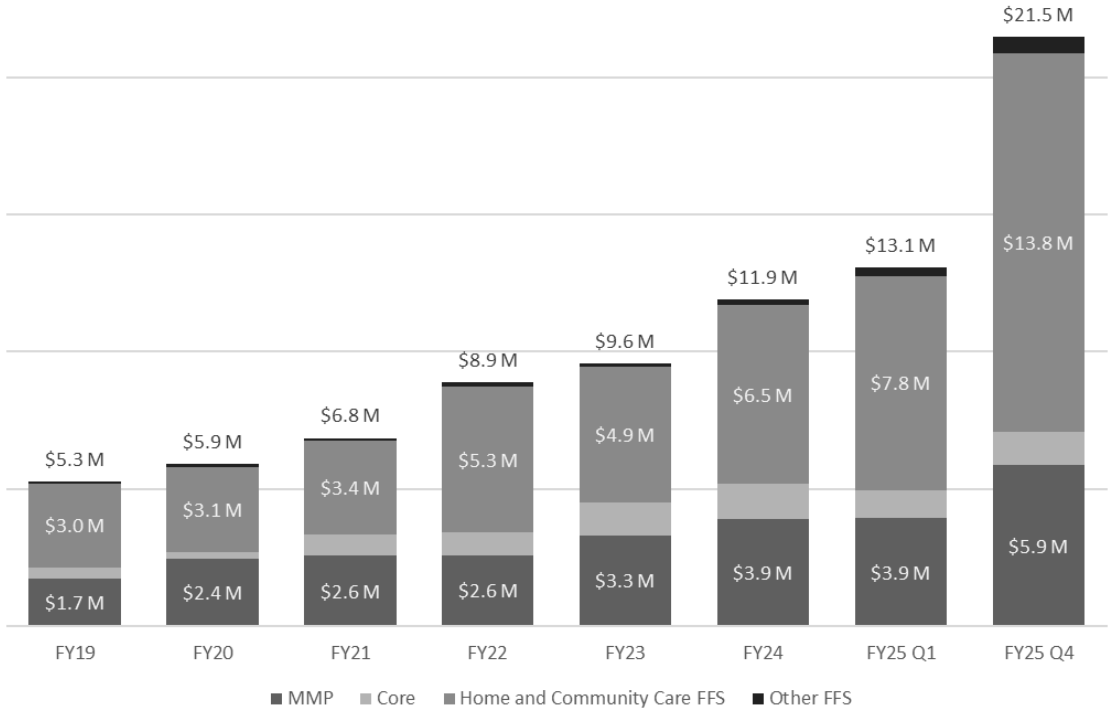



Table X-3. Summary of Home Care Price and Utilization Changes, by FY through 2024 and by quarter in FY 2025

| | 2019 | 2020 | 2021 | 2022 | 2023 | 2024 | 2025 Q4 | FY19 → FY25 Q4 | FY24 → FY25 Q4 |
|---|---|---|---|---|---|---|---|---|---|
| Total Monthly Paid | $5.3 M | $5.9 M | $6.8 M | $8.9 M | $9.6 M | $11.9 M | $21.5 M | 308% | 70% |
| Users per Month | 4,553 | 4,590 | 4,615 | 4,636 | 4,873 | 5,191 | 4,839 | 6.1% | -5% |
| Hours per User per Month | 61 | 64 | 68 | 71 | 79 | 86 | 102 | 67% | 10% |
| Cost per Hour | $22.29 | $23.80 | $25.09 | $30.94 | $27.51 | $28.90 | $43.63 | 95% | 51% |

Table X-4. Summary of PACE Monthly Premiums

| PACE | SFY 2025 | SFY 2026 | SFY 2027 | FY25 → FY26 | FY26 → FY27 |
|---|---|---|---|---|---|
| Medicaid Only | $7,064 | $7,500 | $7,875 | 6.2% | 5.0% |
| Dual, 55-64 y.o. | $5,191 | $5,491 | $5,766 | 5.8% | 5.0% |
| Dual, 65+ y.o. | $5,332 | $5,648 | $5,930 | 5.9% | 5.0% |
| Composite | $5,493 | $5,805 | $6,125 | 5.7% | 5.5% |
| *Average Member Months* | 432 | 465 | 486 | 7.6% | 4.6% |

Table X-5. PACE Price-Volume Comparison

| | Price | Volume | Net |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | ($0.2 M)<br>-0.6% | ($0.0 M)<br>-0.2% | ($0.2 M)<br>-0.7% |
| FY 2026 over FY 2025 | $1.7 M<br>5.7% | $2.2 M<br>7.6% | $3.9 M<br>13.7% |
| FY 2026: Current over Enacted | ($1.2 M)<br>-3.7% | $0.5 M<br>1.4% | ($0.8 M)<br>-2.3% |
| FY 2027 over FY 2026 | $1.9 M<br>5.5% | $1.5 M<br>4.6% | $3.3 M<br>10.3% |

# XI. Pharmacy

| Pharmacy | | | |
|---|---|---|---|
| | | All Funds | General Revenue |
| **FY 2024** | Final | $1,734,617 | $1,036,313 |
| **FY 2025** | Revised Enacted | $2,700,000 | $1,501,649 |
| | Final | **$731,624** | **$625,532** |
| | *Surplus over Revised Enacted* | *$1,968,376* | *$876,117* |
| **FY 2026** | Enacted | $7,800,000 | $3,669,654 |
| | Current | **$1,500,000** | **$950,239** |
| | *Surplus over Enacted* | *$6,300,000* | *$2,719,415* |
| **FY 2027** | Current | **$1,300,000** | **$880,597** |

***FY 2026***

Medicaid's revised forecast for pharmacy in FY 2026 is $1.5 million, a $6.3 million, including $2.7 million GR, surplus compared to the FY 2026 Enacted. The significant surplus is due to the inclusion of the full liability for the high cost of sickle cell gene therapy treatments into the fully capitated managed care rates.

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

***FY 2027***

EOHHS forecasts $1.3 million in pharmacy expenditures, including $0.9 million GR, for FY 2027.

The FY 2027 forecast assumes a 2.7% increase based on the S&P Global Healthcare Cost Review 2027 Q2 forecast for pharmacy, which corresponds to the end of FY 2027, but, like the FY 2026 estimates, accounts for the shift of SCD treatment into managed care.

Revised FY 2026 and FY 2027 pharmacy expenditures and rebates are presented in **Table XI-1.**

Generally, rebates fluctuate due to several reasons:

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

Table XI-1. Summary of Pharmacy Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| FFS Activity | $ 9,022,065 | $0.8 M | $ 15,836,000 | $ 9,860,000 | $6.0 M | $ 10,278,000 | $0.4 M |
| Rebates | (8,400,932) | 0.5 M | (8,072,013) | (8,409,957) | 0.3 M | (9,025,747) | (0.6 M) |
| DRE | (7,130,724) | 0.5 M | (6,757,008) | (7,030,320) | 0.3 M | (7,537,627) | (0.5 M) |
| J-Code | (1,270,208) | (0.1 M) | (1,315,005) | (1,379,637) | 0.1 M | (1,488,120) | (0.1 M) |
| **Subtotal - Pharmacy** | **$ 621,133** | **$1.3 M** | **$ 7,763,987** | **$ 1,450,043** | **$6.3 M** | **$ 1,252,253** | **($0.2 M)** |
| Balance to RIFANS - Accruals/Rounding | 110,491 | (0.1 M) | 36,013 | 49,957 | (0.0 M) | 47,747 | (0.0 M) |
| **Grand Total - Pharmacy** | **$ 731,624** | **$1.2 M** | **$ 7,800,000** | **$ 1,500,000** | **$6.3 M** | **$ 1,300,000** | **($0.2 M)** |
| *General Revenue* | *$0.6 M* | *$0.5 M* | *$3.7 M* | *$1.0 M* | *$2.7 M* | *$0.9 M* | *($0.1 M)* |
| *Federal Funds* | *$0.1 M* | *$0.6 M* | *$4.1 M* | *$0.5 M* | *$3.6 M* | *$0.4 M* | *($0.1 M)* |

# XII. Pharmacy Clawback (Medicare Part D)

| Pharmacy Clawback (Medicare Part D) | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $91,920,942 | $91,920,942 |
| **FY 2025** | Revised Enacted | $92,200,000 | $92,200,000 |
| | Final | **$92,702,111** | **$92,702,111** |
| | *Deficit over Revised Enacted* | *($502,111)* | *($502,111)* |
| **FY 2026** | Enacted | $96,400,000 | $96,400,000 |
| | Current | **$94,600,000** | **$94,600,000** |
| | *Surplus over Enacted* | *$1,800,000* | *$1,800,000* |
| **FY 2027** | Current | **$98,100,000** | **$98,100,000** |

Medicaid's revised FY 2026 estimate of $94.6 million reflects a $1.8 million surplus compared to the Enacted, reflecting an enrollment forecast decline of 702 average monthly beneficiaries.

Medicaid projects spending to increase by $3.5 million to $98.1 million in FY 2027. With modest underlying enrollment growth being offset by H.R.-1-related closures due to a H.R.-1 qualified alien change, Medicaid is forecasting limited growth of 163 average monthly beneficiaries.

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

Table XII-1. Summary of Pharmacy Claw Back Expenditures

| | **SFY 2025** | | **SFY 2026** | | | **SFY 2027** | |
|---|---|---|---|---|---|---|---|
| | **Final** | **Surplus/ (Deficit)** | **Enacted** | **Current** | **Surplus/ (Deficit)** | **Current** | **FY26 → FY27** |
| Part D Premium Payments | $ 92,540,445 | ($0.7 M) | $ 96,340,843 | $ 94,586,780 | $1.8 M | $ 98,014,809 | $3.4 M |
| Balance to RIFANS/Accruals/Rounding | 161,666 | (0.1 M) | 59,157 | 13,220 | 0.0 M | 85,191 | 0.1 M |
| **Total - Pharmacy Clawback** | **$ 92,702,111** | **($0.8 M)** | **$ 96,400,000** | **$ 94,600,000** | **$1.8 M** | **$ 98,100,000** | **$3.5 M** |
| *General Revenue* | *$92.7 M* | *($0.8 M)* | *$96.4 M* | *$94.6 M* | *$1.8 M* | *$98.1 M* | *$3.5 M* |
| Part D Muliplier | $198.35 | -$1.29 | $204.92 | $204.75 | -$0.16 | $211.44 | $6.68 |
| July - September | $194.08 | | $204.52 | $204.52 | | $204.52 | |
| October - December | $194.78 | | $204.52 | $204.52 | | $204.52 | |
| January - March | $204.52 | | $214.75 | $214.75 | | $214.75 | |
| April - June | $204.52 | | $214.75 | $214.75 | | $214.75 | |
| Average Enrollment | 38,947 | 587 | 39,203 | 38,501 | -702 | 38,664 | 163 |

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

| | **Price** | **Volume** | **Net** |
|---|---|---|---|
| FY 2025: Final over Revised Enacted | ($0.6 M) | $1.4 M | $0.8 M |
| | -0.6% | 1.5% | 0.9% |
| FY 2026 over FY 2025 | $3.0 M | ($1.1 M) | $1.9 M |
| | 3.2% | -1.1% | 2.0% |
| FY 2026: Current over Enacted | ($0.1 M) | ($1.7 M) | ($1.8 M) |
| | -0.1% | -1.8% | -1.9% |
| FY 2027 over FY 2026 | $3.1 M | $0.4 M | $3.5 M |
| | 3.3% | 0.4% | 3.7% |

# XIII. Other Services

| Other Services | | | |
|---|---|---|---|
| | | **All Funds** | **General Revenue** |
| **FY 2024** | Final | $159,330,693 | $59,074,873 |
| **FY 2025** | Revised Enacted | $207,700,000 | $76,323,770 |
| | Final | **$205,337,135** | **$74,375,561** |
| | *Surplus over Revised Enacted* | *$2,362,865* | *$1,948,209* |
| **FY 2026** | Enacted | $233,812,840 | $82,131,863 |
| | Current | **$222,500,000** | **$79,588,238** |
| | *Surplus over Enacted* | *$11,312,840* | *$2,543,625* |
| **FY 2027** | Current | **$231,800,000** | **$76,650,469** |

***FY 2026***

Medicaid's revised FY 2026 estimate totals $222.5 million, including $79.6 million GR, for Other Services. This is a surplus of $11.3 million (4.8%), including $2.5 million GR (3.1%), compared to the Enacted.

The surplus is largely driven by $7.1 million less in itioners and Tavares claiming, and $16.2 million less for BHDDH medical services. The latter reflects a shift of $9.1 million in CCBHC expenditures from Other Services to Rhody Health Options. These surpluses are offset by the following activities:

- $1.7 million in rehabilitation and targeted case management claiming, and,
- $1.6 million in physician services claiming.

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

FFS claiming estimates are based on a blend of actual FY 2025 claims data, which emphasis on the median average monthly expenditures and the last quarter of that year. Utilization is also expected to be generally consistent with the FY 2025 experience, expect for BHDDH medical services for which a 5.0% utilization increase is assumed.

Regarding community health worker, FY 2025 claims are excluded from the underlying FFS data used for Medicaid's general IBNR calculation. Instead, EOHHS adds $3.5 million below the line in the appropriate budget lines (i.e., Managed Care, Expansion FFS, and Other Services FFS). This amount was determined based on actual claims activity from FY 2026 to-date and is $2.7 million less than enacted from all sources.

***FY 2027***

The FY 2027 estimate totals $231.8 million, including $76.5 million GR. This reflects an increase of $9.3 million, but a $2.9 million GR decrease, compared to the FY 2026 revised estimate. The year-over-year increase is due to the following:

- $1.7 million increase in Part A Medicaid Premium Payments, and
- $11.5 million increase in Part B Medicaid Premium Payments.
    - This increase is due to annualizing the expansion of the Medicare Savings Program, specifically the Qualifying Individual (QI) subpopulation that is assumed to be 100% federally-financed.

This is partially offset by a $2.9 million reduction in Other Practitioners claiming and a net $1.6 reduction in behavioral health spending after annualizing the shift of CCBHC spending into Rhody Health Options.

The methodology for the FY 2027 estimate is consistent with FY 2026, with a blend of median average expenditures from FY 2025 and the last quarter of that year used for the base analysis. The FY 2027 estimate assumes a 2.9% price increase in the BHDDH Medical services budget line to capture the required Medicare Economic Index inflationary increase for CCBHCs. Medicaid expects utilization to be consistent with FY 2025 except

for BHDDH Medical services, for which Medicaid assumes a 5.0% increase from increased utilization of CCBHCs, and Other Practitioners, for which a 1.5% increase is assumed.

With respect to community health workers, EOHHS holds its total spending level flat with FY 2026—the anticipated result of a marginal decline in utilization (due to reduced overall enrollment in Medicaid) and a 3.31% price increase as required under the state plan. As outlined in the state plan, community health worker rates are updated annually using the March release of the New England Consumer Price Index Card, as determined by the United States Department of Labor for medical care (which contains February data). As this information is not yet available, this inflationary adjustment is based on the September release.

A summary of FY 2026 and FY 2027 expenditures by service type is shown in **Table XIII-1**. **Table XIII-2** summarizes all Other Medical Services expenditures subject to a non-regular matching rate.

Table XIII-1. Summary of Other Medical Services Expenditures

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Surplus/ (Deficit) | Enacted | Current | Surplus/ (Deficit) | Current | FY26 → FY27 |
| **Medicare Premium Payments** | | | | | | | |
| Part A | $ 20,078,796 | ($0.2 M) | $ 22,211,475 | $ 21,748,284 | $0.5 M | $ 23,484,951 | $1.7 M |
| Part B | 89,561,187 | (0.2 M) | 95,775,494 | 97,794,473 | (2.0 M) | 109,267,084 | 11.5 M |
| **Subtotal - Supplemental Payments** | **$ 109,639,983** | **($0.4 M)** | **$ 117,986,969** | **$ 119,542,758** | **($1.6 M)** | **$ 132,752,035** | **$13.2 M** |
| Non-Emergency Transportation | 6,582,432 | 0.1 M | 7,431,450 | 7,113,652 | 0.3 M | 7,732,681 | 0.6 M |
| Recoveries | (15,158,534) | (3.1 M) | (24,000,000) | (16,000,000) | (8.0 M) | (16,000,000) | 0.0 M |
| **FFS Activity** | | | | | | | |
| BHDDH Medical Services | 14,113,763 | 3.7 M | 23,265,000 | 16,541,812 | 6.7 M | 18,409,153 | 1.9 M |
| CCBHC Services | 32,954,536 | 1.0 M | 46,000,000 | 35,449,856 | 10.6 M | 31,944,160 | |
| Rehab & TCM | 22,284,402 | (2.0 M) | 22,525,000 | 24,148,000 | (1.6 M) | 24,148,000 | 0.0 M |
| Tavares | 6,921,633 | 0.5 M | 7,214,000 | 6,890,000 | 0.3 M | 6,890,000 | 0.0 M |
| DME | 3,561,178 | 0.0 M | 3,430,000 | 3,721,000 | (0.3 M) | 3,721,000 | 0.0 M |
| Physician Services | 16,363,184 | (2.2 M) | 15,983,000 | 17,833,000 | (1.9 M) | 17,833,000 | 0.0 M |
| Other Practitioners | 9,745,343 | 4.7 M | 14,008,000 | 7,193,000 | 6.8 M | 4,287,208 | (2.9 M) |
| **Subtotal - FFS Activity** | 105,944,039 | 5.8 M | 132,425,000 | 111,776,668 | 20.6 M | 107,232,520 | (4.5 M) |
| **Subtotal - Other Services** | **$ 207,007,920** | **$2.3 M** | **$ 233,843,419** | **$ 222,433,078** | **$11.4 M** | **$ 231,717,236** | **$9.3 M** |
| Balance to RIFANS/Accruals/Rounding | (1,670,785) | 1.8 M | (30,579) | 66,922 | (0.1 M) | 82,764 | 0.0 M |
| **Total - Other Services** | **$ 205,337,135** | **$4.1 M** | **$ 233,812,840** | **$ 222,500,000** | **$11.3 M** | **$ 231,800,000** | **$9.3 M** |
| *General Revenue* | *$74.4 M* | *$1.7 M* | *$82.1 M* | *$79.6 M* | *$2.5 M* | *$76.7 M* | *($2.9 M)* |
| *Federal Funds* | *$121.5 M* | *$3.4 M* | *$144.3 M* | *$135.5 M* | *$8.8 M* | *$147.8 M* | *$12.2 M* |
| *Restricted Receipts* | *$9.5 M* | *($1.0 M)* | *$7.4 M* | *$7.4 M* | *($0.0 M)* | *$7.4 M* | *$0.0 M* |

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

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| Restricted - Children's Health Account | $ 8,500,000 | $0.0 M | $ 7,350,000 | $ 7,350,000 | $0.0 M | $ 7,350,000 | ($1.2 M) |
| Restricted - Organ Transplant Fund | 15,000 | 0.0 M | 15,000 | 15,000 | 0.0 M | 15,000 | 0.0 M |
| Enhanced FMAP - CCBHC | 34,885,072 | (7.8 M) | 46,000,000 | 35,449,856 | 10.6 M | 31,944,160 | 0.6 M |
| 100% Federal - Qualifying Individuals | 1,750,000 | 0.0 M | 1,750,000 | 3,525,000 | 1.8 M | 9,560,000 | (1.8 M) |
| 100% State - Breast & Cervical Cancer | (200,000) | 0.0 M | (200,000) | (200,000) | 0.0 M | (200,000) | 0.0 M |

Table XIII-3. Medicare Monthly and Part B Premiums

| | SFY 2025 | | SFY 2026 | | | SFY 2027 | |
|---|---|---|---|---|---|---|---|
| | Final | Change | Enacted | Current | Change | Current | FY26 → FY27 |
| Part A PMPM | $ 482.35 | $ (4.42) | $ 513.98 | $ 499.36 | $ (14.61) | $ 524.29 | $ 24.92 |
| July-December | 487.07 | | 511.42 | 511.42 | | 511.42 | |
| January-June | 511.42 | | 536.99 | 536.99 | | 536.99 | |
| Part A - Average Enrollment | 3,469 | 69 | 3,601 | 3,629 | 28 | 3,733 | $ 103.50 |
| Part B PMPM | $ 193.39 | $ 10.32 | $ 203.04 | $ 203.04 | $ 0.00 | $ 203.04 | $ 0.00 |
| July-December | 188.65 | | 198.08 | 198.08 | | 198.08 | |
| January-June | 198.08 | | 207.99 | 207.99 | | 207.99 | |
| Part B - Average Enrollment | 40,636 | (45) | 41,502 | 41,375 | (127) | 41,642 | $ 266.92 |

## Attachments