May 2026
CASELOAD ESTIMATING CONFERENCE

Medical Assistance Testimony

APRIL 27, 2026

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I. General Considerations

Medical Benefits			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$3,617,238,872	$1,339,773,272
	Final	**$3,596,928,809**	**$1,327,702,525**
	Surplus over Revised	*$20,310,063*	*$12,070,747*
FY 2026	Enacted	$3,941,048,697	$1,426,413,116
	November 2025 CEC Adopted	$3,900,800,000	$1,412,741,390
	Current	**$3,887,900,000**	**$1,411,262,232**
	Surplus over Nov CEC	*$12,900,000*	*$1,479,157*
FY 2027	November 2025 CEC Adopted	$3,987,900,000	$1,445,640,866
	Current	**$4,053,300,000**	**$1,449,965,964**
	Deficit over Nov CEC	*($65,400,000)*	*($4,325,098)*

For fiscal year (FY) 2026, Medicaid anticipates benefits expenditures of **$3.888 billion**, including **$1.411 billion in general revenue (GR)**, among the Caseload Estimating Conference (CEC) budget lines. This is a **$12.9 million (0.3%) surplus**, including a **$1.5 million GR (0.1%) surplus**, compared to the November adopted estimate.

For FY 2027, Medicaid projects expenditures to increase by $165.4 million, or 4.3%, to **$4.053 billion**, including **$1.450 billion GR**. This revised projection reflects a **$65.4 million (1.6%) deficit**, including **$4.3 million GR (0.3%) deficit** when compared to the November Conference.

Table I-1 compares Medicaid's fiscal close for FY 2025 and the revised forecasts for FY 2026 and FY 2027. Please note that the FY 2025 figure in the tables throughout the testimony reflect the agency's best attempt to update its unaudited fiscal close for any adjustments that have been accepted or recommended by the RI Office of Auditor General. Overall, Medicaid's GR surplus for FY 2025 reduced by $5.3 million GR when compared to the preliminary fiscal close.

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 **302,455** to **297,438**. This is a decline of 5,017 beneficiaries (1.7%), including 5,566 enrolled in managed care. The average monthly enrollment in FY 2027 is expected to decrease by an additional 4,105 beneficiaries, or 1.1%, to **293,333**.

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			
CEC Budget Line	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Managed Care	$ 1,060,732,263	$ 1,106,800,000	$ 1,091,600,000	$15.2 M	$ 1,165,300,000	$ 1,165,200,000	$0.1 M	$73.6 M
Rhody Health Partners	299,823,909	336,700,000	337,700,000	(1.0 M)	348,900,000	336,000,000	12.9 M	(1.7 M)
Rhody Health Options	217,598,267	242,700,000	247,800,000	(5.1 M)	247,800,000	269,900,000	(22.1 M)	22.1 M
Expansion	698,692,382	741,500,000	724,900,000	16.6 M	701,600,000	733,300,000	(31.7 M)	8.4 M
Hospitals - Regular	353,268,456	408,200,000	402,100,000	6.1 M	418,200,000	414,100,000	4.1 M	12.0 M
Hospitals - DSH	27,646,654	13,900,000	13,900,000	0.0 M	13,900,000	13,900,000	0.0 M	0.0 M
Nursing and Hospice Care	402,946,046	453,000,000	457,700,000	(4.7 M)	478,000,000	489,200,000	(11.2 M)	31.5 M
Home and Community Care	237,449,962	284,600,000	300,100,000	(15.5 M)	291,500,000	309,000,000	(17.5 M)	8.9 M
Pharmacy	731,624	1,500,000	1,300,000	0.2 M	1,300,000	1,200,000	0.1 M	(0.1 M)
Clawback	92,702,111	94,600,000	93,900,000	0.7 M	98,100,000	95,900,000	2.2 M	2.0 M
Other Services	205,337,135	217,300,000	216,900,000	0.4 M	223,300,000	225,600,000	(2.3 M)	8.7 M
Subtotal - CEC Benefits	**$ 3,596,928,809**	**$ 3,900,800,000**	**$ 3,887,900,000**	**$12.9 M**	**$ 3,987,900,000**	**$ 4,053,300,000**	**($65.4 M)**	**$165.4 M**
Health System Transformation Project	6,493,295	0	0	0.0 M	0	0	0.0 M	0.0 M
Special Education	36,297,861	45,400,000	36,900,000	8.5 M	45,400,000	36,900,000	8.5 M	0.0 M
ARPA HCBS Investments	64,430	2,056,214	2,056,214	0.0 M	0	0	0.0 M	(2.1 M)
Total - Benefits	**$ 3,639,784,395**	**$ 3,948,256,214**	**$ 3,926,856,214**	**$21.4 M**	**$ 4,033,300,000**	**$ 4,090,200,000**	**($56.9 M)**	**$163.3 M**

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

	SFY 2025	SFY 2026			SFY 2027			
Funding Source	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
General Revenue	$ 1,327,702,525	$ 1,412,741,390	$ 1,411,262,232	$1.5 M	$ 1,445,640,866	$ 1,449,965,964	($4.3 M)	$38.7 M
Federal Funds	2,300,463,746	2,526,108,610	2,506,165,174	19.9 M	2,580,309,134	2,629,294,762	(49.0 M)	123.1 M
Restricted Receipts	11,618,125	9,406,214	9,428,807	(0.0 M)	7,350,000	10,939,274	(3.6 M)	1.5 M
Total - Benefits	**$ 3,639,784,395**	**$ 3,948,256,214**	**$ 3,926,856,214**	**$21.4 M**	**$ 4,033,300,000**	**$ 4,090,200,000**	**($56.9 M)**	**$163.3 M**

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

	SFY 2025	SFY 2026			SFY 2027			
Enrolled - Full Benefits:	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Rite Care Core	160,145	152,340	149,937	-2,403	151,004	148,506	-2,498	-1,431
Rite Care CSHCN	9,737	9,686	9,734	48	9,853	10,079	226	345
Expansion	79,956	76,407	73,782	-2,625	68,602	70,129	1,527	-3,653
Rhody Health Partners	12,737	12,757	12,758	1	12,761	12,764	3	6
Rhody Health Options (Phase II)	11,418	11,788	11,414	-374	11,377	11,148	-229	-266
PACE	436	465	465	0	486	485	-1	20
Rite Share	1,390	1,971	1,758	-213	2,474	1,779	-695	21
Subtotal Enrolled	**275,819**	**265,414**	**259,848**	**-5,566**	**256,557**	**254,890**	**-1,667**	**-4,958**
Remaining in FFS - Full Benefits:								
Children and Families	2,732	1,946	2,245	299	1,587	2,379	792	134
Children with Special Healthcare Needs	1,508	1,378	1,266	-112	1,418	1,266	-152	0
Expansion	4,385	4,238	4,550	312	4,264	4,643	379	93
Aged, Blind, and Disabled	28,433	29,479	29,529	50	30,246	30,155	-91	626
Subtotal Fee-for-Service	**37,058**	**37,041**	**37,590**	**549**	**37,515**	**38,443**	**928**	**853**
Grand Total - Full Benefits:	**312,877**	**302,455**	**297,438**	**-5,017**	**294,072**	**293,333**	**-739**	**-4,105**
Composite PMPM	*$958*	*$1,075*	*$1,089*	*$15*	*$1,130*		*-$1,130*	*-$1,089*

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

	SFY 2025	SFY 2026			SFY 2027			
Other Capitated Arrangements:	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Rite Smiles	135,389	132,290	130,188	-2,102	134,628	130,410	-4,218	222
Rite Care EFP	2,090	1,577	1,559	-18	980	934	-46	-625
SOBRA	4,367	4,679	4,309	-370	5,082	4,752	-330	443
Transportation Broker	310,128	300,080	294,953	-5,127	290,386	289,303	-1,083	-5,650
Medicare Premium Payments:								
Part A (Hospital)	3,469	3,629	3,636	7	3,733	3,751	18	115
Part B (Professional Services)	40,636	41,375	41,054	-321	41,642	40,969	-673	-85
Part D (Prescription Drugs)	38,961	38,501	38,202	-299	38,664	37,737	-927	-465

II. Major Developments

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

A. FY 2025 Fiscal Close

After adjustments to year-end accruals—adjustments that were either proposed by Medicaid or recommended by the Rhode Island Office of the Auditor General (RIOAG)—Medicaid ended FY 2025 with a surplus of $20.3 million (0.6%) against its $3.597 billion benefits' budget. This included a GR surplus of $12.1 million (0.9%) against a budget of $1.328 billion GR.[1]

The major offsetting drivers of the modest surplus were discussed in November 2025 as were some of the anticipated adjustments since accepted by RIOAG. The post-fiscal close adjustments had a net impact of $10.1 million all funds, $5.1 million GR against the CEC budget lines.

Unfavorable adjustments included:

- An increase to the Inpatient UPL payments that corrected for an overpayment to Rehab Hospital and underpayment to the other in-state hospitals;
- A retroactive FQHC rate revision;
- Net increases to the liabilities owed to health plan due to:
    - higher risk share accruals based on a worsening of health plan performance for SFY 2025 contract period based on updated risk share from the health plan,
    - payments for newborns and enrollment adjustments not yet paid;
- Increased general revenue expenditures due to the shift certain Expansion beneficiaries to the Previously Eligible Expansion group and a resulting loss of 90% FMAP; and,
- Correction to the funding source allocation of the original SFY 2025 Q4 Hospital SDP accrual that resulted in loss of GR.

Favorable adjustments included:

- Improved drug rebate collections based on additional quarter of invoicing and collections, and
- Increased federal claiming (and therefore reduced GR expenditures) for:
    - FY 2025 Q4 adjustment for CHIP children between 133 and 153% FPL that are eligible for Enhanced FMAP instead of the Regular FMAP originally claimed,
    - FY 2025 Q4 adjustment for a subset of state only Cover all Kids expenditure paid for children who the State retroactively learned met eligibility criteria and so could be claimed at Regular FMAP.

B. Medicaid's Revised Forecast Compared to November CEC

Medicaid's revised fiscal estimates for FY 2026 and FY 2027 are generally consistent with its prior estimates as adopted in November. However, despite a two-year variance of 0.6% all funds and 0.1% general revenue, and similarly modest fiscal year variances, there remain some significant offsetting fiscal changes that are outlined below. **Table II-1** and **Table II-2** summarize the FY 2026 and FY 2027 variances, respectively. The major drivers of changes between revised FY 2026 and FY 2027 estimates are outlined in **Figure II-1**. Finally, **Table II-3** summarizes the overall composite price-volume variance of Medicaid's revised estimate across fiscal years and caseload conferences.

[1] Please note that these figures are for informational purposes only as the final FY 2025 close is not yet available in the Budget Formulation and Management system. This above revision reflects adjustments confirmed between RIAOG and Medicaid Finance staff and the marginal impact of these changes applied to the preliminary close previously reported in November 2025 CEC. The actual posted FY 2025 final may differ.

Table II-1. Summary of variances for FY 2026 compared to Nov CEC (excludes non-CEC)

	FY 2026:		
	Revised	Current	Surplus/(Deficit)
Favorable Variances			
Rite Care	$918.9 M	$908.8 M	$10.1 M
Expansion	$710.1 M	$689.8 M	$20.4 M
PACE/Rite Smiles/NEMT/Rite Share	$99.2 M	$98.0 M	$1.2 M
SOBRA	$97.3 M	$89.6 M	$7.7 M
NICU FFS	$33.0 M	$32.3 M	$0.7 M
Supplemental Hospital Payments	$372.7 M	$372.7 M	$0.0 M
Other FFS (Excl. NH/HCBS/NICU)	$306.4 M	$290.3 M	$16.1 M
Other/Miscellaneous	($13.5 M)	($17.1 M)	$3.6 M
Subtotal Favorable	**$2,524.2 M**	**$2,464.4 M**	**$59.8 M**
Unfavorable Variance			
HCBS FFS	$247.0 M	$264.4 M	($17.4 M)
Nursing Home & Hospice FFS	$452.6 M	$457.6 M	($5.1 M)
Risk Share	$10.4 M	$27.0 M	($16.6 M)
RHO II	$239.7 M	$244.8 M	($5.2 M)
RHP	$369.0 M	$369.0 M	($0.1 M)
Medicare Premium Payments	$214.1 M	$214.5 M	($0.4 M)
Drug Rebates	($156.1 M)	($153.9 M)	($2.1 M)
Subtotal Unfavorable	**$1,376.6 M**	**$1,423.5 M**	**($46.9 M)**
Total	**$3,900.8 M**	**$3,887.9 M**	**$12.9 M**
By Funding Source:			
General Revenue	$1,412.7 M	$1,411.3 M	$1.5 M
Federal Funds	$2,480.7 M	$2,469.3 M	$11.4 M
Restricted Receipts	$7.4 M	$7.4 M	($0.0 M)
Total	**$3,900.8 M**	**$3,887.9 M**	**$12.9 M**

Table II-2. Summary of variances for FY 2027 compared to Nov CEC (excludes non-CEC)

	FY 2027:		
	Revised	Prelim Final	Surplus/(Deficit)
Favorable Variances			
Other FFS (Excl. NH/HCBS/NICU)	$314.7 M	$300.4 M	$14.3 M
SOBRA	$110.9 M	$95.3 M	$15.6 M
RHP	$388.9 M	$375.0 M	$13.9 M
PACE/Rite Smiles/NEMT/Rite Share	$106.5 M	$104.9 M	$1.6 M
Drug Rebates	($171.6 M)	($173.1 M)	$1.5 M
Supplemental Hospital Payments	$372.7 M	$372.7 M	$0.0 M
Subtotal Favorable	**$1,122.1 M**	**$1,075.1 M**	**$47.0 M**
Unfavorable Variance			
Expansion	$673.4 M	$710.9 M	($37.4 M)
RHO II	$244.6 M	$266.8 M	($22.2 M)
HCBS FFS	$249.2 M	$268.0 M	($18.8 M)
Risk Share	$0.0 M	$12.5 M	($12.5 M)
Nursing Home & Hospice FFS	$477.5 M	$489.1 M	($11.6 M)
Rite Care	$967.7 M	$976.6 M	($8.9 M)
Medicare Premium Payments	$230.8 M	$231.0 M	($0.3 M)
NICU FFS	$37.7 M	$38.3 M	($0.6 M)
Other/Miscellaneous	($15.1 M)	($15.0 M)	($0.1 M)
Subtotal Unfavorable	**$2,865.8 M**	**$2,978.2 M**	**($112.4 M)**
Total	**$3,987.9 M**	**$4,053.3 M**	**($65.4 M)**
By Funding Source:			
General Revenue	$1,445.6 M	$1,450.0 M	($4.3 M)
Federal Funds	$2,534.9 M	$2,592.4 M	($57.5 M)
Restricted Receipts	$7.4 M	$10.9 M	($3.6 M)
Total	**$3,987.9 M**	**$4,053.3 M**	**($65.4 M)**

Overall reduction in managed care enrollment and premium payments

For FY 2026, managed care (incl. Rite Share) enrollment is down compared to November CEC: 265,414 as adopted in November compared to revised forecast of 259,848, a decline of 5,566 average monthly enrollment. This decline

was driven by the 12,277 closures on January 31, 2026, following the second application of Equifax data for purposes of Post Eligibility Verification of MAGI-eligible beneficiaries (i.e., The Work Number initiative). Further, this decline has not yet been followed by an increase in churn and above-average enrollment (or re-enrollment) of previously closed beneficiaries. Overall, eligibility as of March 31, 2026, was 290,417 and is lower than the pre-COVID-19/Public Health Emergency snapshot of 290,806 on February 29, 2020.

As summarized in **Table II-3**, the current fiscal year's decline in caseload offsets the marginal price increases that Medicaid experienced since its prior estimate. In interpreting the table, the value of $65.4 million represents the overall change in average monthly eligibility (i.e., managed care + fee-for-service) between November and this revised forecast multiplied by overall composite PMPM for the entire Medicaid benefits' program as previously calculated in November (i.e., (Nov CEC Member Months - Current Member Months) × Nov CEC PMPM).

Inclusion of Risk Share

Although the managed care rates are certified as actuarially sound by the state's independent actuary, the performance of some of Rhode Island's managed care partners in certain products in FYs 2025 and 2026 has worsened. Given the comparatively weak plan performance through the second quarter of the current contract period and the large number of closures in February 2026 and potential for additional closures in May 2026, Medicaid has increased its potential risk share liability from 0.5% to 1.5% of total premiums, increasing gross liability for risk share from $10.4 million to $27.0 million. The above-average inflation factor (discussed below) reflected in the preliminary rates for SFY 2027 supports this upwards revision to risk share liability.

Please note that the risk share liability/gain share receivable is continuously reassessed and will be revised for the agency's year-end accruals using the health plans' Q3 reporting and then will be considered again in November 2026 by RIAOG using the health plans' Q4 reporting. The SFY 2026 accrual will not be fully resolved until December 2027 or approximately 18 months after closing the contract period.

The health plans' worsening position in FY 2025 (as reflected in updated accruals) and continued (if somewhat mitigated) losses in FY 2026 contrast with the favorable margins seen in FY 2023 and FY 2024. However, Rhode Island's health plans' less favorable performance mirrors experience across all payers, including Medicaid and non-Medicaid payers. While Medicaid pricing, like most health insurance products, are updated annually and require actuarial soundness that leverages updated baseline experience and prospective assumptions, uncertainty will persist in the market as the states' actuaries consider the financial implications of House Resolution (H.R.)- 1 on managed care enrollments.

There was no provision for risk share for the CMS Demonstration effective through December 31, 2025. The Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) program that commenced on January 1, 2026, includes risk/gain share provisions, however, is not currently assuming any risk share liability as the population is more stable (as the beneficiaries are non-MAGI and experience less churn) and the certified rates exclusively reflected NHPRI's recent experience.

Similarly, for FY 2027, no general risk share is prospectively assumed across the core contracts. This is due to the high composite rate increase reflected in the certified rates for FY 2027 that were completed in early April, the exclusion of certain high-cost drugs from the risk-based contract, and Medicaid's reduced estimate of how H.R.-1 changes will impact managed care enrollment when implemented in SFY 2027.

A separate $12.5 million line item is included in the Managed Care budget line, however, to account for potential fiscal obligations to the health plans as it pertains to the new non-risk based fiscal arrangement for the provision for certain Cell and Gene Therapies (i.e., High-Cost Drug Administrative Services Only (ASO)).

Increased Fee-For-Service (FFS) spending

Overall FFS spending is forecasted to be $5.7 million higher in FY 2026 and $16.2 million higher in FY 2027, compared to the November CEC estimates. Medicaid's revised FY 2027 estimate for the impact of H.R.-1 contributed $3.1 million toward the net FFS spending deficit due to reduction in the anticipated number of noncitizen-related closures and therefore reduction in their associated FFS savings.

In FY 2026, the increase is attributed to higher LTSS spending, with HCBS expenditures estimated to be $17.4 million higher and nursing and hospice spending up by $5.1 million. Similarly, in annualizing the cost overruns in FY 2026, spending on LTSS services in FFS is expected to be $31.4 million higher than prior estimate for FY 2027.

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

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

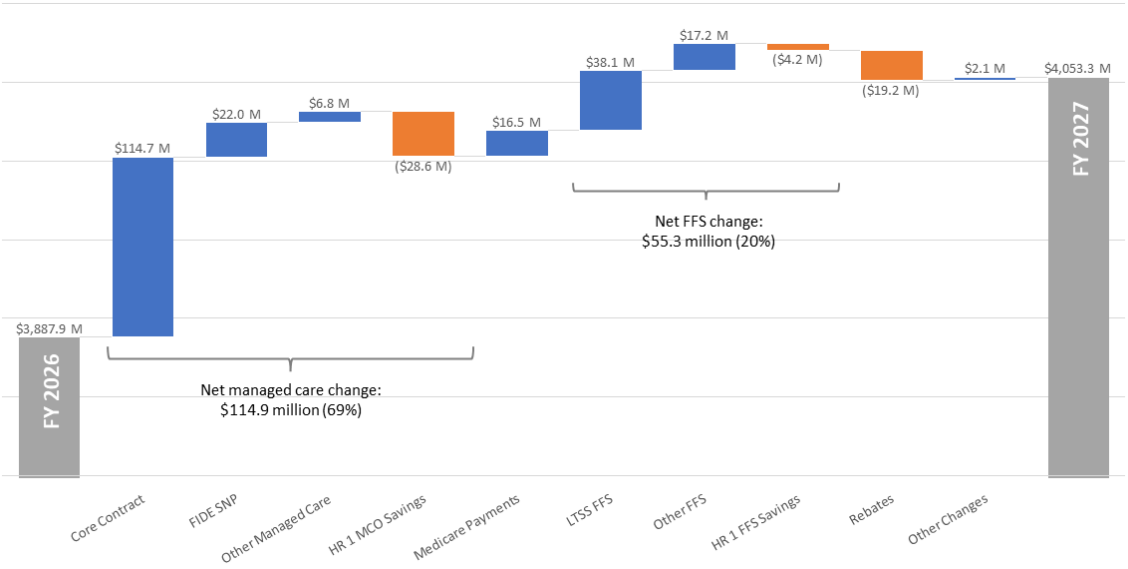


Table II-3. Summary of price-volume analysis, All Funds

	Price	Volume	Net
FY 2025: Final over Enacted	($10.3 M) -0.3%	($10.0 M) -0.3%	($20.3 M) -0.6%
FY 2026 over FY 2025	$468.5 M 13.7%	($177.5 M) -4.9%	$291.0 M 8.1%
FY 2026: Current over Nov CEC	$51.8 M 1.4%	($64.7 M) -1.7%	($12.9 M) -0.3%
FY 2027: Current over Nov CEC	$75.4 M 1.9%	($10.0 M) -0.3%	$65.4 M 1.6%
FY 2027 over FY 2026	$219.1 M 5.7%	($53.7 M) -1.4%	$165.4 M 4.3%

C. Caseload Growth and Trend Development

Rhode Island reached a peak enrollment of 373,325 beneficiaries with full Medicaid benefits in May 2023 at the end of the Public Health Emergency. The data breach in December 2024 temporarily reversed the steep and steady decline in caseload that the state experienced during its Return to Normal Operations and the resumption of regular renewal activities, but overall Medicaid enrollment resumed its decline once the renewal activities recommenced and as of September 2025—i.e., the last completed cycle before November CEC—was 302,927. The subsequent introduction of an income verification process that leveraged more recent data from Equifax during the quarterly post eligibility verification (PEV) runs, contributed to large volumes of gross closures on October 31, 2025, and January 31, 2026, of 10,397 and 12,606 beneficiaries, respectively. Although these closures were partially offset by eligibility of new beneficiaries or return of previously eligible beneficiaries, and subsequent months have seen modest growths, the recent pattern of caseload trends exhibit a steady decline.

As of March 2026—the last completed cycle before May CEC—enrollment is 290,417 with full Medicaid (i.e., not including EFP Only, Early Intervention CNOM, or Medicare Premium Payment Only beneficiaries), including a full-time equivalent (FTE) of 251,042 members enrolled in managed care.

Underlying Trend Factor

Medicaid's prospective forecast assumes an underlying growth rate of 1.5% for the last quarter of FY 2026 and 1.5% for all eligibility groups in FY 2027 except for Expansion that reflects a 2.5% growth factor. A 2.5% growth factor is also applied to PACE enrollment for both periods due to its low enrollment. Any H.R.-1 adjustments are applied after application of the underlying trend factor. The forecast applies this growth linearly across all eligibility groups and managed care products. This is a simplification of anticipated trends given likelihood of continued PEV-related disruption.

While the recent trend has been decidedly negative, the long-term trend over the past 6 years is flat. Prior to January 2020, Medicaid must go back to FY 2016 to see eligibility as low as it is presently. Given the potential for offsetting acuity adjustment to the rates that could be necessary if the enrollment trends remain negative (beyond the noted adjustments for H.R.-1 discussed below), maintaining an underlying negative trend without an offsetting adjustment to the composite rates and/or inclusion of additional risk share payments in FY 2027 seems imprudent from a budgetary perspective.

Many economists have increased their warnings for the likelihood of a recession. For example, the chief economist at Moody's Analytics recently raised his 12-month recession outlook to 48.6%. This warning was issued in early March (i.e., over a month ago) and included the caveat that "if oil prices remain elevated for much longer (weeks and not months), a recession will be difficult to avoid." With Medicaid being a means-tested program, the state could see a positive correlation between job losses and Medicaid eligibility if a recession is realized. If such a recession or softening of the labor market were to occur, the 1.5%-2.5% annual growth rates would likely be insufficient; however, given the downward pressure of the intermittent PEV batch process and general uncertainty over the net effect of H.R.-1 related closures, the underlying trend assumptions remain reasonable.

H.R.-1 offsets to underlying trend

The major reason for Medicaid's prospective caseload decline is due to federal changes included in H.R.-1, or the One Big Beautiful Bill Act, passed in July 2025:

- In FY 2027, a total of 8,145 current beneficiaries—accounting for a total 42,435 member months in FY 2027—are expected to lose eligibility due to federal changes related to immigration status or new community engagement requirements. Due to updated guidance from CMS on impacted noncitizens and a better understanding of the timing for the implementation of the Community Engagement and 6-month renewals requirements, there is a significant reduction in the number of closures and impacted member months in SFY 2027, when compared to November CEC.
- See **Section H** below in the **Major Developments** for additional information.

Figure II-2 puts Medicaid's current enrollment snapshot (as of March 2026) in context, comparing it to Rhode Island's pre- and post-Public Health Emergency Medicaid enrollment, as well to post H.R.-1 eligibility changes as of end of FY 2027.

Figure II-3 compares Medicaid's current enrollment forecast to the Medicaid's prior forecast assumed in November.

Figure III-1 shows the increase in enrollment and costs for the Cover All Kids program since its implementation.

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

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

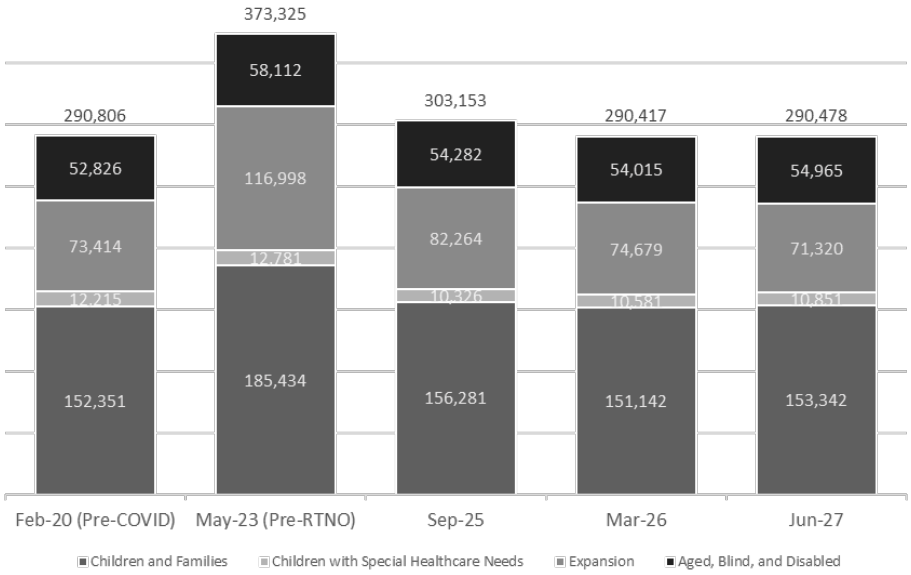
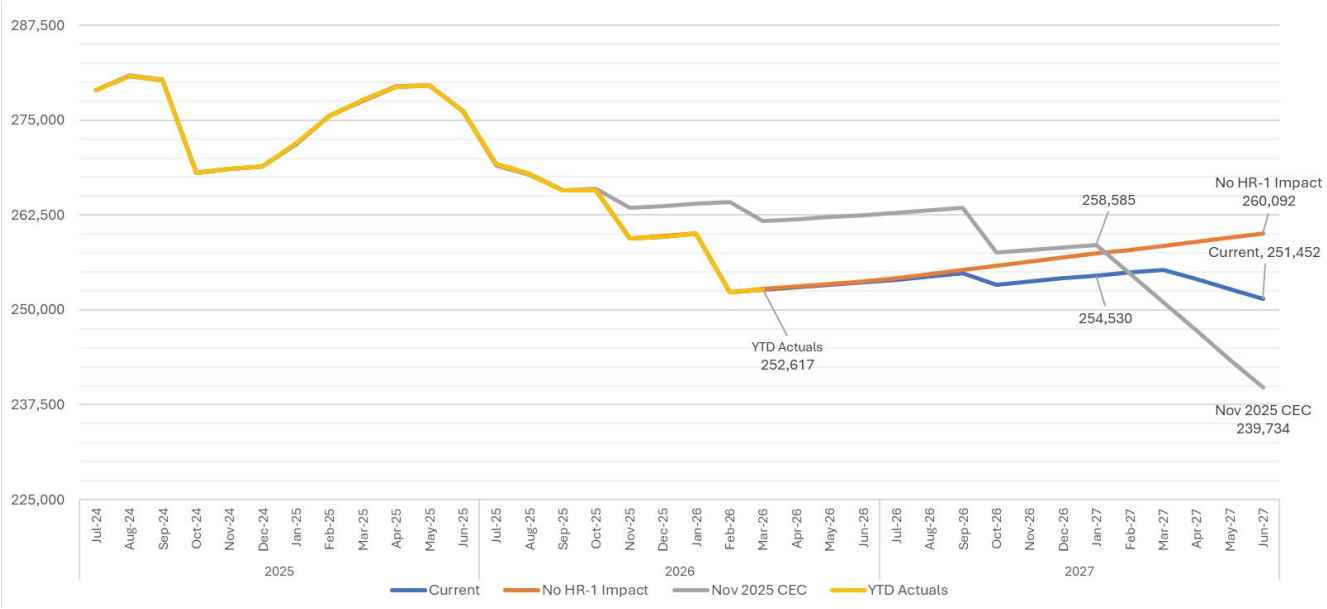


Figure II-3. Full Medicaid beneficiaries <u>enrolled in managed care</u>; current forecast compared to November 2025 CEC[2]



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 revised rates for FY 2026 and draft rates for FY 2027. The revised FY 2027 budget reflects a composite increase of 7.1% across the core contract product lines of Rite Care, Rhody Health Partners, and Expansion. In contrast to the November forecast that used a proxy of 5.0% for potential rate

[2] Monthly managed care enrollment included in Figure II-4 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.

increase, this revised forecast reflects the actuarially certified rates for FY 2027 as issued by the State and shared with the health plans in April 2026. The 7.1% increase is primarily due to a change in the base data and not prospective trends for the continuation of increased utilization and/or rate increases. Specifically, the FY 2026 rates used FY 2024 data and certain prospective assumptions around utilization trends and price changes, some of which were legislatively-defined—for example, the OHIC rate increases—and others that were inherent to the market conditions and necessary to maintain network adequacy. The actual spending in FY 2025 when compared to the FY 2024 experience exhibited higher trends than previously assumed. Further, the emerging experience in FY 2026 suggests that these trends are persistent, resulting in higher-than-anticipated baseline and trends relative to the FY 2026 rates.

While the core contract rates are near-final, the rates for PACE that are presently undergoing a rebasing by the state's certifying actuary and the FIDE SNP rates that are adjusted on a calendar year basis are presently unknown. For PACE, a 5.0% rate increase was applied for SFY 2027 and for FIDE SNP an 8.75% rate increase was included effective January 2027. The high trend factor for the FIDE SNP is largely driven to by uncertainty over how the OHIC rate increases for HCBS and PDPM methodological change for nursing home reimbursements will impact rates in CY 2027.

Table II-4 summarizes the caseload, PMPM, and composite price changes given changes in the underlying enrollment mix.

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

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

Table II-4. 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	FY26 → FY27	FY25 → FY26	FY26 → FY27
Full Benefits:										
Rite Care Core	160,145	149,937	148,506	$362	$398	$434	-6.4%	-1.0%	9.8%	9.1%
Rite Care CSHCN	9,737	9,734	10,079	$1,430	$1,641	$1,710	0.0%	3.5%	14.7%	4.2%
Expansion	79,956	73,782	70,129	$670	$779	$844	-7.7%	-5.0%	16.3%	8.3%
Rhody Health Partners	12,737	12,758	12,764	$2,226	$2,408	$2,437	0.2%	0.0%	8.2%	1.2%
SOBRA Payment	364	359	396	$18,768	$20,789	$20,061	-1.4%	10.3%	10.8%	-3.5%
Subtotal (Caseload subtotal excl. SOBRA)	262,575	246,211	241,478	$612	$696	$745	-6.2%	-1.9%	13.7%	7.1%
Other Major Medical Products										
CMS Demonstration	11,418	11,414	11,148	$1,573	$1,787	$1,991	0.0%	-2.3%	13.6%	11.4%
PACE	436	465	485	$4,748	$5,777	$6,092	6.7%	4.3%	21.7%	5.4%
Subtotal	11,854	11,879	11,633	$1,690	$1,944	$2,162	0.2%	-2.1%	15.0%	11.2%
Other Capitated Arrangements:										
RIte Share [1]	1,390	1,758	1,779	$131	$141	$155	26.5%	1.2%	7.1%	10.2%
Rite Smiles	135,389	130,188	130,410	$18	$19	$19	-3.8%	0.2%	5.0%	3.2%
Rite Care EFP	2,090	1,559	934	$14	$27	$29	-25.4%	-40.1%	101.8%	4.8%
Non-Emergency Transportation [2]	310,128	294,953	289,303	$9	$10	$10	-4.9%	-1.9%	3.2%	7.5%
Medicare Premium Payment:										
Part A (Hospital)	3,469	3,636	3,751	$483	$515	$549	4.8%	3.2%	6.8%	6.5%
Part B (Professional Services)	40,636	41,054	40,969	$184	$199	$212	1.0%	-0.2%	8.5%	6.6%
Part D (Prescription Drugs)	38,961	38,202	37,737	$198	$205	$212	-1.9%	-1.2%	3.4%	3.4%

National Forecasts of Medicaid Enrollment/Expenditures

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

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

- Aged and Blind/Disabled Populations: Spending growth is expected to range from 2% to 5% annually, reflecting moderate adjustments in response to service needs.

- Children Population: Projected spending growth is higher, ranging between 4% and 5% annually.
- Traditional Adult Eligibility Population: Growth rates are projected to remain within the 3% to 6% range annually.
- Expansion Adult Population: This group has the highest projected annual growth, between 4% and 7%, due to anticipated increases in service utilization and policy adjustments.

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

The CBO's forecast is generally consistent with projections published by CMS's Office of the Actuary in June 2025, which anticipates a continued reduction in enrollment of 1.2% in 2025, followed by positive average annual enrollment growth in 2026 to 2027. In comparison, over the CY 2025, Rhode Island enrollment fell by 4.1%, with Medicaid forecasting a further reduction of 1.9% for CY 2026 and additional decline in first of CY 2027 due to impact community engagement requirements. From 2028 to 2033, CMS forecasts enrollment growth of 0.7% in composite across all populations.

From an overall costs' perspective, CMS estimates that Medicaid expenditures will grow 6.8% in 2026-2027 and 6.2% per year from 2028 to 2033. In comparison, Medicaid's current revised budget (excluding DCYF and BHDDH) reflects an increase of 8.9% in FY 2026 over FY 2025 and 4.1% in FY 2027 over FY 2026.

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

The reconciliation bill passed by Congress in July 2025 has changes that are effective in FY 2026 and FY 2027. Only three items include explicit adjustments in EOHHS' benefits testimony: changes to who is considered a "qualified alien" for purposes of eligibility, the imposition of the community engagement requirements, and the removal of the primary care assessment funding from managed care rates effective October 1, 2026. The current estimates account for the latest federal guidance, leading to an overall reduction in the number of expected closures in FY 2027: from 26,982 as previously estimated[3] compared to 8,787 H.R.-1-related closures as estimated now.

CMS published one final rule related to H.R.-1 Medicaid changes; specifically on Section 71117, "Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations – Closing a Health Care-Related Tax Loophole."[4] No interim or final rules are published on community engagement requirements, "qualified alien" changes, state directed payment changes, and other aspects of eligibility and health care tax changes under H.R.-1. Several guidance documents are available from CMS,[5] which informed the updated impacts. CMS also provided email guidance to Medicaid Directors on CMS expectations for Section 71113, Prohibited Entities.

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[6] 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).

[3] In November 2025, EOHHS estimated that 24,630 beneficiaries would lose coverage due to the community engagement requirements; however, 4,105 of this total number of impacted beneficiaries would have been closed at midnight on June 30, 2027 and so would not have resulted in a drop in managed care enrollment until July 2027 or FY 2028. The fiscal estimate and total impacted member months reported for FY 2027 were correct, but the count of beneficiaries impacted was overstated by 1/6th. The figure of 26,982 uses the corrected figure for community engagement.

[4] https://www.federalregister.gov/documents/2026/02/02/2026-02040/medicaid-program-preserving-medicaid-funding-for-vulnerable-populations-closing-a-health

[5] https://www.medicaid.gov/resources-for-states/working-families-tax-cut-legislation

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

The FY 2026 hospital separate payment term SDP, paid at a percentage of the average commercial rate, was approved by CMS on November 20, 2025. As anticipated based on the "Section 71116 SDP Letter," the approval package stated, "based on CMS's preliminary determination, this SDP proposal likely qualifies for the temporary grandfathering period in section 71116(b) of the Working Families Tax Cut (WFTC) legislation (Public Law 119-21). CMS is preparing a notice of proposed rulemaking to revise 42 CFR part 438 as required under section 71116. CMS acknowledges that this determination is preliminary in nature and policies will be finalized as part of notice and comment rulemaking. CMS will enforce all federal requirements, including section 71116, and CMS's assessment may be revised if further information is identified that alters the initial assessment." This means the FY 2026 value of $325 million will be allowable until the FY 2029 rating period when a 10% annual reduction will be applicable until it reaches Medicare levels.

The FY 2026 hospital inflation of 2.9% for inpatient and outpatient services are also considered "SDPs." The uniform percentage increase preprints were approved by CMS on November 14, 2025 and the approval packages were also indicated as likely qualification for temporary grandfathering.

- **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 general revenue for PPSNE non-abortion services. Medicaid and its actuary determined the amount of funding in the rates that may be attributed to base experience for PPSNE patients is immaterial and these patients will likely seek services elsewhere as needed. Therefore, rating adjustments were not made for FY 2026. 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** states that regardless of any provisions to the contrary in the applicable section of law, as of October 1, 2026, federal financial participation (FFP) is available for medical assistance provided only to U.S. citizens, lawful permanent residents (LPRs), certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants.

  The change means that many individuals who have historically been considered qualified noncitizens under federal law–such as refugees, asylees, humanitarian parolees, victims of trafficking, individuals subject to battery and other cruelty, conditional entrants, etc.–will no longer be considered qualified for purposes of full Medicaid and CHIP eligibility. Impacted individuals will need to adjust their status to LPR (i.e., obtain a green card) before they will be eligible for full Medicaid and otherwise will only qualify for Emergency Medicaid coverage. CMS released technical guidance to states in February and a State Health Official letter on April 8, 2026, to provide policy and operational guidance to states on this section.

  <u>Assumption/Analysis Updates:</u> Medicaid's November CEC estimates included assumptions for several areas of uncertainty. One area was whether qualified noncitizens 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 was 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. Since the November conference, planning meetings and the guidance released in February and early April clarified these areas; those currently exempt will remain exempt. The impact analysis from November assumed that all such individuals would become subject to the five-year bar. The option to cover lawfully present children and pregnant/postpartum individuals was also understood to remain in place, which was confirmed in the April guidance. This aligns with our November assumption.

  The Federal Data Services Hub (FDSH) is used to verify citizenship and immigration status for Medicaid applicants. It utilizes the Systematic Alien Verification of Entitlements (SAVE) and Verify Lawful Presence (VLP) interfaces to check naturalized and derived U.S. citizenship, as well as verification of immigration status. Our November estimates used a limited dataset from the state's eligibility system that included FDSH data as of September 2025. The current estimate is based on Medicaid's review of an updated dataset from March 2026 that was provided by our eligibility system vendor after their analysis of CMS' recent technical guidance. This technical guidance includes detailed specifications and new data fields that states can expect

to receive from the VLP interface. Specifically, there will be a new indicator to designate whether someone meets the designation as a qualifying noncitizen eligible for FFP after October 1, 2026. The State and RI Bridges' vendor are actively using the February technical guidance and April State Health Official letter to ensure the eligibility system utilizes the new noncitizen indicator to redetermine eligibility.

Medicaid's updated estimates reduce the beneficiary impact and savings compared to November. The current estimates assume this change impacts approximately 3,700 Rhode Islanders who currently have full or limited Medicaid benefits, through managed care or FFS. The required closure of these beneficiaries will result in lower Medicaid payments estimated to be $24.4 million, including $9.2 million in state funding.

While the May 2026 estimates are more refined based on the latest available guidance, these estimates remain preliminary and will continue to evolve. Medicaid will have more certainty beginning in July when we expect the new indicator to be added to the FDSH dataset and Rhode Island will begin running nightly batches and assess existing qualifying noncitizens for their continued eligibility. This process will take several weeks due to transactional limits until completed, therefore, these estimates should be interpreted cautiously. The impact, if any, of the changes to the qualifying criteria is most uncertain with respect to the SSI population as the Social Security Administration presently confirms eligibility for this subpopulation and RI Bridges does not maintain immigration-related information on them. H.R.-1 did not change the scope of qualifying noncitizens eligible for SSI, and the citizenship criteria for SSI are now broader than Medicaid. CMS is expected to issue additional guidance to states with this SSA arrangement. Medicaid believes this subpopulation should be minimally impacted, if at all; but wants to note the absence of available data to perform any comparable assessment to what was completed for the non-SSI population.

See **Table II-5** for program level impact and an estimate of the FY 2027 reductions attributed to this federal requirement, including a summary of the changes to prior estimates. 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. A shift of some expenditures to emergency Medicaid is shown in the table.

Table II-5. H.R.-1 Closures due to changes regarding Qualifying Non-Citizen, by program

	SFY 2027:		
	Clients Impacted	Member Months [1]	Expenditures
Capitation Payments			
Rite Care	750	6,750	$ 3,776,107
Rite Care - EFP Only	746	6,714	191,752
Expansion	559	5,031	4,184,458
Rhody Health Partners	250	2,250	5,481,213
Rhody Health Options	291	2,619	4,948,869
Medicare Savings Program [2]	162	1,458	1,616,571
Subtotal Subtotal Capitaiton	**2,758**	**24,822**	**$ 20,198,970**
Prior Estimate - Nov CEC	*6,457*	*65,196*	*53,887,547*
Change	*-3,699*	*-40,374*	*(33,688,577)*
Fee-for-Service Activity			
Hospitals			2,906,250
Offset: Hospitals (Emergency Medicaid)			(3,147,656)
Home and Community Based Care			1,993,752
Nursing Homes			910,013
Other Services			1,495,896
Subtotal FFS	**977**	**8,793**	**$ 4,158,254**
Prior Estimate - Nov CEC	*2,500*	*25,242*	*7,742,803*
Change			*(3,584,549)*
Grand Total	**3,735**	**33,615**	**$ 24,357,225**
Prior Estimate - Nov CEC	*8,957*	*90,438*	*61,630,350*
Change	-5,222	-56,823	(37,273,125)

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.

- **Section 71119** imposes a community engagement (CE) requirement, effective January 1, 2027, upon some Medicaid beneficiaries that requires them to work, participate in a work program and/or in community service for at least 80 hours a month, or be in school at least half time. People can also comply based on having income levels consistent with 80+ hours per month of work at the federal minimum wage. The requirement generally applies to those enrolled via Adult Expansion or an expansion-like waiver category. In Rhode Island, this includes the entire Expansion group (i.e., 74,491 beneficiaries as of April 2026).

  Assumption/Analysis Updates: Since November, CMS has clarified that the first renewal cohort subject to CE requirements would be the first renewal cohort initiated after January 1, 2027, which is the March cohort with coverage effective April 1, 2027. Medicaid's November estimate assumed the first group to lose coverage was the January cohort with coverage effective February 1, 2027. Additionally, the requirement for 6-month redetermination does not apply until after their first redetermination after January 1, 2027. For example, the December 2026 cohort does not need to be renewed in June 2027; but can continue to be renewed in December 2027. Thereafter, would be renewed again in June 2028 and December 2028.

  These changes to the first cohort and 6-month redetermination timing assumptions greatly reduce the number of beneficiaries who will be subject to the CE requirement in FY 2027; instead of renewing 100% of expansion beneficiaries subject to new CE requirements between January and June 2027 for effective closures between February and July 2027, only 25% of expansion beneficiaries will be subject to effective closures between April and June 2027.

  There is a set of exemptions in H.R.-1, including for medical frailty. In November, Medicaid used claims data as a proxy to estimate the number of beneficiaries who may meet one of the exemption criteria. Since November, CMS guidance has provided states with discretion on defining medical frailty. Rhode Island has not finalized its list of exemptions at the code level, however, has an inclusive draft list that aligns with approaches that many other states are employing.[7] Medicaid used this list to understand the potential impact on beneficiaries and estimates, however did not make updates to assumptions given the minimal impact on estimates and draft nature of the code list.

  EOHHS has revised downward its total number of beneficiaries who will be closed due to the CE requirement in the first year. Previously, EOHHS anticipated that 32,000 individuals would be subject to the CE requirements and 75% of those, or approximately 24,600, would be at risk of disenrollment, with 20,525 being closed in FY 2026. Medicaid's prior estimate leveraged a July 2025 data extract and 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 and with 75% assumption being based on the experience of two states who implemented requirements.[8] Overall, the number of closures was estimated to be 28.6% of total Expansion enrollment.

  For the revised FY 2027 estimate, the count was scaled downward for the subsequent caseload declines within the Expansion group. The revised estimate adjusts for updated caseload and assumes individuals are assessed for compliance beginning with the March cohort whose eligibility process will begin in January and, if impacted, would not lose coverage until April 2026. The net closure of beneficiaries, measured as 28.6% of the anticipated March 2026 enrollment, is modeled to be spread out evenly over 12 subsequent months, and offset by the continued application of an underlying 2.5% annualized growth factor. Overall, Medicaid anticipates the requirement will adversely impact 20,195 beneficiaries relative to the March 2027 enrollment. However, due to the allowed delay in applying the new requirement, only 5,052 closures are expected during the final quarter of FY 2027.

  The updated expenditure reduction as it pertains to CE for FY 2027 is only $8.4 million, including $0.8 million GR. See **Table II-6** for number of beneficiaries impacted and resulting reduction in member months and premium payments in the second half of FY 2027.

[7] The list of ICD-10 codes are included in a research paper by physicians at the Harvard Chan School of Public Health and Brigham and Women's Hospital who had reviewed Alternative Benefit Plan eligibility in 7 states and condition that they physicians independently deemed as not likely to meet statute requirements implied in H.R.-1 (e.g., mild, generally curable, lasting less than 6 months, etc.) were considered for exclusion.
[8] https://medicaiddirectors.org/wp-content/uploads/2025/07/RWJ-Work-Requirement.pdf

Table II-6. H.R.-1 Closures due to community engagement requirement, Expansion only

	SFY 2027:		
	Clients Impacted	Member Months [1]	Expenditures
Capitation Payments			
Expansion	5,052	10,104	$ 8,403,397
Prior Estimate - Nov CEC	*20,525*	*61,545*	*49,700,914*
Change	*-15,473*	*-51,441*	*(41,297,517)*

- **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. Additionally, as noted above, the 6-month redetermination cycle will not be impactful in FY 2027 due to revised guidance on how states may implement the change. The first double cohort is now not expected until October 2027.

- **Section 71115** modifies the permissible levels of provider taxes, effective October 1, 2026. This section sets the indirect hold harmless threshold equal no more than the lower of the applicable percent of net patient revenue for health care-related taxes enacted and imposed as of July 4, 2025 or the applicable phase down amount beginning in fiscal year (FY) 2028. Effectively, this prevents increases to pre-existing health care-related taxes and the imposition of new health care-related taxes, as the indirect hold harmless threshold would be 0% for taxes that were not enacted and imposed as of July 4, 2025.[9]

  The FY 2026 budget enacted a new primary care assessment was prior to July 4, 2025, but was not imposed until January 1, 2026. CMS defines imposed as: "...a state or local government (directly or by way of a delegated administrative agency) ... actively collecting revenue, as of July 4, 2025 … In other words, "enacted" refers to whether the authority to tax was provided by the relevant authorizing entity/entities by July 4, 2025, and "imposed" refers to whether the tax was actually implemented as of July 4, 2025." The impact of this provision on our testimony is the removal of funding of the FY 2026 enacted assessment from the MCO rates effective October 1, 2026.

- **State Only Programs for Noncitizens Ineligible for Full Medicaid**. While not directly related to a change under H.R.-1, CMS released a State Medicaid Director letter on September 9, 2025[10] that will impact Rhode Island's state-funded programs provided via Medicaid (including Cover All Kids program and Equality in Abortion Coverage). The letter issued updated interpretation of section 1903(v) of the Social Security Act (the Act), which authorizes FFP for care and services necessary for treatment of an emergency medical condition for noncitizens ineligible for full Medicaid benefits. Rhode Island Medicaid is already compliant with the updated state options for coverage of emergency Medicaid as it is currently provided in FFS only.

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

  CMS does not expect to take enforcement action on these updates before the start of the first rating period beginning on or after 1 year following the date of publication of this SMDL. Effectively, this means that Rhode Island must become compliant – for example, remove the Cover All Kids program from Medicaid managed care and separate from Medicaid funded systems - by the start of FY 2028. As a transitional step, Medicaid worked with its actuary to establish separate rates for the Cover All Kids program for FY 2027.

[9] https://www.medicaid.gov/medicaid/downloads/providertax_dcl_11142025.pdf
[10] https://www.medicaid.gov/federal-policy-guidance/downloads/smd25003.pdf

E. FY 2026 Budget Initiative Implementation

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

- Primary Care Rate Increase. *Implemented*. The enacted minimum fee schedule for primary care has been set at 100% of Medicare. FFS is currently paying providers at the enacted fee schedule and the latest MCO amendment establishes/requires this directed payment, noting an effective date of October 1, 2025. The state plan amendment for this primary care initiative is currently with CMS under a request for additional information (RAI); Medicaid provided responses to questions on the fiscal estimates in April.
- FQHC Rate Increase. *Complete*. The enacted budget included $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 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*. System updates are underway for both FFS and managed care. The state plan amendment for this initiative is with CMS under RAI. Currently, EOHHS is not tracking who is receiving the benefit and any savings resulting from the visit, given the implementation status. Once more data are available, Medicaid will submit a data project request to review claims for individuals who received the service. Please note, absent a randomized controlled trial, there are significant methodological limitations to assessing savings.
- Long Term Behavioral Health Beds. *Delayed*. EOHHS submitted the state plan amendment to CMS in November. On February 6, 2026, CMS formally requested additional information. EOHHS worked with BHDDH to draft responses, which were shared with CMS informally in April. EOHHS will provide a formal response to the RAI, which resets the 90-day review period, once CMS provides initial feedback. The FY 2026 estimate includes $0.8 million from all sources of funds in the Hospital program assuming implementation in May. The FY 2027 estimate includes $10.8 million from all sources.
- 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. The second run resulted in closures effective January 31, 2026. The volume of closures in each round were substantial. 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 February 2026 in FY 2026, Medicaid assumes any ongoing savings will be achieved through cost avoidance that depresses the long-term month-over-month growth.
- Rite Share. *Implemented.* As of March 2026, RIte Share enrollment is 1,690 members. This represents an 8.4% decrease relative to the October 2025 figure of 1,832 members. This decrease is the result of the RIte Share team shifting focus from new member enrollments to employer renewals for current members, due to staffing challenges (one vacancy since September 2025 and one team member out on extended medical leave). Since October 2025, 4,275 requests for ESI information have been sent out to employers with less than 15% responding, resulting in 157 new employers who offer cost-effective insurance plans. There is no mandate for employer participation, and no enforcement mechanism for employers who refuse to comply with requests for ESI information (except for employers who are also Medicaid providers).
- Conflict Free Case Management. *In process*. The revised estimate for FY 2026 totals $8.0 million, $0.3 million less than the November CEC. The revised estimate assumes 12,601 beneficiaries may be eligible for CFCM with 5,180 beneficiaries receiving services by June 2026. The decrease is due to DD beneficiaries continuing to receiving services through independent facilitators (IFs) though June, offset by additional referrals expected to occur in the remaining months of FY26. The estimate excludes 768 DD beneficiaries who receive case management through BHDDH staff. The FY26 estimate excludes all DD beneficiaries currently receiving services through IFs. Through March 2025, there are 703 beneficiaries receiving services

from IFs and this is expected to grow. The revised estimate assumes these beneficiaries will transition to case managers in the community beginning in July.

In FY 2027, Medicaid projects $12.6 million and assumes 6,462 beneficiaries will receive CFCM services by June 2027, including 2,413 DD beneficiaries and 4,049 non-DD beneficiaries. The model excludes beneficiaries managed by BHDDH FTEs.

- Community Health Worker Program. *Implemented.* An amendment to the Medicaid State Plan was approved on December 8, 2025.
- Medicare Savings Program (MSP) Expansion. *Implemented.* This initiative required changes to eligibility criteria in the RI Bridges system. The system changes were deployed in late January 2026. As such, new FPL values will be effective on February 1, 2026 for new enrollees and the annual federal FPL inflation adjustment ran eligibility on all MPP only individuals in early March 2026 and transition most beneficiaries from SLMB to QMB at that time. This transition was realized as the number of QMB beneficiaries jumped from 1,628 in January to 5,267 in February and is 5,870 as of April and the number of SLMB beneficiaries declined from 4,057 in January to 308 in April.

  As of early April, there has been only a marginal increase in the total number of MSP beneficiaries and no increase in the number of individuals eligible for 100% federally funded Qualifying Individuals (QI) category. Rather, there has been a marked decline among the QI population—from a monthly average of 1,950 in February to 1,450 in April—as presumably existing beneficiaries have transitioned from QI to either the SLMB or QMB eligibility group and new beneficiaries have not yet enrolled. Nonetheless, increased enrollment into QI is anticipated. To that end, CMS increased Rhode Island's allotment to the limited pool of available funding for CY 2026 for the nation's Qualifying Individual program. Total available federal funds aligns with Medicaid's higher projections for FY 2027.
- Primary Care Health Assessment Impact. *Implemented.* The funding required is in the FY 2026 managed care rates for this new assessment, effective January 1, 2026. Funding is also included in the FY 2027 rates through September 30, 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 is expected to go-live August 2026.
- Mobile Response Stabilization Services (MRSS). *In process*. Planning is underway to ensure the standalone MRSS service begins on October 1, 2026, which will begin as FFS only in FY 2027 to ensure timely implementation. EOHHS posted the SPA for public comment on April 17, 2026 and anticipates submitting to CMS no later than May 29, 2026. Systems work is also underway to establish the MRSS fee schedule and support provider enrollment.

  Funding for MRSS is currently included in the CCBHC PPS rates, which will be rebased for demonstration year three, beginning October 1, 2026. The rebasing process, which includes removal of MRSS expenses, will not be complete until mid-FY 2027. Currently, the MRSS funding remains attributed to the CCBHC program across both FFS and managed care. While a modest reduction in total MRSS program funding is anticipated, due to the uncertainty of the overall CCBHC rebasing process, Medicaid did not make any explicit MRSS funding adjustment in this testimony.
- Pharmacy Review. *In process/delayed.* EOHHS and the State actuarial consultant have been progressing on an analysis to determine available savings from changes to the pharmacy benefit delivery system. Issues obtaining necessary data delayed this analysis but anticipate completion in June 2026.

  The budget initiative for FY 2026 estimated approximately $14.6 million in all funds half-year savings in FY 2027 from changes to EOHHS's approach to pharmacy delivery. However, given delays in data acquisition and hiring, it is unlikely that savings will be realized in FY 2027. EOHHS was authorized for a cap increase of 4.0 FTE positions in FY 2026 to implement new pharmacy delivery systems, receiving full funding for 1.0

FTE position of that group. That position is currently onboarding, and the other positions are set to be posted to support hiring as soon as possible in FY 2027.

- Program Integrity. *In process.* Three of the four new positions were onboarded between December 2025 and January 2026; one was an internal candidate from the existing team, so overall the team has two additional staff (along with turnover in existing positions).

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

  1) The revised forecasts for FYs 2026 and 2027 include $2.5 million in anticipated recoupments against providers that OPI has or in the process of establishing a repayment plan.
  2) OPIs work has resulted in a reassessment of the state's Community Health Worker program, reducing claims expenditures from $4.7 million in SFY 2025 Q2 to less than $100,000 in SFY 2026 Q2, and annualized reduction of at least $18.0 million in cost avoidance.
  3) Since January 2025, $21.0 million in referrals were made to the MFCU (not reflected in testimony).

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

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

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

Medicaid has several patients in various stages of the eligibility process for two diseases – EOHHS was notified of these patients in early 2026. One patient has been approved for CGT treatment for DMD, while one patient has been approved for SCD treatment; a third is being evaluated for SCD treatment. These are all managed care members. The timeline for treatment is unclear for these patients. While it is possible that these drugs and associated expenses will be billed in FY 2026, it is also possible that, given the long eligibility evaluation, the expenses for these patients (should they complete treatment) will be billed in FY 2027. EOHHS estimates that 52 beneficiaries may qualify for SCD treatment based on primary medical criteria, but it is unclear how many are exploring the potential of CGT. It is unclear at this time how many potential beneficiaries could seek treatment for other disorders. Rhode Island has a lower proportion of Medicaid enrollees with SCD (0.3 %) than neighboring states Connecticut (1.2 %) and Massachusetts (2.3%). State comparisons are not available for more specific information, such as the incidence of eligibility for CGT treatment.

Rhode Island's participation in the CGT Access Model began January 1, 2026. For FY 2026, the cost of the drugs was included in managed care capitation rates, totaling approximately $7.5 million for all CGTs across the three managed care organizations (MCOs). There is no historical experience for these drugs, making predicting

expenditures difficult. For FY 2027, EOHHS is utilizing an "administrative services only" (ASO) arrangement with the MCOs for these high-cost drugs, in which the MCOs would pay up-front costs for the drug and EOHHS would reimburse the MCOs on a defined basis. MCOs would be responsible for associated costs such as hospital stays and transportation under the capitation rates. EOHHS includes $12.5 million in FY 2027 for eligible patients. This funding applies to CGT treatments specified on an EOHHS high-cost drug list. EOHHS is including contract language in the managed care contracts to support the new payment arrangement.

G. Cross Budget Line Summaries: Rebates and NEMT

Drug Rebates and J-Code Collections

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

Table II-7 summarizes Medicaid's DRE and J-Code invoices for FY 2025 through FY 2027 projected. DRE rebates total $145.6 million and J-Codes total $8.3 million in FY 2026. Medicaid projects a total of $164.6 million in DRE rebates and $8.6 million in J-Code rebates for FY 2027. The marginal decline in FY 2026 from the November CEC to current projected can be attributed to the continued reduction in caseload and lower spending on drugs overall. Medicaid applied a 5% price factor to the calculated rebate on a Per Member Per Month (PMPM) basis.

Medicaid derived its forecast by dividing the average quarterly rebate amounts invoiced to the drug manufacturers in the four quarters through FY 2026 Q2 by the average managed care enrollment for the same period. The resulting PMPM multiplier, calculated by product line, was applied to Medicaid's enrollment.

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

Table II-7. Summary of Drug Rebate Collections

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
DRE								
Managed Care	$ (46,077,112)	$ (44,455,523)	$ (45,437,901)	$1.0 M	$ (50,465,663)	$ (51,494,361)	$1.0 M	($6.1 M)
Rhody Health Partners	(40,515,730)	(37,073,563)	(36,080,606)	(1.0 M)	(43,077,694)	(42,042,711)	(1.0 M)	(6.0 M)
Expansion	(61,866,819)	(59,256,288)	(56,940,497)	(2.3 M)	(62,196,014)	(63,325,221)	1.1 M	(6.4 M)
Fee-for-Service	(7,125,054)	(7,020,764)	(7,187,589)	0.2 M	(7,491,515)	(7,709,123)	0.2 M	(0.5 M)
Subtotal DRE	**$ (155,584,715)**	**$ (147,806,138)**	**$ (145,646,593)**	**($2.2 M)**	**$ (163,230,886)**	**$ (164,571,416)**	**$1.3 M**	**($18.9 M)**
J-Code								
Managed Care	(2,349,727)	(2,529,194)	(2,321,546)	(0.2 M)	(2,625,750)	(2,418,776)	(0.2 M)	(0.1 M)
Rhody Health Partners	(1,572,734)	(1,400,764)	(1,653,458)	0.3 M	(1,471,570)	(1,736,982)	0.3 M	(0.1 M)
Expansion	(3,051,124)	(2,943,191)	(2,957,183)	0.0 M	(2,774,272)	(2,953,812)	0.2 M	0.0 M
Fee-for-Service	(1,245,380)	(1,379,637)	(1,357,172)	(0.0 M)	(1,488,120)	(1,454,665)	(0.0 M)	(0.1 M)
Subtotal J-Code	**$ (8,218,965)**	**$ (8,252,786)**	**$ (8,289,359)**	**$0.0 M**	**$ (8,359,712)**	**$ (8,564,235)**	**$0.2 M**	**($0.3 M)**
Total Rebates	**$ (163,803,680)**	**$ (156,058,924)**	**$ (153,935,952)**	**($2.1 M)**	**$ (171,590,598)**	**$ (173,135,651)**	**$1.5 M**	**($19.2 M)**
QROA								
Managed Care	1,350,211	1,351,601	1,331,603	0.0 M	1,408,565	1,387,963	0.0 M	$0.1 M
Rhody Health Partners	973,980	870,996	867,588	0.0 M	914,790	911,401	0.0 M	0.0 M
Expansion	459,309	438,547	422,735	0.0 M	412,198	421,879	(0.0 M)	(0.0 M)
Fee-for-Service	313,379	308,239	314,279	(0.0 M)	331,997	336,999	(0.0 M)	0.0 M
QROA	**$ 3,096,879**	**$ 2,969,383**	**$ 2,936,205**	**$0.0 M**	**$ 3,067,550**	**$ 3,058,242**	**$0.0 M**	**$0.1 M**

Non-Emergency Medical Transportation (NEMT)

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

For FY 2027, Medicaid is extending the existing contract and finalizing rates based on a review of recent experience and trends. These preliminary rates are reflected in Medicaid's revised estimate. It is noteworthy that with less than 5.0% utilization across all enrollees, the higher-than-usual composite rate increase of 9.1% reflects the general insensitivity of MTM's gross transportation costs to its realized enrollment. Additionally, the current geopolitical uncertainty around the price of gas and its correlation with overall transportation costs necessitated the higher rate increase to continue to preserve access.

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

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

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Medicaid								
Children and Families	175,506	167,409	164,904	-2,505	166,054	162,868	-3,185	-2,036
Expansion	82,784	78,898	76,797	-2,101	70,763	73,007	2,243	-3,790
Rhody Health Partners	12,732	12,726	12,745	19	12,722	12,734	12	-12
Rhody Health Options	11,392	11,757	11,461	-296	11,345	11,148	-197	-313
Other ABD	26,572	28,042	27,814	-228	28,226	28,293	68	480
Subtotal Medicaid	308,986	298,832	293,720	-5,112	289,109	288,050	-1,059	-5,671
Overall PMPM	*$9.18*	*$9.60*	*$9.46*	($0.14)	*$10.15*	*$10.18*	$0.04	$0.72
Department of Human Services								
OHA Co-Pay	1,142	1,248	1,233	-15	1,277	1,253	-24	20
Elderly Transportation Program	$412.5k per month	$431.5k per month	$431.5k per month		$431.5k per month			

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

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Budget Line								
Managed Care	$ 9,793,212	$ 9,602,571	$ 8,944,393	$0.7 M	$ 9,803,804	$ 9,498,481	$0.3 M	$ 554,088
Expansion	12,248,782	12,014,575	11,676,140	0.3 M	11,574,051	11,940,998	(0.4 M)	264,858
Rhody Health Partners	3,139,711	3,228,437	3,242,434	(0.0 M)	3,485,251	3,480,830	0.0 M	238,396
Rhody Health Options	2,809,267	2,982,495	2,915,636	0.1 M	3,107,939	3,047,303	0.1 M	131,667
Other Services	6,552,717	7,113,652	7,075,776	0.0 M	7,732,681	7,734,266	(0.0 M)	658,490
Subtotal	**$ 34,543,689**	**$ 34,941,730**	**$ 33,854,378**	**$1.1 M**	**$ 35,703,725**	**$ 35,701,877**	**$0.0 M**	**$ 1,847,499**
TANF Charge Back	(500,000)	(500,000)	(500,000)	0.0 M	(500,000)	(500,000)	0.0 M	0
MTM Liquidated Damages	0	0	0	0.0 M	0	0	0.0 M	0
Subtotal Medicaid	**$ 34,043,689**	**$ 34,441,730**	**$ 33,354,378**	**$1.1 M**	**$ 35,203,725**	**$ 35,201,877**	**$0.0 M**	**$1.8 M**

III. Managed Care

Managed Care			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$1,037,600,000	$444,347,574
	Final	**$1,060,732,263**	**$452,351,727**
	Deficit over Revised	*($23,132,263)*	*($8,004,153)*
FY 2026	Enacted	$1,117,462,318	$464,278,305
	November 2025 CEC Adopted	$1,106,800,000	$462,718,463
	Current	**$1,091,600,000**	**$453,424,564**
	Surplus over Nov CEC	*$15,200,000*	*$9,293,898*
FY 2027	November 2025 CEC Adopted	$1,165,300,000	$482,314,196
	Current	**$1,165,200,000**	**$474,654,643**
	Surplus over Nov CEC	*$100,000*	*$7,659,553*

FY 2026

The FY 2026 revised all funds forecast of $1.092 billion reflects a surplus of $15.2 million (1.4%), including $9.3 million GR (2.0%), over the November CEC. Medicaid forecasts an average enrollment of 164,940 Rite Care eligible beneficiaries in FY 2026, a decrease of 2,380 compared to the November CEC. This includes 149,937 beneficiaries enrolled in Rite Care Core, 9,734 in Rite Care CSHCN, 1,758 enrolled in Rite Share, and an average of 3,511 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**:

- $10.5 million reduction in net premium payments for Rite Care Core primarily attributable to a forecasted enrollment decrease of 2,403 respectively;
- $8.3 million reduction in Core FFS and CSHCN FFS;
- $5.9 million reduction in Rite Care SOBRA due to a decrease of 283 forecasted SOBRA births;
- $0.8 million increase in Rebates; and,
- $0.7 million reduction in NICU stays primarily caused by a decrease in forecasted NICU stays by 22.

As illustrated in **Table III-4,** the decrease in overall beneficiaries (*volume*) generates $15.7 million in total savings, a 1.4% reduction compared to November CEC. However, forecasted *price* increases in FY 2026 offset these savings for net savings of $0.5 million.

Forecasted FY 2026 savings are partially offset by:

- The inclusion of a $14.8 million for potential risk share, a $9.8 million increase over the November CEC forecast;
    - Although the rates are actuarially sound/certified, continued review of plan performance has indicated additional risk share exposure/liability. In response, the updated forecast increases potential risk share by 1.0% of total premiums compared to the November CEC, from 0.5% to 1.5%.
- A $1.6 million state-only increase for the Cover All Kids (CAK) program captures the state only spending for this population on other capitation (Rite Smiles and NEMT Broker) as well as FFS spending that was not isolated for purposes of this summary table in Medicaid's prior testimony. Please note, however, that these state-only costs were and continue to be assigned their own funding source and were never treated nor reported as Medicaid-eligible spending.

FY 2027

Medicaid estimates expenditures of $1.165 billion, including $474.7 million GR, in FY 2027. This represents a modest surplus of $0.1 million compared to the November CEC. The drivers behind the changes in spending when comparing to the November forecast are summarized in **Table III-1** through **Table III-4** below. This includes:

- A $19.0 million increase for Rite Care Core, primarily attributable to higher capitation PMPMs compared to the November CEC;
- The introduction of an ASO arrangement for High-Cost Drugs (i.e., CGT) in FY 2027 will add $12.5 million in below the line adjustments;
- Price increases produce a $16.2 million increase (1.4%) that offsets all $16.3 million (1.4%) savings from enrollment decreases (**Table III-4**); and,
- $0.6 million increase in NICU payments.
    - Current projections forecast decreased overall NICU stays by 3 when compared to the forecasted level in the November CEC, but this is offset with an accompanying increase to the cost per stay by $1,496, from $66,293 to $67,789.

Increased spending is offset by the items below:

- $13.3 million decrease in Rite Care SOBRA due to a simultaneous reduction in both forecasted SOBRA births of 246, from 4,740 to 4,494 births, and PMPM at $1,768, from $21,829 to $20,061;
- $8.7 million total decrease (surplus) in Rite Care Cover All Kids and Rite Care CSHCN payments;
    - Composite PMPM for CSHCN is projected to decrease by $76.22 from the November CEC.
- $8.0 million decrease in all FFS spending, including: $6.9 million for Core FFS, $0.9 million for CSHCN FFS, and $0.2 million for Early Intervention FFS.

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 is 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 November estimate.

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

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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Payments to Plans								
RIte Care Core	$ 678,728,637	$ 704,080,062	$ 693,606,150	$10.5 M	$ 732,160,381	$ 751,166,405	($19.0 M)	$57.6 M
Rite Care Cover-All-Kids	16,664,570	18,397,956	20,000,000	(1.6 M)	19,317,854	14,982,750	4.3 M	(5.0 M)
RIte Care CSHCN	166,282,760	190,347,917	190,678,761	(0.3 M)	210,162,959	205,764,477	4.4 M	15.1 M
Rite Care EFP	338,621	515,326	509,497	0.0 M	336,274	320,100	0.0 M	(0.2 M)
Rite Care SOBRA	77,755,077	91,638,705	85,755,821	5.9 M	103,467,749	90,151,899	13.3 M	4.4 M
Withhold	4,306,415	4,564,825	4,537,603	0.0 M	4,753,653	4,897,001	(0.1 M)	0.4 M
Risk Share	13,308,487	5,005,326	14,835,753	(9.8 M)	0	0	0.0 M	(14.8 M)
High Cost Drug ASO Arrangement	0	0	0	0.0 M	0	12,500,000	(12.5 M)	12.5 M
Rite Smiles	26,738,797	26,607,834	27,021,330	(0.4 M)	28,427,568	27,938,938	0.5 M	0.9 M
Subtotal - Payments to Plans	**$ 984,123,364**	**$ 1,041,157,952**	**$ 1,036,944,916**	**$4.2 M**	**$ 1,098,626,437**	**$ 1,107,721,571**	**($9.1 M)**	**$70.8 M**
CCBHC (reflected in "Payments to Plans")	*19,413,076*	*26,743,182*	*27,858,599*	*(1.1 M)*	*29,210,932*	*30,620,947*	*(1.4 M)*	*2.8 M*
Other Payments								
Non-Emergency Transportation	$ 9,793,212	$ 9,602,571	$ 8,944,393	$0.7 M	$ 9,803,804	$ 9,498,481	$0.3 M	$0.6 M
TANF Offset	(500,000)	(500,000)	(500,000)	0.0 M	(500,000)	(500,000)	0.0 M	0.0 M
RIte Share	2,191,368	3,290,315	2,967,934	0.3 M	4,541,490	3,309,561	1.2 M	0.3 M
Premium Assistance Program	46,056	50,000	50,000	0.0 M	50,000	500,000	(0.5 M)	0.5 M
Core FFS	53,262,330	57,330,000	49,941,000	7.4 M	58,144,000	51,292,000	6.9 M	1.4 M
CSHCN FFS	3,433,020	3,703,000	2,796,000	0.9 M	3,824,000	2,930,000	0.9 M	0.1 M
Early Intervention FFS	4,427,147	5,295,000	5,068,000	0.2 M	5,374,000	5,203,000	0.2 M	0.1 M
NICU	32,710,908	32,957,230	32,280,501	0.7 M	37,654,582	38,300,815	(0.6 M)	6.0 M
State Only FFS (Non Medicaid)	1,057,959	1,000,000	1,000,000	0.0 M	1,000,000	1,000,000	0.0 M	0.0 M
Rebates	(48,426,839)	(46,984,717)	(47,759,447)	0.8 M	(53,091,413)	(53,913,137)	0.8 M	(6.2 M)
Premium Collection	(50,000)	(50,000)	(50,000)	0.0 M	(50,000)	(50,000)	0.0 M	0.0 M
Tax Intercept	(105,000)	(100,000)	(100,000)	0.0 M	(100,000)	(100,000)	0.0 M	0.0 M
Subtotal - Other Payments	**$ 57,840,161**	**$ 65,593,399**	**$ 54,638,381**	**$11.0 M**	**$ 66,650,462**	**$ 57,470,720**	**$9.2 M**	**$2.8 M**
Subtotal - Managed Care	**$ 1,041,963,525**	**$ 1,106,751,350**	**$ 1,091,583,297**	**$15.2 M**	**$ 1,165,276,900**	**$ 1,165,192,291**	**$0.1 M**	**$73.6 M**
Balance to RIFANS/Rounding	18,768,739	48,650	16,703	0.0 M	23,100	7,709	0.0 M	(0.0 M)
Total - Managed Care	**$ 1,060,732,263**	**$ 1,106,800,000**	**$ 1,091,600,000**	**$15.2 M**	**$ 1,165,300,000**	**$ 1,165,200,000**	**$0.1 M**	**$73.6 M**
General Revenue	$452.4 M	$462.7 M	$453.4 M	$9.3 M	$482.3 M	$474.7 M	$7.7 M	$21.2 M
Federal Funds	$608.4 M	$644.1 M	$638.2 M	$5.9 M	$683.0 M	$690.5 M	($7.6 M)	$52.4 M

Table III-2. Average Managed Care Caseload

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Full Benefits by Delivery System								
Rite Care Core	160,145	152,340	149,937	-2,403	151,004	148,506	-2,497	-1,431
Rite Care CSHCN	9,737	9,686	9,734	48	9,853	10,079	226	345
Rite Share	1,390	1,971	1,758	-213	2,474	1,779	-695	21
Remaining in FFS - Core	2,732	1,946	2,245	299	1,587	2,379	792	134
Remaining in FFS - CSHCN	1,508	1,378	1,266	-112	1,418	1,266	-152	0
Total - Full Benefits	175,511	167,320	164,940	-2,380	166,335	164,009	-2,326	-931
Overall PMPM	$504	$551	$552	$0	$584	$592	$8	*$41*
% Enrolled in Managed Care	96.8%	96.8%	96.8%		96.7%	96.7%		
Other Caseload Factors								
EFP Only	2,090	1,577	1,559	-18	980	934	-46	-625
Rite Smiles	135,389	132,290	130,188	-2,102	134,628	130,410	-4,219	222
Non-Emergency Transportation	175,506	167,409	164,904	-2,505	166,054	162,868	-3,185	-2,036

Table III-3. Medicaid Births and NICU Stays

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
SOBRA Births								
RIte Care	4,143	4,408	4,125	-283	4,740	4,494	-246	369
Expansion	224	271	184	-87	342	258	-84	74
Total - SOBRA Births	4,367	4,679	4,309	-370	5,082	4,752	-330	443
Cost per SOBRA Birth	*$18,768*	*$20,789*	*$20,789*	*$0*	*$21,829*	*$20,061*	*-$1,768*	*-$729*
NICU Stays	494	522	500	-22	568	565	-3	65
Cost per NICU Stay	*$66,216*	*$63,136*	*$64,561*	*$1,425*	*$66,293*	*$67,789*	*$1,496*	*$3,228*

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

	Price	Volume	Net
FY 2026 over FY 2025	$94.8 M	($63.9 M)	$30.9 M
	9.5%	-6.0%	2.9%
FY 2026: Current over Nov CEC	$0.5 M	($15.7 M)	($15.2 M)
	0.0%	-1.4%	-1.4%
FY 2027: Current over Nov CEC	$16.2 M	($16.3 M)	($0.1 M)
	1.4%	-1.4%	0.0%
FY 2027 over FY 2026	$79.8 M	($6.2 M)	$73.6 M
	7.3%	-0.6%	6.7%

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.	$860	$768	$858	-10.8%	11.7%
MF 1-4 y.o.	$302	$345	$412	14.2%	19.6%
MF 5-14 y.o.	$246	$265	$296	7.6%	11.7%
M 15-44 y.o.	$300	$334	$348	11.1%	4.2%
F 15-44 y.o.	$453	$504	$529	11.3%	5.0%
MF 45+ y.o.	$661	$753	$813	13.9%	8.0%
Composite	$365	$398	$434	8.9%	9.1%
Average Member Months	160,145	149,937	148,506	-6.4%	-1.0%
RIte Care CSHCN					
Substitute Care	$1,063	$1,157	$1,154	8.9%	-0.3%
SSI <15	$2,448	$2,736	$2,931	11.8%	7.1%
SSI 15-20	$1,627	$1,832	$1,954	12.6%	6.6%
Katie Beckett	$4,403	$4,319	$3,123	-1.9%	-27.7%
Adoption Subsidy	$810	$968	$1,015	19.5%	4.9%
Composite	$1,453	$1,641	$1,710	12.9%	4.2%
Average Member Months	9,737	9,734	10,079	0.0%	3.5%
SOBRA Payment	$18,768	$20,789	$20,061	10.8%	-3.5%
EFP Only	$14	$27	$29	101.8%	4.8%
Katie Beckett - Care Management	$130	$94	$76	-27.7%	-18.6%
Rite Share	$131	$141	$155	7.1%	10.2%

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	8.1%	1.9%
MF 3-5	$15	$17	$17	11.9%	0.1%
MF 6-10	$22	$24	$24	7.2%	2.2%
MF 11-15	$25	$26	$27	3.8%	2.1%
MF 16-19	$17	$18	$19	2.9%	7.0%
MF 20+	$17	$18	$19	2.9%	7.0%
Composite	$18	$19	$19	5.0%	3.2%
Average Enrollment	135,389	130,188	130,410	-3.8%	0.2%

Table III-7. CHIP Offsets

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	FY26 → FY27
CHIP Offset	**$ 153,862,012**	**$ 136,743,139**	**$ 165,487,257**	**$28.7 M**	**$ 135,803,666**	**$ 175,648,976**	**$39.8 M**	**$10.2 M**
Additional GR Relief	*$20.3 M*	*$17.6 M*	*$21.2 M*	$3.7 M	*$17.2 M*	*$22.3 M*	$5.1 M	$1.0 M
CHIP FMAP	69.19%	70.04%	70.04%		70.42%	70.42%		
Regular FMAP	55.99%	57.20%	57.20%		57.73%	57.73%		

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

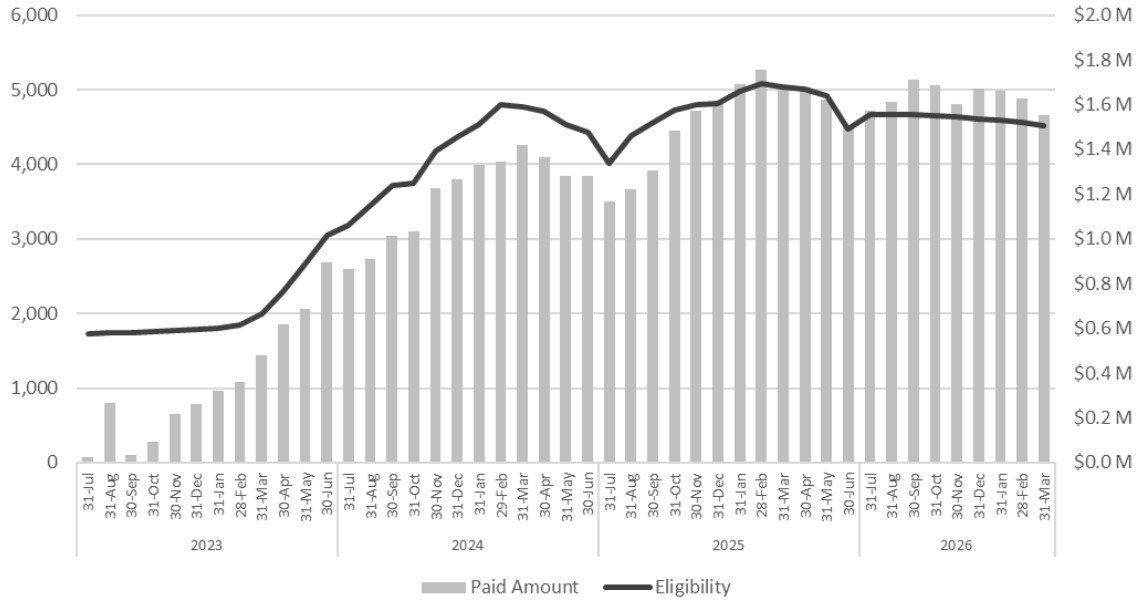
	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Nov CEC	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	FY26 → FY27
Family Planning Offset	**$ 8,500,000**	**$ 8,700,000**	**$ 8,500,000**	**($0.2 M)**	**$ 8,900,000**	**$ 8,700,000**	**($0.2 M)**	**$0.2 M**
Additional GR Relief	*$2.9 M*	*$2.9 M*	*$2.8 M*	($0.1 M)	*$2.9 M*	*$2.8 M*	($0.1 M)	$0.0 M
Family Planning FMAP	90.00%	90.00%	90.00%		90.00%	90.00%		
Regular FMAP	55.99%	57.20%	57.20%		57.73%	57.73%		

Table III-9. CCBHC Claiming

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Nov CEC	Increase/ (Decrease)	Nov CEC	Current	Increase/ (Decrease)	FY26 → FY27
CCBHC Offset	**$ 19,413,076**	**$ 26,743,182**	**$ 27,858,599**	**$1.1 M**	**$ 29,210,932**	**$ 30,620,947**	**$1.4 M**	**$2.8 M**
Additional GR Relief	*$2.6 M*	*$3.4 M*	*$3.6 M*	$0.1 M	*$3.7 M*	*$3.9 M*	$0.2 M	$0.3 M
CHIP FMAP	69.19%	70.04%	70.04%		70.42%	70.42%		
Regular FMAP	55.99%	57.20%	57.20%		57.73%	57.73%		

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

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



IV. Rhody Health Partners

Rhody Health Partners			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$311,400,000	$133,700,651
	Final	**$299,823,909**	**$129,082,711**
	Surplus over Revised	*$11,576,091*	*$4,617,940*
FY 2026	Enacted	$341,201,948	$140,718,732
	November 2025 CEC Adopted	$336,700,000	$140,087,281
	Current	**$337,700,000**	**$140,319,670**
	Deficit over Nov CEC	*($1,000,000)*	*($232,389)*
FY 2027	November 2025 CEC Adopted	$348,900,000	$143,184,438
	Current	**$336,000,000**	**$137,519,801**
	Surplus over Nov CEC	*$12,900,000*	*$5,664,637*

FY 2026

For Rhody Health Partners (RHP), Medicaid forecast expenditures of $337.7 million, including $140.3 million GR. This represents a deficit of $1.0 million (0.3%), including $0.2 million (0.2%) GR compared to the November CEC. The deficit is primarily attributed to a decrease in anticipated rebate collections of $0.7 million. In addition, there is a moderate projected increase of $0.3 million for premium payments for Rhody Health Partners and FFS.

Medicaid forecasts an average fiscal year enrollment of 12,758 in FY 2026, which is consistent with the November CRC projection of 12,757 beneficiaries per month.

FY 2027

The RHP forecast of $336.0 million, including $137.5 million GR for FY 2027. This represents a decrease/surplus of $12.9 million (3.7%), including $5.7 million GR (4.0%), compared to the November CEC. This surplus is largely due to a $13.9 million decrease in premium payments because of a flat enrollment projection and a projected $85 composite PMPM decrease, partially offset by a $0.7 million decrease in pharmacy rebate collections.

Medicaid forecasts an average enrollment of 12,764 beneficiaries in RHP in FY 2027; a modest increase of four members when compared to November CEC.

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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Payments to Plans								
Rhody Health Partners	$ 338,451,423	$ 367,124,088	$ 367,183,713	($0.1 M)	$ 386,946,555	$ 373,096,330	$13.9 M	$5.9 M
Withhold	1,700,672	1,843,468	1,843,656	(0.0 M)	1,936,525	1,866,786	0.1 M	0.0 M
Risk Share	0	1,834,086	1,834,381	(0.0 M)	0	0	0.0 M	(1.8 M)
Subtotal - Payment to Plans	**$ 340,152,096**	**$ 370,801,642**	**$ 370,861,749**	**($0.1 M)**	**$ 388,883,080**	**$ 374,963,116**	**$13.9 M**	**$4.1 M**
CCBHC (reflected in "Payments to Plans")	*28,991,308*	*38,094,352*	*39,591,264*	*(1.5 M)*	*41,058,958*	*42,701,337*	*(1.6 M)*	*3.1 M*
Other Payments								0
Non-Emergency Transportation	3,139,711	3,228,437	3,242,434	(0.0 M)	3,485,251	3,480,830	0.0 M	0.2 M
FFS	993,656	1,071,000	1,306,000	(0.2 M)	1,071,000	1,309,000	(0.2 M)	0.0 M
Rebates	(42,077,896)	(38,474,327)	(37,734,064)	(0.7 M)	(44,549,264)	(43,779,693)	(0.8 M)	(6.0 M)
Subtotal - Other Payments	**$ (37,944,528)**	**$ (34,174,890)**	**$ (33,185,630)**	**($1.0 M)**	**$ (39,993,013)**	**$ (38,989,863)**	**($1.0 M)**	**($5.8 M)**
Subtotal - Rhody Health Partners	**$ 302,207,567**	**$ 336,626,753**	**$ 337,676,119**	**($1.0 M)**	**$ 348,890,066**	**$ 335,973,253**	**$12.9 M**	**($1.7 M)**
Balance to RIFANS/Accruals/Rounding	(2,383,658)	73,247	23,881	0.0 M	9,934	26,747	(0.0 M)	0.0 M
Total - Rhody Health Partners	**$ 299,823,909**	**$ 336,700,000**	**$ 337,700,000**	**($1.0 M)**	**$ 348,900,000**	**$ 336,000,000**	**$12.9 M**	**($1.7 M)**
General Revenue	*$129.1 M*	*$140.1 M*	*$140.3 M*	*($0.2 M)*	*$143.2 M*	*$137.5 M*	*$5.7 M*	*($2.8 M)*
Federal Funds	*$170.7 M*	*$196.6 M*	*$197.4 M*	*($0.8 M)*	*$205.7 M*	*$198.5 M*	*$7.2 M*	*$1.1 M*

Table IV-2. RHP Average Enrollment

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Rhody Health Partners								
SSI 21-44	3,536	3,567	3,556	-11	3,564	3,539	-25	-17
SSI 45+	6,099	6,085	6,115	30	6,084	6,149	65	34
SPMI	1,994	1,905	1,861	-44	1,909	1,835	-74	-26
I/DD	1,108	1,201	1,227	26	1,204	1,242	38	15
Total	12,737	12,757	12,758	1	12,761	12,764	4	6
Composite RHP PMPM	*$2,226*	*$2,422*	*$2,422*	*$0*	*$2,540*	*$2,448*	*-$92*	*$26*
Overall PMPM (incl. of Other Payments)	*$1,962*	*$2,199*	*$2,206*	*$6*	*$2,278*	*$2,194*	*-$85*	*-$12*
Other Caseload Factors								
Non-Emergency Transportation	12,732	12,726	12,745	19	12,722	12,734	12	-12

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

	Price	Volume	Net
FY 2026 over FY 2025	$37.4 M 12.4%	$0.5 M 0.2%	$37.9 M 12.6%
FY 2026: Current over Nov CEC	$1.0 M 0.3%	$0.0 M 0.0%	$1.0 M 0.3%
FY 2027: Current over Nov CEC	($13.0 M) -3.7%	$0.1 M 0.0%	($12.9 M) -3.7%
FY 2027 over FY 2026	($1.9 M) -0.6%	$0.2 M 0.0%	($1.7 M) -0.5%

Table IV-4. RHP Monthly Premiums

	SFY 2025	SFY 2026	SFY 2027	FY25 → FY26	FY26 → FY27
Rhody Health Partners					
SSI 21-44	$1,680	$1,762	$1,556	4.9%	-11.7%
SSI 45+	$2,321	$2,522	$2,466	8.7%	-2.2%
SPMI	$3,721	$3,835	$4,707	3.0%	22.8%
I/DD	$1,390	$1,554	$1,458	11.8%	-6.2%
Composite	$2,277	$2,408	$2,437	5.8%	1.2%
Average Member Months	12,737	12,758	12,764	0.2%	0.0%

V. Rhody Health Options / FIDE-SNP

Rhody Health Options			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$212,400,000	$94,373,080
	Final	**$217,598,267**	**$95,669,061**
	Deficit over Revised	*($5,198,267)*	*($1,295,981)*
FY 2026	Enacted	$220,353,823	$94,258,122
	November 2025 CEC Adopted	$242,700,000	$102,582,565
	Current	**$247,800,000**	**$104,762,329**
	Deficit over Nov CEC	*($5,100,000)*	*($2,179,764)*
FY 2027	November 2025 CEC Adopted	$247,800,000	$102,087,959
	Current	**$269,900,000**	**$111,336,117**
	Deficit over Nov CEC	*($22,100,000)*	*($9,248,158)*

FY 2026

The Rhody Health Options (RHO) forecast of $247.8 million, including $104.8 million GR, represents a deficit of $5.1 million (2.1%), including $2.2 million GR (2.1%), compared to the November CEC. Despite this deficit, Medicaid forecasts a declining average enrollment of 11,414, a decrease of 374 beneficiaries per month, compared to the November forecast.

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

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

Changes in Medicaid's FY 2026 forecast are attributable to higher-than-expected price growth in the FIDE-SNP, as well as the inclusion of CCBHC expenditures effective January 2026. Overall enrollment declined by 3.2% compared to November. These trends resulted in a $93 increase in PMPM costs over the prior forecast, rising from $1,716 to $1,809, indicating that the variance was driven by higher per-member costs rather than changes in enrollment.

FY 2027

Medicaid forecasts spending for the FIDE-SNP program to increase by $22.1 million (8.9%), including $9.2 million GR (9.1%), in FY 2027 compared to the November CEC. This increase is driven by two major items:

- The annualization of the mid-FY 2026 shift to FIDE SNP and the significant rate increase that was effective January 1, 2026; and
- Medicaid's assumption of an 8.75% rate increase effective January 1, 2027.

While total enrollment is projected to decline by 2.3%, growth is concentrated in the SPMI population, which is expected to increase by 20.7% to 1,288 beneficiaries compared to FY 2026, or a 54.3% increase from the November forecast for the same year. Additionally, monthly premiums for the SPMI population are projected to increase by 36.2%, rising from $1,692 in FY 2026 to $2,305 in FY 2027. Similar price increases are projected for the I/DD (28.9%) and Community Non-LTSS (18.9%) populations; however, these costs are partially offset by enrollment declines of 3.3% and 8.0%, respectively, and the comparatively low PMPM of these rating categories.

All together, these price and volume changes result in higher per-member costs, with the overall PMPM increasing by $208 from $1,809 in FY 2026 to $2,018 in FY 2027, driving the projected increase in expenditures for Rhody Health Options.

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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Payments to Plans								
CMS Demonstration/FIDE-SNP (RHO II)	$ 208,070,852	$ 235,017,807	$ 240,204,607	($5.2 M)	$ 244,627,531	$ 266,796,814	($22.2 M)	$26.6 M
Withhold	6,385,664	4,642,463	4,630,036	0.0 M	0	0	0.0 M	(4.6 M)
Subtotal - Payment to Plans	**$ 214,456,516**	**$ 239,660,269**	**$ 244,834,643**	**($5.2 M)**	**$ 244,627,531**	**$ 266,796,814**	**($22.2 M)**	**$22.0 M**
Other Payments								
Non-Emergency Transportation	$ 2,809,267	$ 2,982,495	$ 2,915,636	$0.1 M	$ 3,107,939	$ 3,047,303	$0.1 M	$0.1 M
Rebates	(10,568)	0	0	0.0 M	0	0	0.0 M	0.0 M
Subtotal - Other Payments	**$ 2,798,699**	**$ 2,982,495**	**$ 2,915,636**	**$0.1 M**	**$ 3,107,939**	**$ 3,047,303**	**$0.1 M**	**$0.1 M**
Subtotal - Rhody Health Options	**$ 217,255,215**	**$ 242,642,764**	**$ 247,750,279**	**($5.1 M)**	**$ 247,735,470**	**$ 269,844,117**	**($22.1 M)**	**$22.1 M**
Balance to RIFANS/Accruals/Rounding	343,052	57,236	49,721	0.0 M	64,530	55,883	0.0 M	0.0 M
Total - Rhody Health Options	**$ 217,598,267**	**$ 242,700,000**	**$ 247,800,000**	**($5.1 M)**	**$ 247,800,000**	**$ 269,900,000**	**($22.1 M)**	**$22.1 M**
General Revenue	*$95.7 M*	*$102.6 M*	*$104.8 M*	*($2.2 M)*	*$102.1 M*	*$111.3 M*	*($9.2 M)*	*$6.6 M*
Federal Funds	*$121.9 M*	*$140.1 M*	*$143.0 M*	*($2.9 M)*	*$145.7 M*	*$158.6 M*	*($12.9 M)*	*$15.5 M*

Table V-2. RHO Average Enrollment

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Rhody Health Options								
SPMI	814	860	1,067	207	835	1,288	453	221
I/DD	1,259	1,246	1,194	-53	1,209	1,155	-55	-39
Community LTSS	2,319	2,485	2,544	59	2,405	2,566	161	21
Institutional LTSS	610	602	566	-36	584	573	-10	7
Community Non-LTSS	6,417	6,596	6,043	-552	6,344	5,566	-778	-477
Total	11,418	11,788	11,414	-374	11,377	11,148	-229	-267
Overall PMPM	*$1,588*	*$1,716*	*$1,809*	*$93*	*$1,815*	*$2,018*	*$203*	*$208*
Other Caseload Factors								
Non-Emergency Transportation	11,392	11,757	11,461	-296	11,345	11,148	-197	-313

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

	Price	Volume	Net
FY 2026 over FY 2025	$30.3 M 13.9%	($0.1 M) 0.0%	$30.2 M 13.9%
FY 2026: Current over Nov CEC	$12.8 M 5.4%	($7.7 M) -3.2%	$5.1 M 2.1%
FY 2027: Current over Nov CEC	$27.1 M 11.2%	($5.0 M) -2.0%	$22.1 M 8.9%
FY 2027 over FY 2026	$27.9 M 11.5%	($5.8 M) -2.3%	$22.1 M 8.9%

Table V-4. Summary of RHO Monthly Premiums

	SFY 2025	SFY 2026	SFY 2027	FY25 → FY26	FY26 → FY27
Rhody Health Options					
SPMI	$883	$1,692	$2,305	91.7%	36.2%
I/DD	$232	$298	$384	28.5%	28.9%
Community LTSS	$5,390	$5,231	$5,294	-3.0%	1.2%
Institutional LTSS	$5,380	$5,230	$5,294	-2.8%	1.2%
Community Non-LTSS	$286	$327	$388	14.1%	18.9%
Composite	$1,647	$1,787	$1,991	8.5%	11.4%
Average Member Months	11,418	11,414	11,148	0.0%	-2.3%

VI. Expansion

Expansion		All Funds	General Revenue
FY 2025	Revised Enacted	$705,100,000	$76,172,839
	Final	**$698,692,382**	**$72,406,135**
	Surplus over Revised	*$6,407,618*	*$3,766,704*
FY 2026	Enacted	$730,790,208	$78,747,971
	November 2025 CEC Adopted	$741,500,000	$80,528,026
	Current	**$724,900,000**	**$78,127,935**
	Surplus over Nov CEC	*$16,600,000*	*$2,400,091*
FY 2027	November 2025 CEC Adopted	$701,600,000	$76,636,668
	Current	**$733,300,000**	**$79,044,159**
	Deficit over Nov CEC	*($31,700,000)*	*($2,407,491)*

FY 2026

Medicaid's FY 2026 forecast for Expansion is $724.9 million, including $78.1 million GR, reflecting a surplus of $16.6 million (2.2%), including $2.4 million GR (3.1%) compared to the November CEC. Average monthly enrollment of 78,342 represents a reduction of 2,321 beneficiaries compared to the prior CEC forecast. Of this total, 73,782 beneficiaries are enrolled in this product, 2,625 fewer than the November CEC.

The surplus is primarily driven by reduced enrollment, resulting in a $21.3 million volume decrease, which is partially offset by a $4.7 million price increase (0.7%).

In addition to these price-volume dynamics, the surplus is also due to 87 fewer SOBRA births than projected, resulting in $1.8 million in savings. A $3.2 million decrease in FFS spending also contributes to the surplus compared to the November CEC. Further, the May forecast includes additional Risk Share of $10.4 million, reducing the overall surplus.

FY 2027

Medicaid projects Expansion expenditures of $733.3 million for FY 2027, including $79.0 million GR. This represents an increase of $8.4 million (1.2%), including $0.9 million GR (1.2%), compared to the updated forecast for FY 2026 and a deficit of $31.7 million, including $2.4 million GR, compared to the November CEC.

Excluding RIte Share and FFS, average monthly enrollment for FY 2027 is projected at 70,129, a decrease of 3,653 beneficiaries (5.0%) from the revised FY 2026 with declines expected across all rate cells in the Expansion population. Strong year-over-year price growth (6.0%), driven in part by managed care rate increases, offsets the savings from declining enrollment, resulting in a marginal increase in total expenditures.

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 $15.9 million in FY 2026 and $16.4 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 November CEC 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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Payments to Plans								
Expansion	$ 624,630,827	$ 688,495,850	$ 670,407,027	$18.1 M	$ 651,309,045	$ 690,907,029	($39.6 M)	$20.5 M
Expansion - Previously Eligible	14,800,000	18,108,168	15,900,000	2.2 M	18,792,904	16,400,000	2.4 M	0.5 M
RIte Smiles	1,942,578	1,933,044	1,940,438	(0.0 M)	2,065,247	2,006,333	0.1 M	0.1 M
SOBRA	4,203,935	5,633,868	3,825,229	1.8 M	7,465,395	5,175,610	2.3 M	1.4 M
Withhold	3,213,338	3,541,568	3,447,534	0.1 M	3,345,658	3,549,776	(0.2 M)	0.1 M
Risk Share	27,044,632	3,552,149	10,351,984	(6.8 M)	0	0	0.0 M	(10.4 M)
Subtotal - Payments to Plans	**$ 675,835,310**	**$ 721,264,647**	**$ 705,872,213**	**$15.4 M**	**$ 682,978,249**	**$ 718,038,748**	**($35.1 M)**	**$12.2 M**
CCBHC (reflected in "Payments to Plans")	*22,825,747*	*31,330,970*	*31,146,932*	*0.2 M*	*30,821,127*	*32,690,965*	*(1.9 M)*	*1.5 M*
Other Payments								
Non-Emergency Transportation	$ 12,248,782	$ 12,014,575	$ 11,676,140	$0.3 M	$ 11,574,051	$ 11,940,998	($0.4 M)	$0.3 M
Expansion FFS	68,772,176	70,415,000	67,175,000	3.2 M	72,006,000	69,507,000	2.5 M	2.3 M
Rebates	(64,917,943)	(62,199,479)	(59,897,680)	(2.3 M)	(64,970,286)	(66,279,033)	1.3 M	(6.4 M)
DRE	(61,866,819)	(59,256,288)	(56,940,497)	(2.3 M)	(62,196,014)	(63,325,221)	1.1 M	(6.4 M)
J-Code	(3,051,124)	(2,943,191)	(2,957,183)	0.0 M	(2,774,272)	(2,953,812)	0.2 M	0.0 M
Subtotal - Other Payments	**$ 16,103,015**	**$ 20,230,096**	**$ 18,953,460**	**$1.3 M**	**$ 18,609,765**	**$ 15,168,965**	**$3.4 M**	**($3.8 M)**
Subtotal - Expansion	**$ 691,938,326**	**$ 741,494,742**	**$ 724,825,673**	**$16.7 M**	**$ 701,588,014**	**$ 733,207,712**	**($31.6 M)**	**$8.4 M**
Balance to RIFANS/Accruals/Rounding	6,754,056	5,258	74,327	(0.1 M)	11,986	92,288	(0.1 M)	0.0 M
Total - Expansion	**$ 698,692,382**	**$ 741,500,000**	**$ 724,900,000**	**$16.6 M**	**$ 701,600,000**	**$ 733,300,000**	**($31.7 M)**	**$8.4 M**
General Revenue	*$72.4 M*	*$80.5 M*	*$78.1 M*	*$2.4 M*	*$76.6 M*	*$79.0 M*	*($2.4 M)*	*$0.9 M*
Federal Funds	*$626.3 M*	*$661.0 M*	*$646.8 M*	*$14.2 M*	*$625.0 M*	*$654.3 M*	*($29.3 M)*	*$7.5 M*

Table VI-2. Summary Medicaid Expansion Average Enrollment

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Enrolled								
F 19-24	7,832	7,477	7,321	-156	6,695	6,947	252	-374
F 25-29	4,606	4,422	4,257	-165	3,958	4,016	57	-241
F 30-39	5,696	5,624	5,415	-208	5,053	5,072	19	-344
F 40-49	4,690	4,632	4,497	-135	4,188	4,335	147	-162
F 50-64	12,341	11,497	11,107	-390	10,435	10,734	300	-373
M 19-24	8,145	7,562	7,315	-247	6,759	6,895	136	-420
M 25-29	6,247	5,768	5,459	-309	5,115	5,000	-115	-459
M 30-39	11,701	11,343	10,831	-511	10,103	10,138	35	-694
M 40-49	7,600	7,522	7,382	-140	6,761	7,152	391	-230
M 50-64	11,098	10,561	10,199	-363	9,536	9,841	305	-358
Subtotal - Enrolled	79,956	76,407	73,782	-2,625	68,602	70,129	1,526	-3,653
Rite Share	34	18	10	-9	31	16	-15	6
Remaining in FFS	4,385	4,238	4,550	312	4,264	4,643	379	92
Total - Expansion	84,375	80,663	78,342	-2,321	72,897	74,787	1,890	-3,555
Overall PMPM	*$690*	*$766*	*$771*	*$5*	*$802*	*$817*	*$15*	*$46*
% Enrolled in Managed Care	94.8%	94.7%	94.2%		94.1%	93.8%		
Other Caseload Factors								
Non-Emergency Transportation	82,784	78,898	76,797	-2,101	70,763	73,007	2,243	-3,790
SOBRA Births	224	271	184	-87	342	258	-84	74

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

	Price	Volume	Net
FY 2026 over FY 2025	$76.2 M	($50.0 M)	$26.2 M
	11.7%	-7.2%	3.8%
FY 2026: Current over Nov CEC	$4.7 M	($21.3 M)	($16.6 M)
	0.7%	-2.9%	-2.2%
FY 2027: Current over Nov CEC	$13.5 M	$18.2 M	$31.7 M
	1.9%	2.6%	4.5%
FY 2027 over FY 2026	$41.3 M	($32.9 M)	$8.4 M
	6.0%	-4.5%	1.2%

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

	SFY 2025	SFY 2026	SFY 2027	FY25 → FY26	FY26 → FY27
Expansion					
F 19-24	$369	$417	$452	12.9%	8.5%
F 25-29	$511	$577	$649	12.9%	12.5%
F 30-39	$748	$838	$912	12.0%	8.9%
F 40-49	$949	$1,060	$1,203	11.7%	13.4%
F 50-64	$945	$1,063	$1,136	12.5%	6.9%
M 19-24	$231	$315	$317	36.6%	0.5%
M 25-29	$409	$473	$482	15.4%	2.0%
M 30-39	$613	$691	$726	12.7%	5.1%
M 40-49	$866	$970	$1,060	12.0%	9.3%
M 50-64	$958	$1,112	$1,203	16.1%	8.2%
Composite	$682	$779	$844	14.2%	8.3%
Average Member Months	79,956	73,782	69,496	-7.7%	-5.8%

VII. Hospitals – Regular

Hospitals - Regular			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$346,900,000	$112,626,926
	Final	**$353,268,456**	**$117,057,409**
	Deficit over Revised	*($6,368,456)*	*($4,430,483)*
FY 2026	Enacted	$408,226,193	$130,443,116
	November 2025 CEC Adopted	$408,200,000	$132,296,877
	Current	**$402,100,000**	**$130,587,632**
	Surplus over Nov CEC	*$6,100,000*	*$1,709,246*
FY 2027	November 2025 CEC Adopted	$418,200,000	$138,078,841
	Current	**$414,100,000**	**$131,507,911**
	Surplus over Nov CEC	*$4,100,000*	*$6,570,930*

FY 2026

Medicaid's revised estimate for **Hospital – Regular** totals $402.1 million, including $130.6 million GR, in FY 2026; a $6.1 million (1.5%) surplus, including $1.7 million GR (1.3%), compared to the November adopted.

The gross decline in **Hospital – Regular** expenditures is driven primarily by reduced inpatient ($3.7 million) hospital claims activity, with a modest decline ($0.1 million) in outpatient hospital claims activity as well.

Medicaid's methodology for revising its current year estimate uses FY26 claims activity, specifically the impact of FY26 Q2, and adjusts for an incurred but not reported (IBNR) factor.

FY 2027

FY 2027 hospital spending is expected to increase by $12.0 million to $414.1 million, including $131.5 million GR. Compared to the November CEC, this reflects a surplus of $4.1 million, including $6.6 million GR. The greater general revenue savings is attributed to the increased proportion of total hospital spending by Expansion-eligible members such that the state share of the Hospital State Directed Payment (SDP) lessens.

The year-over-year increase is due to an estimated $14.8 million increase in inpatient and $0.4 million increase in outpatient hospital claims activity. Changes in FY 2027 include offsetting impacts related to the qualified noncitizens changes included in H.R.-1:

- Reduction of $2.9 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 due to changes from H.R.-1; and,
- Increase of $3.1 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 anticipated placements in the new long term behavioral health unit at St. Joseph/Fatima Hospital. The November adopted estimate assumes placements beginning in January 2026, pending CMS approval. The revised FY 26 estimate assumes placements will begin in May for total FY26 expenses of $0.8 million from all sources, $3.3 million less than adopted. For FY 2027, the estimate includes $10.8 million, $0.5 million less than adopted, due to the delay in placements.

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 2.5% utilization increase in FY 2027.

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

Table VII-1. Summary of Hospital – Regular Expenditures

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Supplemental Payments								
Inpatient UPL	$ 11,528,853	$ 18,528,018	$ 18,528,018	$0.0 M	$ 18,528,018	$ 18,528,018	$0.0 M	$0.0 M
Regular	8,613,871	14,079,257	13,843,351	0.2 M	14,079,257	13,843,351	0.2 M	0.0 M
Expansion	2,914,982	4,448,761	4,684,667	(0.2 M)	4,448,761	4,684,667	(0.2 M)	0.0 M
Outpatient UPL	7,846,189	8,926,997	8,926,997	0.0 M	8,926,997	8,926,997	0.0 M	0.0 M
Regular	5,693,473	6,288,797	6,477,746	(0.2 M)	6,288,797	6,477,746	(0.2 M)	0.0 M
Expansion	2,152,716	2,638,200	2,449,251	0.2 M	2,638,200	2,449,251	0.2 M	0.0 M
SDP - Hospital Payments	281,032,815	324,718,048	324,718,048	0.0 M	324,718,048	324,718,047	0.0 M	(0.0 M)
SDP - MCO Tax	5,735,364	6,626,899	6,626,899	0.0 M	6,626,899	6,626,899	0.0 M	(0.0 M)
Subtotal - Supplemental Payments	**$ 306,143,221**	**$ 358,799,962**	**$ 358,799,962**	**$0.0 M**	**$ 358,799,962**	**$ 358,799,961**	**$0.0 M**	**($0.0 M)**
FFS Activity								
Inpatient FFS	$ 36,529,674	$ 38,030,000	$ 34,375,000	$3.7 M	$ 47,333,813	$ 46,053,406	$1.3 M	$11.7 M
Outpatient FFS	8,715,992	8,969,000	8,840,000	0.1 M	9,404,000	9,192,000	0.2 M	0.4 M
Subtotal - FFS Activity	**$ 45,245,666**	**$ 46,999,000**	**$ 43,215,000**	**$3.8 M**	**$ 56,737,813**	**$ 55,245,406**	**$1.5 M**	**$12.0 M**
Subtotal - Hospitals - Regular	**$ 351,388,887**	**$ 405,798,962**	**$ 402,014,962**	**$3.8 M**	**$ 415,537,775**	**$ 414,045,367**	**$1.5 M**	**$12.0 M**
Balance to RIFANS/Accruals/Rounding	1,879,569	2,401,038	85,038	2.3 M	2,662,225	54,633	2.6 M	
Total - Hospitals - Regular	**$ 353,268,456**	**$ 408,200,000**	**$ 402,100,000**	**$6.1 M**	**$ 418,200,000**	**$ 414,100,000**	**$4.1 M**	**$12.0 M**
General Revenue	*$117.1 M*	*$132.3 M*	*$130.6 M*	*$1.7 M*	*$138.1 M*	*$131.5 M*	*$6.6 M*	*$0.9 M*
Federal Funds	*$236.2 M*	*$275.9 M*	*$271.5 M*	*$4.4 M*	*$280.1 M*	*$282.6 M*	*($2.5 M)*	*$11.1 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	2.5%	$0.9 million	Medicaid
Subtotal Inpatient		***$2.0 million***	
Outpatient	**Percent**	**Dollar Impact**	**Source**
Price	3.3%	$0.3 million	CY 26 Outpatient Hospital PPS Market Basket - No Productivity Adjustment
Utilization	2.5%	$0.2 million	Medicaid
Subtotal Outpatient		***$0.5 million***	
TOTAL		**$2.5 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 H.R.-1 related changes (i.e., reduced FFS claiming for beneficiaries losing coverage and increased Emergency Medicaid costs)

Upper Payment Limit (UPL)

FY 2025: Rehab Hospital Adjustment

In completing the FY 2025 UPL Payment model, Medicaid miscalculated the inpatient UPL amount due to Rehab Hospital of Rhode Island. As a result of the erroneous calculation, Medicaid overpaid Rehab while underpaying the remaining hospitals whose relative shares of the overall payment amount were artificially reduced. Further, the inclusion of additional claims raised the overall Medicaid payment amount for all hospitals, in turn lowering the gap between what Medicaid and Medicare would have paid, the result of which is the basis for the UPL gap amount (i.e., 100% Medicare Allowed – Medicaid Paid) that may be paid to the hospitals.

In FY 2025, the original UPL payments totaled $10.5. The corrected payment amount is $11.5, a difference of $1.0 needed to remedy the issue (net of $251,290 recoupment from Rehab). Table VII-3 shows the corrected inpatient UPL payments.

Table VII-3. FY 2025 Inpatient UPL payments, original amount versus adjusted amount

FY25 UPL	SFY 25 Paid	Corrected Amounts	Variance
ROGER WILLIAMS HOSPITAL	$ 491,783	$ 553,960	$ 62,177
OUR LADY OF FATIMA	590,272	664,900	74,628
NEWPORT HOSPITAL	176,694	199,034	22,340
RHODE ISLAND HOSPITAL	2,781,441	3,133,099	351,658
SOUTH COUNTY HOSPITAL	69,716	78,531	8,815
KENT COUNTY MEMORIAL HOSPITAL	650,973	733,276	82,303
WOMEN & INFANTS HOSPITAL	4,305,503	4,849,848	544,345
LANDMARK MEDICAL CENTER	299,639	337,522	37,883
THE MIRIAM HOSPITAL	824,459	928,696	104,237
THE WESTERLY HOSPITAL	36,076	40,637	4,561
REHABILITATION HOSPITAL OF RI	260,641	9,351	(251,290)
	$ 10,487,197	**$ 11,528,854**	**$ 1,041,657**

FY 2026

The FY 2026 estimate is comprised of $18.5 million for inpatient and $8.9 million for outpatient, which is unchanged from November Adopted. The FY 2026 estimate has been revised where applicable 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 25% 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.

Managed Care State Directed Payment (SDP) to Hospitals

FY 2026

Medicaid assumes $331.3 million from all funds for the managed care hospital SDP, including $102.6 million GR, consistent with the enacted budget. Hospitals receive $324.7 million in total payments, while $6.6 million is allocated to the premium tax paid by the MCOs. The FY 2026 SDP allocation by hospital was forecasted by distributing funds based on the FY 2026 Q2 payment distribution.

FY 2027

Medicaid maintains general revenue support of $98.8 million, inclusive of the tab liability incurred by the plans, which is consistent with the November Adopted. The total SDP($331.3 million AF) is assumed to match FY26, with the GR support adjusted based on the FFY 2027 FMAP rates and utilization mix across the different eligibility groups, i.e., Expansion, CHIP, and Regular Medicaid.

Table VII-4 summarizes the estimated SDP forecasted and other hospital supplemental payments.

Table VII-4. Supplemental Payments by Hospital, FY 2026

	SFY 2025	SFY 2026:					
				UPL:		Total	FY25 → FY26
	Total	SDP [1],[2]	DSH [3]	Inpatient	Outpatient	Supplemental	
Bradley	$ 21,130,074	$ 23,257,194	$ -	$ -	$ -	$ 23,257,194	$2.1 M
Butler	22,694,664	24,084,957	-	-	-	24,084,957	1.4 M
Eleanor Slater	7,000,000	-	12,900,000	-	-	12,900,000	5.9 M
Kent	22,934,796	21,614,497	40,473	1,467,312	647,622	23,769,904	0.8 M
Landmark	12,861,842	14,266,924	-	691,432	395,337	15,353,693	2.5 M
Miriam	27,634,746	29,707,401	-	1,581,584	999,541	32,288,526	4.7 M
Newport	8,441,916	8,746,754	-	335,734	217,121	9,299,609	0.9 M
Rehab	147,516	97,604	-	21,525	-	119,129	(0.0 M)
Rhode Island	120,740,570	129,167,212	412,959	5,379,808	4,989,363	139,949,342	19.2 M
Roger Williams	17,329,529	14,084,710	352,256	825,564	450,456	15,712,986	(1.6 M)
Our Lady of Fatima	10,832,641	10,394,231	122,646	974,391	299,700	11,790,968	1.0 M
South County	4,797,441	4,425,795	-	100,002	155,931	4,681,728	(0.1 M)
Westerly	3,977,907	2,794,639	71,666	62,654	79,593	3,008,552	(1.0 M)
Women & Infants	41,623,087	41,795,960	-	7,088,012	692,333	49,576,305	8.0 M
Encompass Rehab [4]	-	280,171	-	-	-	280,171	0.3 M
Total	$ 322,146,729	$ 324,718,048	$ 13,900,000	$ 18,528,018	$ 8,926,997	$ 366,073,063	**$43.9 M**

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

Note 2. Total SDP payment reflects amount included in SFY 2026 Enacted budget and distributed based on SFY 2026 Q2 payments. Actual final distribution may vary.

Note 3. DSH total may change due to allowances under uncompensated care and its interaction with the State Directed Payment. New DSH workbooks are anticipated to be submitted to EOHHS in May 2026

Note 4. New hospital - operations began in August 2024, no supplemental payments received in FY25.

VIII. Hospitals - DSH

Hospitals - DSH Payments		All Funds	General Revenue
FY 2025	Revised Enacted	$27,638,872	$12,075,423
	Final	**$27,646,654**	**$12,075,423**
	Deficit over Revised	*($7,782)*	*$0*
FY 2026	Enacted	$13,900,000	$5,794,894
	November 2025 CEC Adopted	$13,900,000	$5,907,500
	Current	**$13,900,000**	**$5,907,500**
	Deficit over Nov CEC	*$0*	*$0*
FY 2027	November 2025 CEC Adopted	$13,900,000	$5,864,410
	Current	**$13,900,000**	**$5,864,410**
	Deficit over Nov CEC	*$0*	*$0*

FY 2026

Medicaid estimates a $13.9 million DSH payment in FY 2026, no change from the adopted estimate. 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 makes several private hospitals ineligible for DSH payments.

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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
DSH - Private Hospitals	$ 14,738,872	$ 1,000,000	$ 1,000,000	$0.0 M	$ 1,000,000	$ 1,000,000	$0.0 M	$0.0 M
DSH - Eleanor Slater Hospital	12,900,000	12,900,000	12,900,000	0.0 M	12,900,000	12,900,000	0.0 M	0.0 M
Balance to RIFANS/Accruals/Rounding	7,782	0	0	0.0 M	0	0	0.0 M	0.0 M
Total - Hospitals - DSH	**$ 27,646,654**	**$ 13,900,000**	**$ 13,900,000**	**$0.0 M**	**$ 13,900,000**	**$ 13,900,000**	**$0.0 M**	**$0.0 M**
General Revenue	*$12.1 M*	*$5.9 M*	*$5.9 M*	*$0.0 M*	*$5.9 M*	*$5.9 M*	*$0.0 M*	*($0.0 M)*
General Revenue	*$15.6 M*	*$8.0 M*	*$8.0 M*	*$0.0 M*	*$8.0 M*	*$8.0 M*	*$0.0 M*	*$0.0 M*

FFY 2022 DSH Audit

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

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

Table VIII-2. FFY 2022 DSH Recoupment and Redistribution

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

FFY 2023 DSH Audit

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

SFY 2026 DSH Allotment

CMS notified Medicaid in November 2025 that scheduled DSH reductions for 2026 were delayed. The 2026 unreduced federal allotment of $95.6 million allows for a maximum DSH payment of $166.3 million. Medicaid maintains the adopted amount of $13.9 million, with the state's share 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. Adopted	Total DSH vs. Adopted	Effective FMAP
Enacted/Adopted	$ 7,992,500	5,907,500	$ 13,900,000	$ -	$ -	57.50%
May Testimony	7,992,500	5,907,500	13,900,000	-	-	57.50%
Max DSH	$ 95,603,127	$ 70,663,181	$ 166,266,308	$ 64,755,681	$ 152,366,308	57.50%

SFY 2027 DSH Allotment

Section 6105 of the Consolidated Appropriations Act (CAA/HR 7148) of 2026 (signed into law on February 3, 2026) eliminated the FFY 2026 and 2027 DSH allotment reductions required under section 1923(f)(7)(A) of the Social Security Act (the Act). This is reflected in the CAA language and confirmed by Medicaid's DSH independent auditing firm but has not yet been confirmed by CMS.

Currently, the DSH allotment reductions required under section 1923(f)(7)(A) of the Act are in effect for 2028 only, at $8 billion for that fiscal year. Medicaid has not yet received its preliminary FFY 2027 federal allotment. Absent the allotment, Medicaid maintains the amount of $13.9 million, 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. Adopted	Total DSH vs. Adopted	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	95,603,127	69,771,595	165,374,722	63,864,095	151,474,722	57.81%

IX. Nursing and Hospice Care

Nursing and Hospice Care			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$425,000,000	$187,042,500
	Final	**$402,946,046**	**$177,274,058**
	Surplus over Revised	*$22,053,954*	*$9,768,442*
FY 2026	Enacted	$477,321,981	$204,266,507
	November 2025 CEC Adopted	$453,000,000	$193,884,000
	Current	**$457,700,000**	**$195,895,600**
	Deficit over Nov CEC	*($4,700,000)*	*($2,011,600)*
FY 2027	November 2025 CEC Adopted	$478,000,000	$202,050,600
	Current	**$489,200,000**	**$206,784,840**
	Deficit over Nov CEC	*($11,200,000)*	*($4,734,240)*

FY 2026

The FY 2026 revised estimate for the nursing and hospice budget line totals $457.7 million, including $195.9 million GR. This represents a $4.7 million (1.0%) deficit compared to the adopted November estimate, including $2.0 million GR. This deficit reflects increased 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 a 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), the effective increase in direct Medicaid costs is estimated to be 6.2%.

The revised estimate includes actual expenses paid from July through December 2025. It uses expenses from the second quarter, which includes the 5.3% rate increase, to project the remaining two quarters of the current year. In the November estimate, Medicaid lowered its prior (i.e., as reflected in its May 2025 CEC testimony) utilization factor from 2.5% to 0.0% after years of overestimating Nursing and Hospice expenses. However, actual experience in FY 2026 suggests a slight increase in utilization.

On October 1, 2025, Medicaid transitioned from a Resource Utilization Group (RUG-IV) based nursing facility payment methodology to a Patient Driven Payment Model (PDPM) methodology. This shift in methodology was implemented in a manner to be budget neutral. While changes in coding patterns could have unintended consequences in terms of gross revenues if average acuity increases because of this change, the projected increase for FY 26 over the November estimated appears to be utilization based. As part of the PDPM Implementation, the MMIS was closely monitored for accuracy of the nursing facility and hospice payments – throughout November, December, and January all payments were successfully processed and validated – budget neutrality validations were successfully demonstrated. Overall, for FY 2026, based on 3 months of data (completed for IBNR), there is no indication that the transition has led to unintended consequences nor that the increase compared to the revised FY 2026 estimate is related to the new model. Medicaid will continue to monitor.

FY 2027

The FY 2027 estimate totals $489.2 million, including $206.8 million GR, reflects an increase of $31.5 million (6.9%), including $10.8 million GR, over the current fiscal year. The revised estimate is $11.2 million ($4.7 million GR) greater than the November adopted estimate for FY 2027.

This estimate reflects a 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% from the perspective of Medicaid outlays.

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

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

Table IX-2 shows the average nursing facility per diem before and after patient share. Noteworthy, between 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.[11]

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

Figure IX-1 summarizes the increase in overall spending on nursing facilities and the average monthly Medicaid census at Rhode Island nursing facilities across all payers and funding sources. 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-1: Summary of Nursing Home and Hospice Expenditures

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
FFS Activity								
Hospice	$ 32,764,401	$ 38,477,000	$ 41,959,000	($3.5 M)	$ 40,752,000	$ 45,220,000	($4.5 M)	$3.3 M
Nursing Home	373,785,254	414,074,000	415,673,000	(1.6 M)	436,727,974	443,886,987	(7.2 M)	28.2 M
Subtotal FFS	**$ 406,549,655**	**$ 452,551,000**	**$ 457,632,000**	**($5.1 M)**	**$ 477,479,974**	**$ 489,106,987**	**($11.6 M)**	**$31.5 M**
Balance to RIFANS/Rounding	(3,603,609)	449,000	68,000	0.4 M	520,026	93,013	0.4 M	0.0 M
Total - Nursing and Hospice Care	**$ 402,946,046**	**$ 453,000,000**	**$ 457,700,000**	**($4.7 M)**	**$ 478,000,000**	**$ 489,200,000**	**($11.2 M)**	**$31.5 M**
General Revenue	*$177.3 M*	*$193.9 M*	*$195.9 M*	*($2.0 M)*	*$202.1 M*	*$206.8 M*	*($4.7 M)*	*$10.9 M*
Federal Funds	*$225.7 M*	*$259.1 M*	*$261.8 M*	*($2.7 M)*	*$275.9 M*	*$282.4 M*	*($6.5 M)*	*$20.6 M*

Table IX-2. Average Nursing Home Medicaid per diem

	Per Diem:			Annual Increase:	
ctive Date	Gross	Patient Share	Medicaid Paid	Per Diem	Patient Share
October 1, 2020	$240	$40	$200		
October 1, 2021	$249	$42	$207	3.8%	6.5%
October 1, 2022	$261	$45	$216	4.7%	7.1%
October 1, 2023	$283	$47	$235	8.2%	4.0%
October 1, 2024	$329	$49	$281	16.6%	3.5%
October 1, 2025	$335	$46	$288	1.6%	-5.0%
CAGR (2021 → 2025)	7.7%	2.3%	8.7%		

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%	$12.0 million	FFY 26 Actual Skilled Nursing Facility PPS Market Basket - No Productivity Adjustment
Utilization	1.5%	$7.2 million	Medicaid
Patient Share	0.56%	$1.2 million	Medicaid
Subtotal Nursing & Hospice Care		***$20.4 million***	
Annualization of prior Oct 1 increase		$11.4 million	Annualization of FY 2026 5.3%
Total Nursing & Hospice Care		**$31.8 million**	

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

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

X. Home and Community Care

Home and Community Care			
		All Funds	General Revenue
FY 2025	Revised Enacted	$248,600,000	$109,408,860
	Final	**$237,449,962**	**$104,082,796**
	Surplus over Revised	*$11,150,038*	*$5,326,064*
FY 2026	Enacted	$293,779,386	$125,703,952
	November 2025 CEC Adopted	$284,600,000	$121,808,800
	Current	**$300,100,000**	**$128,442,800**
	Deficit over Nov CEC	*($15,500,000)*	*($6,634,000)*
FY 2027	November 2025 CEC Adopted	$291,500,000	$123,217,050
	Current	**$309,000,000**	**$130,614,300**
	Deficit over Nov CEC	*($17,500,000)*	*($7,397,250)*

FY 2026

Medicaid's revised forecast for home and community care is $300.1 million, including $128.4 million GR; a $15.5 million deficit over the November CEC, including $6.6 million GR. This deficit is the result of greater utilization than accounted for in the November estimate primarily for personal care. The November estimate assumes utilization increase of 2.5% for all HCBS services over the FY 2025 actual experience.

The revised FY 2026 estimate is based on actual current year claims experience through December, with greater emphasis on the second quarter. The estimate includes projected deficits of $15.6 million for personal care and $1.2 million for shared living. The increase is partially offset by $0.9 million less in self-directed expenditures, $0.3 million less for adult day care, and $0.2 million less for assisted living. The estimate also includes $0.2 million in savings due to few PACE expenditures, discussed on the next page.

Regarding CFCM, Medicaid projects FFS expenditures totaling $8.0 million based on current utilization, $0.3 million less than the November estimate. The November estimate assumed certification of an additional provider by January 2026 that would allow for the transition of DD beneficiaries currently receiving services from IFs to community case managers. All beneficiaries supported by IFs were anticipated to transition between February and June 2026. However, this is delayed to July (FY 2027) in the revised estimate. This is offset by growth in the program, as one new CFCM agency has been certified that was not contemplated in November and another existing provider has committed to significant growth. 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. 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 $309.0 million, including $130.6 million GR. This is a $17.5 million, including $7.4 million GR, more than the November estimate. The increase is driven by an assumed 1.5% utilization increase over the FY 2026 revised estimate, less than the 2.5% increase assumed in November. While claims data continue to show year-over-year increases and there is no expectation this will slow, growth in the most recent quarter was lower than in previous quarter. This suggests that investments in program integrity appear to be somewhat slowing the trend. As program integrity interventions continue, Medicaid believes that use of a smaller utilization factor in the estimate is appropriate. 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, which results in a 3.19% increase for FY 2027. When applied to the blended trend and utilization assumed for HCBS services, the projected inflationary increase is equivalent to $39,117.

For conflict free case management, FFS expenditures are expected to be $12.6 million in FY 2027 vs. the $11.8 million that was included in November estimate. This is $0.8 million more than previously estimated and $4.6 million more than the revised FY 2026 estimate primarily reflecting the annualization of projected new referrals occurring in FY 2026 and the 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 by 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.

Program of All Inclusive Care for the Elderly (PACE)

FY 2026

Medicaid's FY 2026 forecast totals $32.2 million, a surplus of $0.2 million compared to the November adopted estimate due to lower spending.

FY 2027

Medicaid's FY 2027 forecast totals $35.4 million, an increase of $3.2 million compared to the FY 26 revised estimate due to increased enrollment ($1.4 million) and spending ($1.8 million).

Medicaid submitted a PACE SPA to CMS on March 25, 2025 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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
PACE	$ 24,848,860	$ 32,383,051	$ 32,200,126	$0.2 M	$ 35,723,545	$ 35,416,298	$0.3 M	$3.2 M
Enrollment	*436*	*465*	*465*	*0*	*486*	*485*	*-2*	*20*
FFS Activity								
Self-Directed	$ 28,435,448	$ 30,453,000	$ 29,512,858	$0.9 M	$ 31,183,000	$ 30,197,715	$1.0 M	$0.7 M
Adult Day	6,519,892	7,413,000	7,095,000	0.3 M	7,598,000	7,201,000	0.4 M	0.1 M
Home Care	141,104,192	165,935,000	181,507,000	(15.6 M)	166,127,497	183,463,248	(17.3 M)	2.0 M
Shared Living	10,565,144	11,812,000	13,041,000	(1.2 M)	12,107,000	13,295,000	(1.2 M)	0.3 M
Assisted Living	25,428,533	28,022,000	27,799,000	0.2 M	28,722,000	28,187,000	0.5 M	0.4 M
Other HCBS	6,367,559	8,560,403	8,936,000	(0.4 M)	9,976,894	11,180,000	(1.2 M)	2.2 M
Subtotal FFS	**$ 218,420,768**	**$ 252,195,403**	**$ 267,890,858**	**($15.7 M)**	**$ 255,714,391**	**$ 273,523,963**	**($17.8 M)**	**$5.6 M**
Subtotal - Home and Community Care	**$ 243,269,628**	**$ 284,578,454**	**$ 300,090,984**	**($15.5 M)**	**$ 291,437,936**	**$ 308,940,261**	**($17.5 M)**	**$8.8 M**
Balance to RIFANS/Rounding	(5,819,666)	21,546	9,016	0.0 M	62,064	59,739	0.0 M	0.1 M
Total - Home and Community Care	**$ 237,449,962**	**$ 284,600,000**	**$ 300,100,000**	**($15.5 M)**	**$ 291,500,000**	**$ 309,000,000**	**($17.5 M)**	**$8.9 M**
General Revenue	*$104.1 M*	*$121.8 M*	*$128.4 M*	*($6.6 M)*	*$123.2 M*	*$130.6 M*	*($7.4 M)*	*$2.2 M*
Federal Funds	*$133.4 M*	*$162.8 M*	*$171.7 M*	*($8.9 M)*	*$168.3 M*	*$178.4 M*	*($10.1 M)*	*$6.7 M*

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

	SFY 2025	SFY 2026	Current: Mar-26	FY25 → FY26
PACE	436	465	456	6.7%
HCBS Authorization in FFS				
Assisted Living	724	816	821	12.7%
Shared Living	331	440	455	32.9%
Self-Directed	700	778	782	11.1%
Home Care	3,424	4,156	4,221	21.4%
Subtotal HCBS	5,179	6,190	6,279	19.5%
HCBS Enrolled in RHO	2,630	2,939	2,926	11.7%
% of HCBS (excl. PACE) in RHO	*33.7%*	*32.2%*	*31.8%*	

Note 1. Figures represent LTSS authorizations for home-based services. There may be a lag in authorizations.
Note 2. HCBS Authorizations do not include Preventive Only authorizations and include members with full benefits only.

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

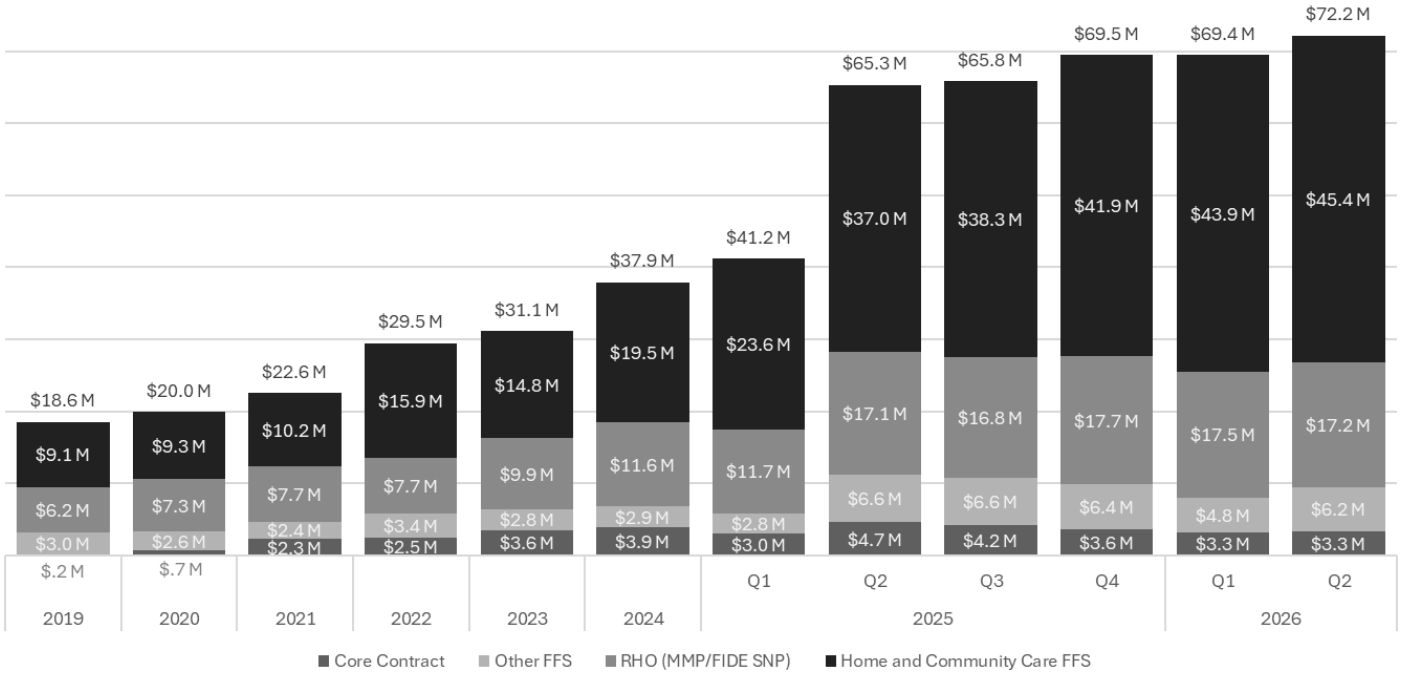


Table X-3. Summary of PACE Monthly Premiums

	SFY 2025	SFY 2026	SFY 2027	FY25 → FY26	FY26 → FY27
PACE					
Medicaid Only	$6,300	$7,486	$7,860	18.8%	5.0%
Dual, 55-64 y.o.	$4,525	$5,471	$5,745	20.9%	5.0%
Dual, 65+ y.o.	$4,580	$5,625	$5,906	22.8%	5.0%
Composite	$4,748	$5,777	$6,092	21.7%	5.4%
Average Member Months	436	465	485	6.5%	4.3%

Table X-4. PACE Price-Volume Comparison

	Price	Volume	Net
FY 2026 over FY 2025	$5.7 M 21.7%	$1.6 M 6.5%	$7.4 M 29.6%
FY 2026: Current over Nov CEC	($0.2 M) -0.5%	($0.0 M) -0.1%	($0.2 M) -0.6%
FY 2027: Current over Nov CEC	($0.2 M) -0.6%	($0.1 M) -0.3%	($0.3 M) -0.9%
FY 2027 over FY 2026	$1.8 M 5.4%	$1.4 M 4.3%	$3.2 M 10.0%

XI. Pharmacy

Pharmacy			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$2,700,000	$1,501,649
	Final	**$731,624**	**$625,532**
	Surplus over Revised	*$1,968,376*	*$876,117*
FY 2026	Enacted	$7,800,000	$3,669,654
	November 2025 CEC Adopted	$1,500,000	$950,239
	Current	**$1,300,000**	**$870,679**
	Surplus over Nov CEC	*$200,000*	*$79,561*
FY 2027	November 2025 CEC Adopted	$1,300,000	$881,507
	Current	**$1,200,000**	**$844,239**
	Surplus over Nov CEC	*$100,000*	*$37,268*

FY 2026

Medicaid's revised forecast for FFS pharmacy in FY 2026 is $1.3 million, a $6.5 million surplus compared to the FY 2026 Enacted budget and a $0.2 million surplus relative to the November CEC. This is due to the removal of the full liability for the high cost of cell and gene therapy (CGT) treatments from fee-for-service (FFS) lines and inclusion in MCO rates in FY 2026; so far in FY 2026, no enrollees have begun treatment with CGTs. In FY 2027, these treatments will be handled through an ASO arrangement with the State MCOs (see Section G of Major Developments for additional details.)

The estimate reflects average monthly spend during the first half of FY 2026 and rebate information is based on invoices issued to manufacturers through March 2026, for prescriptions incurred through December 31, 2025.

FY 2027

EOHHS forecasts $1.2 million in pharmacy expenditures for FY 2027, $0.1 million less than the November CEC. This significant decrease relative to FY 2026 Enacted is due to moving CGT treatments out of FFS and into managed care, either through the rates or, as in FY 2027, through the ASO arrangement.

The FY 2027 forecast assumes a 5.0% increase based on the S&P Global Healthcare Cost Review 2027 Q2 forecast for pharmacy.

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

Table XI-1. Summary of Pharmacy Expenditures

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
FFS Activity	$ 9,035,307	$ 9,860,000	$ 9,794,000	$0.1 M	$ 10,279,000	$ 10,265,000	$0.0 M	$0.5 M
Rebates	(8,370,434)	(8,400,401)	(8,544,761)	0.1 M	(8,979,635)	(9,163,788)	0.2 M	(0.6 M)
DRE	(7,125,054)	(7,020,764)	(7,187,589)	0.2 M	(7,491,515)	(7,709,123)	0.2 M	(0.5 M)
J-Code	(1,245,380)	(1,379,637)	(1,357,172)	(0.0 M)	(1,488,120)	(1,454,665)	(0.0 M)	(0.1 M)
Subtotal - Pharmacy	**$ 664,873**	**$ 1,459,599**	**$ 1,249,239**	**$0.2 M**	**$ 1,299,365**	**$ 1,101,212**	**$0.2 M**	**($0.1 M)**
Balance to RIFANS - Accruals/Rounding	66,751	40,401	50,761	(0.0 M)	635	98,788	(0.1 M)	0.0 M
Grand Total - Pharmacy	**$ 731,624**	**$ 1,500,000**	**$ 1,300,000**	**$0.2 M**	**$ 1,300,000**	**$ 1,200,000**	**$0.1 M**	**($0.1 M)**
General Revenue	*$0.6 M*	*$1.0 M*	*$0.9 M*	*$0.1 M*	*$0.9 M*	*$0.8 M*	*$0.0 M*	*($0.0 M)*
Federal Funds	*$0.1 M*	*$0.5 M*	*$0.4 M*	*$0.1 M*	*$0.4 M*	*$0.4 M*	*$0.1 M*	*($0.1 M)*

Generally, rebates fluctuate due to several reasons:

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

XII. Pharmacy Clawback (Medicare Part D)

Pharmacy Clawback (Medicare Part D)			
		All Funds	**General Revenue**
FY 2025	Revised Enacted	$92,200,000	$92,200,000
	Final	**$92,702,111**	**$92,702,111**
	Deficit over Revised	*($502,111)*	*($502,111)*
FY 2026	Enacted	$96,400,000	$96,400,000
	November 2025 CEC Adopted	$94,600,000	$94,600,000
	Current	**$93,900,000**	**$93,900,000**
	Surplus over Nov CEC	*$700,000*	*$700,000*
FY 2027	November 2025 CEC Adopted	$98,100,000	$98,100,000
	Current	**$95,900,000**	**$95,900,000**
	Surplus over Nov CEC	*$2,200,000*	*$2,200,000*

Medicaid's revised FY 2026 estimate of $93.9 million reflects a $0.7 million surplus compared to November CEC, reflecting forecasted enrollment decline of 283 average monthly beneficiaries.

Medicaid projects spending to increase to $95.9 million in FY 2027. This is a surplus of $2.2 million relative to the November CEC. With modest underlying enrollment growth being offset by H.R.-1-related closures, Medicaid is forecasting a limited enrollment decrease of 225 average monthly beneficiaries relative to November CEC.

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	**Nov CEC**	**Current**	**Surplus/ (Deficit)**	**Nov CEC**	**Current**	**Surplus/ (Deficit)**	**FY26 → FY27**
Part D Premium Payments	$ 92,575,234	$ 94,586,780	$ 93,828,068	$0.8 M	$ 98,014,809	$ 95,821,549	$2.2 M	$2.0 M
Balance to RIFANS/Accruals/Rounding	126,877	13,220	71,932	(0.1 M)	85,191	78,451		
Total - Pharmacy Clawback	**$ 92,702,111**	**$ 94,600,000**	**$ 93,900,000**	**$0.7 M**	**$ 98,100,000**	**$ 95,900,000**	**$2.2 M**	**$2.0 M**
General Revenue	*$92.7 M*	*$94.6 M*	*$93.9 M*	*$0.7 M*	*$98.1 M*	*$95.9 M*	*$2.2 M*	*$2.0 M*
Part D Muliplier	$198.28	$204.75	$204.83	$0.08	$211.44	$211.78	$0.34	$6.94
July - September	$194.08	$204.64	$204.64		$204.52	$207.57		
October - December	$194.78	$199.07	$199.07		$204.52	$206.06		
January - March	$204.64	$207.57	$207.57		$214.75	$214.75		
April - June	$204.64	$207.57	$207.57		$214.75	$214.75		
Average Enrollment	38,961	38,501	38,202	-299	38,664	37,737	-928	-466

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

	Price	**Volume**	**Net**
FY 2026 over FY 2025	$3.0 M	($1.8 M)	$1.2 M
	3.3%	-1.9%	1.3%
FY 2026: Current over Nov CEC	$0.0 M	($0.7 M)	($0.7 M)
	0.0%	-0.8%	-0.7%
FY 2027: Current over Nov CEC	$0.2 M	($2.4 M)	($2.2 M)
	0.2%	-2.4%	-2.2%
FY 2027 over FY 2026	$3.1 M	($1.1 M)	$2.0 M
	3.4%	-1.2%	2.1%

XIII. Other Services

Other Services			
		All Funds	General Revenue
FY 2025	Revised Enacted	$207,700,000	$76,323,770
	Final	**$205,337,135**	**$74,375,561**
	Surplus over Revised	*$2,362,865*	*$1,948,209*
FY 2026	Enacted	$233,812,840	$82,131,863
	November 2025 CEC Adopted	$217,300,000	$77,377,638
	Current	**$216,900,000**	**$79,023,524**
	Surplus over Nov CEC	*$400,000*	*($1,645,886)*
FY 2027	November 2025 CEC Adopted	$223,300,000	$73,225,196
	Current	**$225,600,000**	**$75,895,543**
	Deficit over Nov CEC	*($2,300,000)*	*($2,670,347)*

FY 2026

Medicaid's revised FY 2026 estimate totals $216.9 million, including $79.0 million GR, for Other Services. This is a surplus of $0.4 million (0.2%), but a deficit of $1.3 million GR compared to the November CEC.

The surplus is largely driven by a $0.4 million net reduction for BH services. For the purpose of the following summary table, Medicaid has split CCBHC expenses from other BHDDH Medical Services. Medicaid also projects $1.8 million fewer expenses for other practitioners, Physician Services, DME, and Tavares claiming. This is offset by $1.2 million more for Medicare Premium Payments for Part A ($0.7 million) and Part B ($0.4 million) due to updated premium costs and $0.1 million for rehabilitation and targeted case management.

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

FFS claiming estimates are based on a blend of actual claims data for the first half of FY 2026, which emphasizes the median average monthly expenditures and the last quarter of that year. Utilization is also expected to be generally consistent with the year-to-date experience.

With respect to recoveries, EOHHS includes $20.5 million or $0.7 million less than November CEC. This reflects estate recoveries as well as recoveries anticipated to be collected by Medicaid's program integrity efforts. Note the budgeted amount includes estate recoveries that increased from $16.0 million to $18.0 million, based on our current collection activities. An additional $2.5 million in each year is included within the "recoveries" line for anticipated cash recoupments collected from providers for inappropriate billing practices. Not included is ongoing cost avoidance from program integrity's committed efforts assessing community health worker and personal care expenses. For example, in FY 2025 community health worker expenditures totaled $12.6 million while FY 2026 expenditures are projected to be $0.9 million. This cost avoidance from either explicit payment holds or a change in any resulting change in provider billing practices is not included in the total. Also excluded from the recoveries amount are any collections that are pending action with the MFCU, to whom Medicaid has made referrals totaling $21.0 million. Given the great uncertainty on eventual value of any collections and the timing of any such collections, Medicaid recommends booking such recoveries on a cash basis when achieved.

FY 2027

The FY 2027 estimate totals $225.6 million, including $75.9 million GR. This reflects an increase of $2.3 million, including $2.7 million GR, compared to the November CEC. The year-over-year increase is due to an additional $1.4 million for Part A and $1.9 million for Part B Medicare Premium Payments, reflected expected increase in the cost of premiums as notified by CMS. As of the April eligibility snapshot of QMB, SLMB, and QI populations as well as May 2026 invoicing for Part A and Part B received in April from CMS, the total enrollment in the MSP remains

consistent with prior month enrollments. However, CMS approved Rhode Island's request to increase its allotment for the QI expansion for CY 2026 and so the FY 2027 budget continues to reflect this increase.

This is partially offset by $3.6 million in BH expenses, including CCBHC and BHDDH Medical Services spending.

The methodology for the FY 2027 estimate is consistent with FY 2026, with a blend of median average expenditures from the first half of FY 2026 and specifically the second quarter for the base analysis. The FY 2027 estimate assumes a 2.0% price increase in the BHDDH Medical services budget line to capture the required Medicare Economic Index inflationary increase for CCBHCs. Medicaid expects utilization to be consistent with FY 2026 thus far except for BHDDH Medical services, for which Medicaid assumes a 2.5 % increase.

A summary of FY 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	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Medicare Premium Payments								
Part A	$ 20,092,312	$ 21,748,284	$ 22,480,681	($0.7 M)	$ 23,484,951	$ 24,712,983	($1.2 M)	$2.2 M
Part B	89,632,074	97,794,473	98,220,085	(0.4 M)	109,267,084	110,485,945	(1.2 M)	12.3 M
Subtotal - Supplemental Payments	**$ 109,724,386**	**$ 119,542,758**	**$ 120,700,766**	**($1.2 M)**	**$ 132,752,035**	**$ 135,198,928**	**($2.4 M)**	**$14.5 M**
Non-Emergency Transportation	6,552,717	7,113,652	7,075,776	0.0 M	7,732,681	7,734,266	(0.0 M)	0.7 M
Recoveries	(15,158,534)	(21,200,000)	(20,500,000)	(0.7 M)	(24,400,000)	(20,500,000)	(3.9 M)	0.0 M
FFS Activity								
BHDDH Medical Services	14,127,449	16,541,812	15,468,670	1.1 M	18,409,153	17,021,103	1.4 M	1.6 M
CCBHC Services	32,785,072	35,449,856	36,114,731	(0.7 M)	31,944,160	29,784,519	2.2 M	(6.3 M)
Rehab & TCM	23,227,507	24,148,000	24,276,000	(0.1 M)	24,148,000	24,219,000	(0.1 M)	(0.1 M)
Tavares	6,906,114	6,890,000	6,559,000	0.3 M	6,890,000	6,533,000	0.4 M	(0.0 M)
DME	3,519,370	3,721,000	3,660,000	0.1 M	3,721,000	3,643,000	0.1 M	(0.0 M)
Physician Services	15,825,384	17,833,000	17,087,000	0.7 M	17,833,000	17,126,000	0.7 M	0.0 M
Other Practitioners	9,721,882	7,193,000	6,359,000	0.8 M	4,287,208	4,775,104	(0.5 M)	(1.6 M)
Subtotal - FFS Activity	106,112,778	111,776,668	109,524,401	2.3 M	107,232,520	103,101,726	4.1 M	(6.4 M)
Subtotal - Other Services	**$ 207,231,347**	**$ 217,233,078**	**$ 216,800,943**	**$0.4 M**	**$ 223,317,236**	**$ 225,534,920**	**($2.2 M)**	**$8.7 M**
Balance to RIFANS/Conferees/Rounding	(1,894,212)	66,922	99,057	(0.0 M)	(17,236)	65,080	(0.1 M)	(0.0 M)
Total - Other Services	**$ 205,337,135**	**$ 217,300,000**	**$ 216,900,000**	**$0.4 M**	**$ 223,300,000**	**$ 225,600,000**	**($2.3 M)**	**$8.7 M**
General Revenue	*$74.4 M*	*$77.4 M*	*$79.0 M*	*($1.6 M)*	*$73.2 M*	*$75.9 M*	*($2.7 M)*	*($3.1 M)*
Federal Funds	*$121.5 M*	*$132.6 M*	*$130.5 M*	*$2.1 M*	*$142.7 M*	*$138.8 M*	*$4.0 M*	*$8.3 M*
Restricted Receipts	*$9.5 M*	*$7.4 M*	*$7.4 M*	*($0.0 M)*	*$7.4 M*	*$10.9 M*	*($3.6 M)*	*$3.6 M*

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

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Restricted - Children's Health Account	$ 8,500,000	$ 7,350,000	$ 7,372,593	($0.0 M)	$ 7,350,000	$ 10,939,274	($3.6 M)	$3.6 M
Restricted - Organ Transplant Fund	15,000	0	0	0.0 M	0	0	0.0 M	0.0 M
Enhanced FMAP - CCBHC	34,885,072	35,449,856	39,783,743	(4.3 M)	31,944,160	33,762,367	(1.8 M)	(6.0 M)
100% Federal - Qualifying Individuals	1,750,000	3,525,000	3,525,000	0.0 M	9,560,000	9,560,000	0.0 M	6.0 M
100% State - Breast & Cervical Cancer	(200,000)	(200,000)	(200,000)	0.0 M	(200,000)	(200,000)	0.0 M	0.0 M

Table XIII-3. Medicare Monthly and Part B Premiums

	SFY 2025	SFY 2026			SFY 2027			
	Final	Nov CEC	Current	Change	Nov CEC	Current	Change	FY26 → FY27
Part A PMPM	$ 482.68	$ 499.36	$ 515.28	$ 15.92	$ 524.29	$ 549.03	$ 24.74	$ 33.75
July-December	487.71	542.21	542.21		542.21			
January-June	542.21	555.77	555.77		555.77			
Part A - Average Enrollment	3,469	3,629	3,636	6	3,733	3,751	18	115
Part B PMPM	$ 199.37	$ 199.37	$ 199.37	$ 0.00	$ 212.46	$ 212.46	$ 0.00	$ 13.09
July-December	188.94	188.94	188.94		209.83			
January-June	209.83	209.83	209.83		215.08			
Part B - Average Enrollment	40,636	41,375	41,054	(321)	41,642	40,969	(673)	(86)

Attachments