November 2025 Caseload Estimating Conference

Questions for the Executive Office of Health and Human Services

RIBRIDGES DATA BREACH

1. **Please provide an update related to the RIBridges data breach, including, but not limited to:**
    a. **The effect on the normal cycle of redeterminations, including:**
        i. **How backlogs are paced over the remaining months**
        ii. **Impacts on costs**
        iii. **Any discrepancies or outliers in the reported data provided to Conferees**

    Renewals resumed in March with the associated closures effective April 30 for May 2025 closures. Renewal activities for the impacted months (i.e., December, January, February, March) were caught up by August.

    Although some of the renewal cohorts that would have originally been renewed between March and June were smoothed out through December in an attempt to generally even out the number of discrete renewals over the 10-month period (i.e., between March and December), this change is not significant enough to impact churn assumptions for the remaining months in the CY from a general modeling perspective. Especially when layered on top of the resumption of post eligibility verification processes.

    There are no discrepancies or outliers in the data provided to the conferees. While enrollment in Q3 and Q4 of FY 2024 is higher than it would have otherwise been, enrollment as of September 2025 is below where it was prior to the data breach.

MEDICAL ASSISTANCE

All tables requested by these questions are consolidated into one Excel workbook (emailed as an excel attachment along with the questions). References to each tab are included throughout this document.

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

    See testimony and accompanying Excel workbook.

2) **Please update "Tab 1" of the attached file (or provide a similar file) showing average caseload and average capitation rates for all managed care product lines to reflect the Executive Office's estimates for FY 2026 and FY 2027. Please include any necessary updates for FY 2025.**

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

3) **Please provide, where possible, details on the risks to federal funding.**

    See **H.R.-1 Federal Changes Impacting FY 2026 and 2027** in the Major Developments section

FY 2025 Closing

1) **Please provide a FY 2025 closing analysis by program (in the same format that has been used for prior November testimony) with a separate column identifying any variance to the preliminary closing.**

a. **Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position.**

See Summary of FY 2025 Closing in the Major Developments section of testimony.

b. **Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2025 preliminary closing.**

Transportation Broker expenditures for Aged, Blind, and Disabled clients are initially reported against Funding Source 10. This funding source is assigned to Other Services. As part of year-end close, Medicaid reallocates spending from Other Services to Rhody Health Partners and Rhody Health Options, assuming one month of Transportation Broker premium for every member month of enrollment in the respective managed care products.

The FY 2025 Final is consistent with this reallocation.

2) **Please include a column for FY 2025 preliminary closing figures in the summary tables within each section of your testimony.**

Each summary table includes the FY 2025 preliminary closing figures, which are reflective of the latest data available to EOHHS.

FY 2025 Budget

1) Please include a status update on budget initiatives as outlined in "Tab 2." Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate, and any known barriers to approval.

a. **Include all relevant details regarding the status of pending submissions to CMS, including the 1115 demonstration waiver.**

See **Attachment 2a** and the **FY 2026 Budget Initiative Implementation** section within the Major Developments section of testimony for a detailed description of the status of pending submissions to CMS.

2) Please provide an update on progress toward receiving authority for certain programs while the State waits for its delayed 1115 demonstration waiver approval.

See the **1115 Waiver Update** in the **Major Developments** section of Medicaid's testimony file.

Federal Issues and Contract Status

1) Please provide an update on CMS approval for the 1115 waiver extension and progress toward receiving authority for as-yet-approved programs while the State waits for approval.

Please see above question 2.

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

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

<u>Consolidated Appropriations Act of 2023</u>

The Consolidated Appropriations Act of 2023 requires states to provide screening and diagnostic services and targeted case management services to Medicaid-eligible incarcerated individuals who are either

under age 21 or eligible for Medicaid as former foster youth (under age 26) who are in the final 30 days before their scheduled release. The state must also ensure that this population receives targeted case management for 30 days after release. This rule applies only to individuals who have been sentenced; there is a state option to provide the full range of Medicaid services to youth who are in a pre-trial status, but RI has not elected to implement. States are required to implement this by January 1, 2025, although CMS offered flexibility if states are underway and have an operational plan in place on that date, which Medicaid has done. Medicaid is working closely with DOC and DCYF to become compliant. This work includes:

- Systems changes to ensure bidirectional information sharing between Medicaid and both RIDOC and DCYF (with respect to data about individuals incarcerated at the ACI and RITS, respectively);
- Changes to the Medicaid Management Information System (MMIS) to identify individuals who are entitled to these services and ensure that payment can be made. Both RIDOC and DCYF identified that due to the very low volume of services involved, it would cost more to implement Medicaid billing than the revenue generated by doing so. Consequently, the focus on MMIS payment will be on post-release targeted case management provided by community providers;
- Working with correctional service providers and community service providers to ensure that the CAA population receives services;
- Developing processes and procedures to ensure “warm hand-offs" to community providers after release; and
- Working with DOC and DCYF to maximize these agencies’ ability to support new Medicaid applications for incarcerated individuals not already enrolled in Medicaid.

EOHHS does not anticipate any additional Medicaid spending on screening and diagnosis services or pre-release targeted case management; the correctional agencies already provide these in almost all applicable cases, and as noted above, the correctional agencies do not intend to pursue Medicaid billing at this time due to the low volume of possible claims and substantial administrative cost to establish Medicaid billing.

Both RIDOC and DCYF currently provide some post-release targeted case management, which will continue largely unchanged and without new Medicaid billing. EOHHS anticipates that a small volume of new targeted case management services will be provided by community providers. At the earliest, this new spending will occur in spring 2026. The reason for the estimates of very low volume of new spending is primarily that only approximately 110 individuals who fall into the CAA youth population are released each year from the ACI and RITS combined, many of whom currently receive these services from existing reentry staff at the ACI and Transition Probation Officers at RITS. The new TCM benefit is only required by the CAA for 30 days. Assuming about 50 individuals receive 2 hours of TCM per week for 4 weeks, the total annual cost would be about $35,000 all funds.

<u>Medicaid Access Rule and Medicaid Managed Care Rule</u>

In May 2024, CMS finalized its Medicaid Access Rule and Medicaid Managed Care Rule, which represent significant changes to the Medicaid program, imposing new requirements to enhance and standardize reporting, monitoring, and evaluation of Medicaid access to services. RI Medicaid completed an in-depth review of these new rules and requirements and has mapped out initial plan of resources to implement the work, which was phased in starting July 2024.

The following slides present an overview of these two rules, including major changes.

Attachment_Medicaid New Rules.pdf

Medicaid has eight working groups developing implementation plans. The implementation is occurring based on the federal deadline. As such, any new requirement to be implemented by 7/1/2026 is taking precedence over the remaining new requirements that are to be implemented in 2027 and beyond.

- Rhode Island Medicaid, in collaboration with BHDDH, DHS, and DCYF, is required to establish a Home and Community Based Services (HCBS) grievance system for FFS enrollees by July 9, 2026. The system would allow individuals to file complaints about state/provider performance with person-centered planning, services plans and HCBS settings requirements.

  The system must:
  - Accept grievances either orally or in writing and provide members with reasonable assistance in completing procedural steps
  - Allow another individual or entity to file a grievance on one's behalf with written consent
  - Ensure decisions on grievances are not made by individuals involved with the issue being addressed
  - Provide individuals with a reasonable opportunity to present evidence related to their grievance, with translation and interpreter services
  - Resolve grievances within 90 days of receipt

  EOHHS is working to establish the grievance system and will collaborate with the other agencies to ensure one centralized system exists as required by the final rule.

- Rhode Island must submit to CMS an assurance and analysis (1) at the time the state submits for readiness review, (2) on an annual basis and no later than 180 days after the end of the contract year, and (3) any time there has been a significant change that would affect the adequacy of capacity and services and with the submission of the associated contract. The assurances and analyses require an amendment to the existing Managed Care contract by July 1, 2026. The state must also include specific contract language regarding provider incentive payments by July 1, 2026. Contract amendments are currently being drafted to reflect the new requirements.

- By July 9, 2026, Rhode Island Medicaid must publish fee-for-service rates, including the date of last update, bundled rate components, with stratification by population (pediatric and adult), and geographic region, if applicable. Medicaid must conduct comparative rate analysis to Medicare for primary care, OB/GYN, and outpatient mental health and SUD services. EOHHS is already in compliance with some aspects of this requirement but is working to comply with the rate analyses by the deadline.

Non-compliance with the final rules will lead to federal corrective action plans, holds on approval of federal authority requests, and future impact to Federal Financial Participation (FFP) for Rhode Island Medicaid benefit programs.

<u>Nursing Facility Minimum Staff Ratios and Cost Reporting</u>

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

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

On April 7, 2025, the US District Court for Northern Texas ruled to overturn two components of this rule:

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

H.R.-1 delays implementation of the minimum staffing elements of the rule, giving nursing home providers more time to evaluate and adjust their staffing models before federal minimum standards are enforced. Rhode Island has its own state law for minimum staffing in nursing facilities, updated in the FY 2026 enacted budget.

3) **Please identify the changes under HR 1 that are effective for FY 2026 and FY 2027, as well as their impact on Medicaid expenses. Have federal guidelines been issued? Please identify the specific changes in each of the programs.**

See H.R.-1 Federal Changes Impacting FY 2026 and 2027 section of testimony.

4) **Please provide an update on the timeline for procuring new managed care contracts when the existing contracts expire on June 30, 2026.**

Medicaid extended the current managed care contracts with Neighborhood Health Plan of Rhode Island (NHPRI), Tufts, and UnitedHealthcare through June 30, 2026. EOHHS plans to seek another extension to the current contract.

All Programs – Rate and Caseload Changes

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

See **Attachment 8**.

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

See Cell and Gene Therapy (CGT) Access Model in Major Developments section of testimony.

GLP-1 drugs have been provided in Medicaid coverage for several years for both Type 2 diabetes and weight loss. Growth in GLP-1 drug expenditures for weight loss are expected to continue increasing in Medicaid. In SFY 2025, there was approximately $11.1 million in all-funds expenditure on claims volume of 24,980 prescriptions written on drugs explicitly indicated for obesity. This represents more than double the SFY 2024 expenditure total of $5.2 million on 13,510 prescription claims for obesity.

Based on current enrollment projections the rates provide funding of at least $25 million for GLP-1 prescriptions (although not all this funding is for obesity treatment). The portion of composite capitation dedicated to weight loss GLP-1 drugs was initially $3.88 PMPM for FY 2026; however, in the final rate certification this was adjusted to $5.91 PMPM after review of emerging experience. Medicaid's actuarial consultant estimates that in SFY 2027 GLP-1 coverage for obesity will comprise, at the high end of the estimate, $8.25 PMPM of the capitation rates.

3) **Please fill out Tab 3a to update initiatives in the FY 2026 enacted budget and the FY 2027 savings assumed for the pharmacy containment proposal. Provide expenses/savings by program for:**
   a. **Community Health Workers – Tab 3b**
   b. **Pharmacy containment – Tab 3c**
   c. **E-Consults – Tab 3d**
   d. **Equifax's The Work Number – 3e & 3f**

[1] KFF, https://www.kff.org/policy-watch/texas-judge-overturns-controversial-nursing-facility-staffing-rule/, April 11, 2025.

The workbook is completed as requested.

Additional information on The Work Number process:

The Work Number, or Equifax, transaction is initiated either as part of quarterly batch process (for Post Eligibility Verification), annual renewals, or in real-time (for new applications and changes in circumstances).

The 89,739 transactions in August were primarily for Post Eligibility Verification. A few thousand were for real-time verifications for new applications or reported changes in circumstances. The transactions are associated with the closures indicated in November.

The 22,245 transactions in September were for Annual Renewals and Real-Time Verifications. Approximately 5,000 of these transactions were from the be annual renewal process.

PEV Process:

1. UHIP makes request to Equifax. Request includes a client SSN.
2. Equifax attempts to match clients' SSN to its employer data files. If match exists, the record (i.e. transaction) is returned to UHIP. Please note that a client may have multiple matches if they have multiple employers and so transaction count is not equivalent to client count.
3. UHIP receives Equifax file and runs Post Eligibility Verification (PEV) processes and recalculates client FPL based on the current information received and determines if client remains eligible.
    a. If UHIP does not receive a match, it will attempt to verify against SWICA
4. If client is over income, an Additional Documentation Request (ADR) is initiated. Clients have 15 days to respond.
5. After 15 days, for those who have not responded with new information, a closure is prospectively initiated. As this is after the current month's negative action date, the closure is set for the end of the following month.

    For Example, the August transactions initiated a PEV process on August 30. The negative action closure date for September, was September 10. The due date for the ADR was September 14, and so closures were set for end of day October 31, 2025. Reducing premium payments made for November.[2]

Annual Renewals:

1. Generally, PEV and annual renewals follow the same process (as it relates to Equifax); however, instead of a 15-day ADR process, the renewal notices and any ADR, if applicable, are sent on the first of the month and are due in 30 days.
2. For those not responding within the 30 days, closures are set to process on the negative action date in the subsequent month.

    For example, October 31 renewal notices were sent on September 1. EOHHS ran closure process on October 14 for terminations effective October 31.

Real-Time Process:

1. In addition to its use for PEV, the Equifax data is also used for real-time eligibility verifications. There are two general types of such verifications.
    a. ***New applications for health insurance coverage Medicaid & HSRI.*** These are new clients using the state's eligibility portal to get health insurance coverage. They could be eligible for either Medicaid or HSRI coverage, and the transactions would include both. These transactions do not initiate a closure but would result in an eligibility segment for:

[2] For the initial TWN batch process, the termination process for individuals that did NOT response to the ADR ran on 9/26 and so individuals were given extra time to respond to the ADR. This delay was due to desire for additional quality control on letters prior to them being sent to individuals. Regardless, any terminations were always to be effective 10/31.

Medicaid, a Qualified Health Plan, or neither. For Medicaid, the eligibility coverage is retroactive to the start of the current month, with enrollment in managed care prospective and dependent upon type of Medicaid eligibility.

b. ***Change in circumstance for Medicaid clients only.*** When a client self-reports a change in their household income, a transaction is initiated against Equifax to verify new information. If this results in a closure, depending on whether the change in circumstance was initiated before or after the negative closure date for the month, the closure could be effective end of current or end of the following month.

Calculation of TWN-related savings

Closure savings are a cost avoidance and so a proxy amount must be calculated. Presumably, anyone identified through the PEV batch process would have otherwise retained eligibility. And so, by closing them, the state is reducing its costs. However, these clients would have eventually been identified for closure during the client's next annual renewal (or if the client self-reported a change in their household income). Given this, EOHHS proposes cost avoidance greater than 1 month but less than 12 months. Assuming a savings equivalent to 3- or 6-months of premium payments paid on behalf of the client is a reasonable proxy for the net cost avoidance per client.

Please note any closure resulting from the Equifax data may have occurred using SWICA data. However, as Equifax has largely replaced SWICA, the savings reflect absolute amount of cost avoidance and not the marginal increase in cost avoidance compared to pre-Equifax status quo.

Long-Term Care

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

a. For FY 2026, please note expenses through September 2025 and those starting October 1, 2025, under the new Patient-Driven Payment Model.

i. Claims paid through September for nursing facility and hospice services in the FFS program total $78.6 million, which reflect dates of service in July and August 2025. PDPM was implemented on October 1, 2025, for dates of services beginning October 1. No claims have been submitted to date under this model. The next nursing facility payment date is scheduled for November 14, 2025.

b. If there is an increase compared to the enacted budget for FY 2026, how much is related to the new model? The FY 2026 enacted budget assumed sufficient funding in the current year for both rate models.

See **Nursing and Hospice Care** section of testimony.

2) Please provide the nursing home and hospice days needed for the long-term care financing adjustment (Sullivan-Perry).

The average daily census in FY 2024 was 4,559. This compares to 4,486 in FY 2025. This is a decline to the daily census of 73 beneficiaries. However, this is prior to an adjustment for outstanding FFS claims and does not account for delays in data submissions from the health plans. The lag on a proportion of these payments for these institutional facilities can well-exceed 6 months.

As Medicaid accrued $56.0 million at the end of FY 2025 for Nursing Home and Hospice expenditures on the FFS side alone and there continue to be outstanding claims activity, Medicaid assumes that this variance will erode and ultimately there will be general stability or a slight increase to the overall census. To not understate the Perry Sullivan calculation, EOHHS recommends taking into consideration this missing data when assessing year-over-year changes.

Figure IX-1 in the **Nursing and Hospice Care** section of testimony summarizes change in average daily Medicaid census at nursing facilities over the course of the public health emergency through the end of FY

2025. Although the census has steadily increased over the past few fiscal years, the average census remains below its pre-Covid peaks.

3) **Please provide the enrollment and capitation rate information for the PACE program and, where applicable, for all the monthly Medicaid reporting of the categories of Assisted Living, PACE, A&D, Waiver, Personal Choice/HAB Waiver, Habilitation Community Services, Habilitation Group Home, Preventative Community Services, and Core Community Services.**

See **Home and Community Care** section of testimony**.**

4) **Please provide explanations of how the categories included in the testimony, including Self-Directed, Home Care, Adult Day, Home Care, Shared Living, and Assisted Living. Please provide a breakdown of the type of service for home and community care expenses identified as "All Other HCBS" in the monthly Medicaid Expenditure report.**

The monthly Medicaid Expenditure Reports produced by Gainwell and provided to fiscal staff by Medicaid reflect FFS claims on a paid basis. Medicaid's testimony reflects claims on an incurred basis completed for IBNR and forecasted current and subsequent fiscal year.

The "All Other HCBS" as defined by Gainwell consists primarily of home care, shared living, and adult day. These expenditures are separated into explicit subcategories within Home and Community Care budget line in Medicaid's testimony. The "All Other HCBS" reported by Gainwell also includes expenditures for Targeted Case Management and DME for members in wavier categories; these expenditures as classified among the "Other HCBS" in Medicaid's testimony. Note that most Case Management and DME expenditures are reflected in the Other Services budget line.

Crosswalk

Caseload Name	**Attachment 6D – MA Caseload**
Self-Directed	Choice/HAB Waiver
Home Care	A&D Waiver, Personal Core Community Service Preventive Community Svc*
Adult Day	Not distinctly reported**
Shared Living	Shared Living***
Assisted Living	Assisted Living Core Community Service

*Expenditures included in the Home Care FFS activity, but members are not counted in the HCBS authorizations

**Adult Day is not an authorization grouping, rather it is a service available across HCBS categories. (For example, expenditures related to this service could be included across multiple Attachment 6D categories)

***It appears this is reported under managed care, but not as a distinct line under HCBS.

5) **Please provide an update on all current LTSS activities, including the most current initiatives.**

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

3b - LTSS Update.pptx

6) **Please provide details on the LTSS application backlog vs. the number of applications.**

Information on LTSS applications is available on the transparency portal.[3] As of September 18, 2025, the chart below shows a total of 167 overdue LTSS applications.

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	158	158	316	150	143	293	609
SNAP Non-Expedited	407	290	697	94	53	147	844
CCAP	46	146	192	14	62	76	268
GPA - Burial	0	23	23	0	1	1	24
SSP	0	30	30	0	0	0	30
GPA	33	66	99	4	1	5	104
RIW	175	64	239	25	25	50	289
Undetermined Medical	35	307	342	61	369	430	772
Medicaid - MAGI	28	16	44	46	71	117	161
Medicare Premium Payments	9	156	165	9	141	150	315
Medicaid Complex	7	311	318	12	413	425	743
LTSS	19	248	267	5	162	167	434
Grand Total	917	1,815	**2,732**	420	1,441	**1,861**	4,593

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

Nursing home per diems are comprised of the following components:

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

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

- A Provider Base Rate which is the sum of the components below:
    - Other direct care reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities. As a result of the FY 2024 Rate Review, this component was increased 25.5% to $84.09. It is

[3] https://transparency.ri.gov/uhip/documents/legislative-reports/2025/September%202025%20House%20Oversight%20RIBridges%20Report%20-final.pdf

updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.

- Indirect care reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
- Fair rental value is facility specific and was determined as of 7/1/2012 based on a formula included in the current Principles of Reimbursement. Updated annually, pursuant to the State Plan which requires Medicaid to use the IHS Markit Healthcare Cost Review. The 10/1/2025 increase was 2.5%.
- A per diem tax is facility specific and based on real estate, property taxes, and fire tax paid, and the Medicaid census days. Updated annually based on information from the BM-64 Cost Reports.

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

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

Patient Share Adjustment

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

With nursing facility rates increasing by 5.3% in FFY 2026 and a projected 3.2% increase in FFY 2027, Medicaid does not expect current patient share collections will keep pace with these increases. As such, the percentage of the per diem paid by the resident will decrease, and the effective increase of Medicaid's costs will exceed that of the price increase.

Over the past six years, the average patient share amount per day has gone up about $2 annually. Meanwhile, the overall nursing home cost per day (i.e., prior to patient share) has generally increased by a greater percentage amount. If the base nursing home rate goes up faster than patient share this means that patient share will account for a smaller proportion of the total revenues collected by the nursing home and the State will need to make up the proportional shortfall from this mixed funding stream. For example, in FY 2026, the average nursing home per diem increased 5.3%. However, if the increase in patient share contribution remains steady at just $2—i.e., increasing collections from $49 per day to $51 per day—this is equivalent to just a 4.1% increase in the proportion of nursing facility's net revenue funded by patient share. As a result, the state will need to further increase its direct payments to the nursing home by $5 to keep the nursing facility whole and make up for the inability of patient share to keep pace with the overall price inflation of a nursing home stay (i.e., $51 × 14.7% - $2 = $5.49 shortfall). The result is that the effective increase for the state of a 5.3% increase to the nursing facility per diem becomes 6.2%

Patient share accounts for about 15% of total nursing home charges. If a resident's income increases 2.7% in January 2026 and 2.5% in January 2027 (a total of 5.2%), but total charges increase significantly faster, by the end of FY 2027, the patient share will account approximately 15% of charges, and rates have increased (5.3% + 3.2%, or 8.5%). An increase to the direct reimbursement by Medicaid is needed to make up for this differential.

8) Please include the projected cost of rate changes for both FY 2026 and FY 2027, including the amount of the rate increase and the index upon which it is based.

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

9) Please provide an update on the implementation of the Conflict Free Case Management program, including an update specific to the IDD population. Please consult with BHDDH so that testimony regarding the status of CFCM for the IDD population is consistently reported.

a. Is the system fully operational through WellSky in FY 2026? If not, what is the projected timeframe for implementation?

b. **The May 2025 CEC testimony included 12,672 eligible with staggered dates based on available monthly case management. This assumes 8,266 non-DD clients and 2,101 DD clients. Please update this information and include how many individuals are receiving case management services from DHS staff, BHDDH staff, or the certified agencies.**

The system is live with basic functionality, for example, case management can and does happen in the system (i.e. receive referrals, create person centered plans, etc.) Work is ongoing to achieve desired functionality.

Agencies include: Access Point, Bethel Behavioral Associates, CareLink, Child and Family, East Bay Community Action Program, Healthcare Connect, Revive Therapeutic Services, Seven Hills, Tri-County Community Action Agency, and Westbay Community Action Program.

CFCM Implementation Timeline

Date	Item
October 2023	Certification standards available for public comment.
November – December 2023	State updated and finalized certification standards.
January 2024	Final certification standards and application open to any willing provider Medicaid began accepting and reviewing applications on a rolling basis. DHS began conducting all initial functional needs assessments for LTSS eligibility determination for the EAD population.
April 2024	CFCM code and rate go live.
May 2024	First fully certified vendors.
July 2024	OHA no longer overseeing case management of Medicaid EAD participants aged 60 and older.
December 2024	2,746 people receiving CFCM using new rate with eight certified CFCM agencies.

SFY 26 Enacted vs. SFY 26 Nov. Revised Estimate

Item	**Enacted**	**Nov CEC**
Total Eligible	12,672 eligible with staggered start dates based on available monthly case management.	12,590 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	10,367 (8,266 non-DD clients; 2,101 DD clients)	5,154 (3,519 non-DD clients; 1,635 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators*	200 people will shift from Independent Facilitators each month from Feb. 2026 through May 2026. (IFs will begin to decrease by 8, beginning in Feb so there will be none by June-end 2026.)	200 people will shift from Independent Facilitators each month from Feb. 2026 through May 2026, so there will be none by June-end 2026.)
FMAP	57.20%	57.2%
Rate	$170.87 Per Month	$170.87 Per Month
Amount in Medicaid Budget	$13,450,888	$8,293,175

SFY 27 Nov. Estimate

Item	Nov. CEC
Total Eligible	12,710 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	6,270 (4,371 non-DD clients; 1,899 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators (IFs)	0
FMAP	57.73%
Rate	$170.87 Per Month
Amount in Medicaid Budget	$11,807,459

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

10) **Please confirm that the statutorily required behavioral health care enhancement for certified nursing assistants and homemakers who have completed the necessary training is included in the FY 2026 and FY 2027 estimates**.

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

Managed Care

1) Please provide estimates for Managed Care, broken down by Rite Care, Rite Share and fee-for-service for FY 2026 and FY 2027

See **Managed Care** section of testimony.

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

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

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

The table below provides a brief schedule of in-plan services. The exhibit is found in the SFY 2025 final rate certification dated April 25, 2025, and is consolidated from **Attachment A** "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

Figure 3: Medicaid Managed Care Benefit Package

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

Covered services are consistent with the SFY 2025 benefit package. Detailed benefit coverage information for all benefits listed in this figure can be found within Attachment A, "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts. In-lieu-of services may also be provided with written approval from EOHHS.

Please see **Attachment A** on page 240 of Tufts Health Plan's contract, for a more in-depth example of in-plan services, available on EOHHS' website.[4] All MCO contracts have the same structure so there is no differentiation between Tuft's contract compared to the others. When available, please refer to Amendment 19 and 20 of the health plans for the most up to date MCO contract.

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

3) Please provide the monthly capitation rate(s) for RIte Care.

a. If FY 2026 is different from the rate assumed in May 2025, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.

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

In October 2025, the state reissued its capitation rates for the fiscal year that incorporated adjustments for 2025 legislative session and emerging CCBHC, GLP-1, and administrative cost emerging experience and the resulting increase in average acuity, with the composite PMPMs exceeding those assumed in the prior testimony. The impact on RIte Care Core was 4.4% (Rite Care Children: 4.0%, Rite Care Adults: 4.8%) and on RIte Care CSHCN was 2.1%.

4) Please provide the projected CHIP funding for FY 2026 and FY 2027, as well as a breakdown of any state-only expenditures and CNOM-funded expenditures in the estimates. If the estimate has changed since the May Conference, please provide an explanation for the change.

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

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

5) **Please provide the separate payments by the managed care plans to the Accountable Entities from FY 2019 through FY 2025.**

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

Please see the spreadsheet below with incentive payments made through SFY 2025. Please note, SFY 2025 payments included in this file are not complete and do not reflect the accrual for any remaining incentive funding. Total aggregate incentive payments have reduced over time, with minimal incentive funding remaining.

Updated HSTP Incentive Funds Paic

The following file includes shared savings (or loss) payments made by the plans to the accountable entities based on TCOC results each year. Please note, these payments are on a two-year lag due to claims run out and reporting timelines. Program Year 6, FY 2024, is the latest year with TCOC payments. FY 2025 TCOC results will be finalized at the end of FY 2026.

Shared Savings (Loss) Summary.xlsx

Rhody Health Partners

1) **Please provide estimates for Rhody Health Partners for FY 2026 and FY 2027. Please delineate those aspects of managed care programs not covered under a payment capitation system.**

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

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

2) **If FY 2026 rates are different from the prior capitation rate included in the May 2025 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

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

Rhody Health Options

1) **Please provide estimates for Rhody Health Options for FY 2026 and FY 2027. Please delineate those aspects of managed care programs not covered under a payment capitation system.**

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

Effective January 1, 2026, the Rhody Health Options will implement a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) with NHPRI from the current MMP model. A FIDE SNP is a type of Medicare Advantage plan that combines Medicare and Medicaid benefits into a single health plan for individuals who qualify for both. Also beginning January 1, 2026, CCBHC expenditures will be included in the managed care rates for Rhody Health Options.

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

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

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

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

4) **If FY 2026 rates are different from the prior capitation rate included in the May 2025 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

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

There is an increase of approximately 1.5% to the composite rates for the first 6 months of SFY 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. An increase in the composite price for the FIDE-SNP effective January 2026 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.

5) **For the move to a Fully Integrated Eligible Special Needs Plan, the May 2025 Caseload Conference testimony noted that a new contract with NHPRI was anticipated, and Medicaid staff were actively engaged with its certifying actuary to establish rates effective January 1, 2026. FY 2026 assumes current RHO costs through FY 2026 with a rate increase effective January 2025.**

There is no question above, however, please see **Rhody Health Options** section of testimony.

6) **Please provide any updates to this initiative for FY 2026 and FY 2027.**

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

Hospitals

1) **Please provide separate inpatient and outpatient estimates for hospital services in FY 2026 and FY 2027.**

    a. **Please provide an update on the Long-Term Behavioral Health Unit rate increase and any progress being made by the community hospitals in opening new units.**

    See **Hospitals – Regular** section of testimony and **FY 2026 Budget Initiative Implementation** section of **Major Developments** in testimony.

2) **What is the current DSH allotment over the next several federal fiscal years?**

See **Hospitals – Regular** section of testimony

3) **Please provide an update on the Hospital State-Directed Payment Program, including any changes to assumptions about Medicaid match rates and how changes in HR 1 impact this payment for FY 2026 and FY 2027?**

Total SDP Appropriation:

- For SFY 2026, the November CEC forecast of $331.3 million in all funds financing is consistent with the enacted budget. This includes $324.7 million for payments to hospitals and $6.6 million for the premium tax paid by the MCOs. While consistent with the enacted budget, this represents a shift of $0.6 million from payments to hospitals to the MCO tax.
- For FY 2027, the Nov. CEC forecast equates the enacted general revenue amount from the previous fiscal year ($99.5 million), inclusive of tax liability, and calculates all funds amount by applying the FFY 2027 federal Medicaid match rates and utilization mix across eligibility groups. This calculation produces an all-funds appropriation of $318.4 million, a reduction of $12.9 million, including $312.1 million for payments to hospitals. This methodology is consistent with last May's CEC for the budget year (FY 2026).

Determination of Medicaid Matching Rates:

The following are the primary factors that impact the forecasted splits for the hospital state directed payment.

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

  See **H.R.-1 Federal Changes Impacting FY 2026 and 2027** section of testimony for detail on how H.R.-1 may impact this payment in the current and out-year.

a. Has the plan included in the FY 2026 enacted budget received federal approval? If not, what is the impact on the program?

The SFY 2026 SDP plan in the enacted budget is under CMS review. EOHHS has completed two rounds of CMS questions on the preprint and is awaiting the adjudication letter (preprint approval provided to states upon review completion). EOHHS anticipates this letter will provide preliminary feedback on CMS's initial assessment of the impact of section 71116, including whether the preprint is likely eligible for the grandfathering period. This letter is critical in determining next steps. If CMS indicates that the SFY 2026 is not likely to be "grandfathered," this means that the maximum payment in SFY 2026 would likely be capped at the SFY 2025 level, a reduction of $44 million all funds.

4) For the phase-down of the 6% provider tax threshold to 3.5% by FY 2032 for expansion states, including Rhode Island, please provide the cumulative revenue impact by fiscal year and, if possible, by hospital or hospital network.

See the following table for the phase down of the tax hold harmless threshold through 2032. Medicaid does not have access to total revenues paid to the State in FY 2025 by hospital or network. Medicaid has self-reported total revenues by hospital, which do not align with the state fiscal year nor reflect the base for which the tax was assessed. Given this, Medicaid cannot provide the revenue impact by hospital as it would not be consistent with the aggregate totals below.

SFY	Threshold (%)	Hospital Licensing Fee*
2028	**5.5%**	($12.2 million)
2029	**5.0%**	($31.9 million)
2030	**4.5%**	($51.7 million)
2031	**4.0%**	($71.5 million)
2032	**3.5%**	($91.3 million)

Pharmacy

1) Please provide separate estimates of pharmacy expenditures and rebates for FY 2026 and FY 2027, as well as the funding source breakout for the separate estimates.

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

Medicaid Expansion

1) Please provide updated caseload and expenditure estimates for FY 2026 and FY 2027 for the ACA-based Medicaid expansion population.

See **Expansion** section of testimony.

2) If the FY 2026 capitation rates differ from the May 2025 estimate, please document the change and include contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.

See the **Expansion** section of testimony.

In October 2025, the State reissued its capitation rates for the fiscal year that incorporated adjustments for 2025 legislative session and emerging CCBHC, GLP-1, and administrative cost emerging experience and the resulting increase in average acuity, with the composite PMPMs exceeding those assumed in the prior testimony. The impact on Expansion was 4.4%.

Other Medical Services

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

See **Other Services** section of testimony.

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

See **Other Services** section of testimony.

For purposes of testimony, the BHDDH Medical Services includes payments to behavioral health providers not enrolled in managed care. Most of the clients are Dual eligible clients.

Going forward Medicaid will differentiate between CCBHC services and non-CCBHC services. The non-CCBHC that Medicaid has still designated as "BHDDH Medical Services" include any remaining IHH and ACT services at EBCAP and Elwynn, but approximately 90% of the remaining dollars are for MHPRR services for those not enrolled in managed care.

3) Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2026 and FY 2027

The forecast for Medicare Buy-In (Part A/B) is based on invoices received through September 2025 for enrollment through October 2025. In addition to the baseline expenditures reflected in the current invoices and growth assumption of 2.5%, Medicaid's estimate includes a below-the-line adjustment for the Medicare Savings Program expansion.

The estimate included in Enacted reflected the full year cost of the expansion to the program and included a start date of January 2026. Medicaid anticipates the program to be fully operational by April 2026 (with some transition occurring between January and April). As such, FY 2026 includes an amount equivalent to one quarter of the original estimate. The full amount is reflected in FY 2027. Ultimately, this program is expected to expand Medicare Savings Program coverage to additional 3,250 Rhode Islanders.

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

See **Other Services** section of testimony.

4) Provide an update on the increase in the eligibility threshold to be in effect on January 1, 2026.

See above and **FY 2026 Budget Initiatives Update** section of **Major Developments** in testimony.

5) What are the state-only costs in FY 2026 and FY 2027?

State only expenditures are shown below.

Budget Line	Description	FY 2026	FY 2027
Managed Care	Cover all Kids	$18,400,000	$19,400,000
Managed Care	Abortion Coverage	$1,000,000	$1,000,000

Behavioral Health:

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

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

Please see response to next question for expenses for program.

Certified Community Behavioral Health Clinics (CCBHCs). *Implemented.* Rhode Island was approved for the CCBHC Demonstration in June 2024.[5] The Demonstration authorizes the program and grants the State an enhanced matching rate (CHIP rate) on CCBHC services not eligible for the Expansion FMAP. The Demonstration lasts for four years, and the State must follow all Demonstration rules.

Table 1 below includes investments in the CCBHC program. These amounts reflect actual FFS expenditures (less TPL collections) as well as the value of the CCBHC program included in MCO premiums and, for FY 2027, anticipated quality bonus payments. The managed care related costs are inclusive of all associated administrative costs, margins, and premium taxes.

Medicaid estimates $141.9 million in FY 2026, a decrease of $15.9 million from the SFY 2026 Enacted Budget. This decrease is due to slower utilization increases than the CCBHCs originally anticipated. Although all CCBHCs have seen significant growth, with Thrive and Newport seeing a near tripling of their pre-CCBHC expenditures and overall growth reflecting a 135% increase compared to pre-Covid expenditures, this remains marginally less than originally anticipated. Gateway has seen the lowest growth, but even they have seen PPS-2-related revenues increase by 100% when compared to their pre-Covid IHH/ACT revenues.

The enhanced FMAP provides $13.9 million GR savings in FY 2026. For FY 2027, Medicaid estimates $157.9 million, an increase of $16.0 million compared to the revised estimate for FY 2026. This includes a Quality Bonus Payment of $3.8 million associated with CY2025 activities, to be awarded sometime in early CY 2027 (i.e., Q3 or Q4 of SFY 2027). Given uncertainty around performance and total amount of award, it is unlikely that EOHHS will accrue for this in the current fiscal year. The enhanced FMAP will provide $16.1 million GR savings in FY 2027.

[5] Source: https://www.hhs.gov/about/news/2024/06/04/biden-harris-administration-expands-access-mental-health-substance-use-services-addition-10-new-states-ccbhc-medicaid-demonstration-program.html (Accessed April 17, 2025).

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

	SFY 2025:	SFY 2026:			SFY 2027:
		Enacted	Current	Surplus/(Deficit)	Current
Managed Care					
RC Core	$ 17,593,448	$ 24,329,419	$ 20,947,026	$3.4 M	$ 23,049,647
RC CSHCN	$ 4,513,726	$ 6,450,776	6,104,508	0.3 M	6,357,745
RHP	32,557,982	45,674,707	38,094,352	7.6 M	41,058,958
Expansion	25,882,959	35,445,290	31,330,970	4.1 M	30,821,127
RHO II	0	0	10,070,368	(10.1 M)	20,938,541
Subtotal	$ 80,548,116	$ 111,900,193	$ 106,547,225	5.4 M	$ 122,226,018
Fee For Service					
Other Services	$ 34,885,072	$ 46,000,000	$ 35,449,856	$10.6 M	$ 31,944,160
Managed Care	679,773	800,000	800,000	0.0 M	800,000
Expansion	1,439,594	2,100,000	2,100,000	0.0 M	2,100,000
TPL Collections	(2,100,000)	(3,000,000)	(3,000,000)	0.0 M	(3,000,000)
Subtotal	$ 32,785,072	$ 45,900,000	$ 35,349,856	10.6 M	$ 31,844,160
Quality Payment					3,861,389
Grand Total	**113,333,188**	**157,800,193**	**141,897,081**	**15.9 M**	**157,931,567**

2) Please provide enrollment and costs expected to be incurred in FY 2026 and FY 2027, for the following programs and their relationship with the CCBHC payments. Please indicate the costs to programs individually.

- **a. CCBHC**
- **b. MHPRR**
- **c. IHH, ACT, OTP Programs**
- **d. Behavioral Health Link Program**
- **e. Centers of Excellence**
- **f. Peer Supports Programs**

Please note that Medicaid added "CCBHC" to the list of individual programs included in response.

The exhibit below shows expenditures by program in FY 2024 and FY 2025 (by quarter)—along with estimates for FY 2026 and FY 2027. The OHIC rate review and the CCBHC program had a significant impact on spending in FY 2025. Please note that these are provider payments and do not include any adjustment for IBNR or missing data; nor do these expenditures include the additional administrative costs paid to the managed care plans and included in the overall cost of the program.

Except for the continued IHH and ACT programs at East Bay Community Action Program (EBCAP) and Elwyn (also known as Fellowship), most IHH and ACT is now subsumed within the CCBHC Demonstration. The newly designated CCBHC providers will continue to provide some non-CCBHC activities (such as SUD Residential and MHPRR) outside of the PPS-2 rates.

Significantly, between FY 2024 and FY 2026 with the full annualization of the both the OHIC-mandated rate increases for behavioral health providers and implementation of the CCBHC demonstration program, spending for specific BH providers supporting the state's BH safety net has increased by $130 million, over 50%—from $228.0 million in FY 2024 to and estimated $360.6 million in FY 2026.

Table 2. BH Spending – all payers, FY 2024 and FY 2025 actuals

Paid		FY 2024	FY 2025 Q1	Q2	Q3	Q4	FY 2025 Total	Q2-Q4 Annualized
CCBHC	CCBHC PPS-2 (T1041)		$0	$29,648,960	$32,562,262	$33,429,685	$95,640,907	$127,521,209
	Assertive Community Treatment (H0040)	$16,177,185	$3,886,005				$3,886,005	$0
	Housing_Stabilization (H0044)	$388,263	$111,547				$111,547	$0
	Integrated Health Home (H0037)	$28,659,484	$6,954,702				$6,954,702	$0
	Peer Support_Program(H0038)	$155,849	$25,990				$25,990	$0
	Other BH/SUD Services	$11,188,455	$2,688,355				$2,688,355	$0
CCBHC Total		**$56,569,236**	**$13,666,599**	**$29,648,960**	**$32,562,262**	**$33,429,685**	**$109,307,506**	**$127,521,209**
OHIC	Assertive Community Treatment (H0040)	$1,539,899	$411,844	$419,355	$478,747	$499,570	$1,809,517	$1,863,563
	BH Link (S9485)	$928,872	$274,712	$282,048	$275,051	$285,576	$1,117,386	$1,123,565
	Integrated Health Home (H0037)	$2,921,767	$728,955	$835,567	$828,797	$755,878	$3,149,197	$3,226,989
	MHPRR (H0019)	$18,306,919	$5,364,065	$6,502,691	$6,865,115	$6,956,162	$25,688,032	$27,098,623
	Opioid Treatment Program (H0037 - Provider Type 060)	$585,276	$148,391	$291,198	$272,718	$298,522	$1,010,829	$1,149,918
	Peer Support_Program(H0038)	$409,772	$69,841	$57,303	$57,171	$58,383	$242,698	$230,476
	Other BH/SUD Services	$135,417,501	$30,972,794	$38,358,749	$40,446,339	$39,293,691	$149,071,573	$157,465,038
OHIC Total		**$160,110,006**	**$37,970,601**	**$46,746,910**	**$49,223,938**	**$48,147,781**	**$182,089,231**	**$192,158,173**
Other	Housing_Stabilization (H0044)	$487,894	$198,021	$394,056	$482,102	$455,456	$1,529,634	$1,775,484
	Other BH/SUD Services	$10,796,965	$2,519,575	$3,865,942	$4,086,742	$3,911,718	$14,383,977	$15,819,202
Other Total		**$11,284,859**	**$2,717,596**	**$4,259,997**	**$4,568,844**	**$4,367,174**	**$15,913,611**	**$17,594,686**
Grand Total		**$227,964,102**	**$54,354,797**	**$80,655,868**	**$86,355,043**	**$85,944,640**	**$307,310,348**	**$337,274,068**
% Managed Care		**85.89%**	**85.34%**	**76.98%**	**76.93%**	**76.82%**	**78.40%**	

Table 3. BH spending, all payers - FY 2026 and FY 2027 Estimate

Paid		FY 2024	FY 2025	FY 2026 Est.	FY 2027 Est.
CCBHC	CCBHC PPS-2 (T1041)		$95,640,907	$140,404,676	$152,914,793
	Assertive Community Treatment (H0040)	$16,177,185	$3,886,005		
	Integrated Health Home (H0037)	$28,659,484	$6,954,702		
	Housing_Stabilization (H0044)	$388,263	$111,547		
	Peer Support_Program(H0038)	$155,849	$25,990		
	Other BH/SUD Services	$11,188,455	$2,688,355		
CCBHC Total		**$56,569,236**	**$109,307,506**	**$140,404,676**	**$152,914,793**
OHIC	Assertive Community Treatment (H0040)	$1,539,899	$1,809,517	$1,956,741	
	Integrated Health Home (H0037)	$2,921,767	$3,149,197	$3,388,338	
	BH Link (S9485)	$928,872	$1,117,386	$1,179,744	$1,209,237
	MHPRR (H0019)	$18,306,919	$25,688,032	$28,453,554	$29,164,893
	Opioid Treatment Program (H0037 - Provider Type 060)	$585,276	$1,010,829	$1,207,414	$1,237,600
	Peer Support_Program(H0038)	$409,772	$242,698	$241,999	$248,049
	Other BH/SUD Services	$135,417,501	$149,071,573	$165,338,290	$169,471,748
OHIC Total		**$160,110,006**	**$182,089,231**	**$201,766,081**	**$206,810,233**
Other	Housing_Stabilization (H0044)	$487,894	$1,529,634	$1,864,258	$1,910,865
	Other BH/SUD Services	$10,796,965	$14,383,977	$16,610,162	$17,025,417
Other Total		**$11,284,859**	**$15,913,611**	**$18,474,421**	**$18,936,281**
Grand Total		**$227,964,102**	**$307,310,348**	**$360,645,178**	**$378,661,308**
% Managed Care		**85.89%**	78.40%		