MEDICAL ASSISTANCE

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

   See testimony and accompanying Excel workbook.

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

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

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

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

FY 2025 Closing -Update

1. **Please provide a FY 2025 updated closing analysis by program (in the same format that has been used for prior November testimony) with a separate column identifying any variance to the preliminary closing.**
   a. **Include an explanation of the impact of accruals and any prior period adjustments on the program's final closing position.**
   b. **Identify any adjustments made between programs for non-emergency transportation services compared to the FY 2025 final budget.**

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

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

   Each summary table includes the FY 2025 closing figures.

FY 2026 Budget

1. **Please include a status update on budget initiatives as outlined in "Tab 2" which retains the November 2025 data and has new columns for May 2026. Please include information regarding regulatory changes and amendment submissions/approvals, where appropriate and any known barriers to approval.**
   a. **Include all relevant details regarding the status of any pending submissions to CMS.**

      See Attachment 2a and the **FY 2026 Budget Initiative Implementation section** within the Major Developments section of testimony.

Federal Issues and Contract Status

1. **Please provide an update to the November Caseload testimony on how the CMS finalized rules for its Medicaid Access Rule and Medicaid Managed Care Rule will impact projected caseload and programming. This includes streamlining the Medicaid, Children's Health Insurance Program and Basic Health Program Applications, Eligibility Determination, Enrollment and Renewal Processes (including but not limited to impacts on eligibility (including justice-involved youth deadline of January 1, 2025); FFS Rate Transparency & Rate Restructuring; State Directed Payments; In Lieu of Services; HCBS Payment Adequacy; HCBS Quality Measure Set; and Nursing Facility Minimum Staff Ratios and Cost Reporting).**
    a. **Please also include any updated timelines for the changes and any specific impacts to these items from HR 1.**

    <u>Update on Impacts of CMS Final Rules on Caseload and Programming – CAA Section 5121</u>

    This update expands upon the November caseload testimony to reflect the anticipated impact of the CMS final rules on Rhode Island's projected caseload and programming. Particular emphasis is placed on implementation of Section 5121 of the Consolidated Appropriations Act, 2023 for justice-involved youth under age 21, as well as eligible former foster youth up to age 26. In keeping with federal rules, individuals who are incarcerated are placed on suspended Medicaid status during their incarceration and disenrolled from Medicaid Managed Care when applicable. When an individual is released from incarceration, their Medicaid status is changed to active, and they are re-enrolled in Medicaid Managed Care when applicable.

    The State is building system and operational enhancements to streamline re-enrollment into Managed Care Organizations (MCOs) for individuals transitioning from both RITS and RIDOC, minimizing gaps in coverage and ensuring seamless continuity of care upon release. The CMS Access Rule supports this approach by streamlining eligibility and renewal processes, reducing administrative barriers, and improving timeliness of coverage activation and maintenance. Rhode Island anticipates a moderate increase in pre-release eligible individuals, including both youth under 21 and eligible former foster youth up to age 26, driven by improved continuity of coverage, more timely activation, and streamlined managed care re-enrollment processes.

    In alignment with Section 5121, Rhode Island is implementing a phased service delivery model to ensure required services are both authorized and delivered during the pre-release period.

    - The State is developing infrastructure to enable RITS and RIDOC to directly deliver and bill for Targeted Case Management (TCM) and other required pre-release services via the Fee for Service delivery system
    - Operational workflows are being developed to ensure services are delivered within the pre-release window, including screening, assessment, and care planning
    - Leveraging existing eligibility to initiate services, while concurrently building billing and documentation infrastructure to support reimbursement.

    Programming Impact:

    - Expansion of carceral facility-based care coordination capacity, including TCM delivered by RITS and RIDOC

- Development of clinical and care management workflows within carceral facilities
- Increased reliance on data sharing to support coordination and continuity

Initial efforts are focused on enabling RITS and RIDOC to directly deliver and bill for targeted case management and other required services through a fee-for-service model, while longer-term strategies include improving managed care re-enrollment processes and evaluating the role of MCOs in supporting continuity, financing, and outcomes for this population.

Medicaid Access Rule and Medicaid Managed Care Rule

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

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

- The Access Rule requires Rhode Island Medicaid, in collaboration with BHDDH, DHS, and DCYF, to establish a Home and Community Based Services (HCBS) grievance system for FFS enrollees. The effective date set by the rule was initially July 9, 2026, but CMS has issued guidance that CMS is exercising enforcement discretion until December 2027. The system would allow individuals to file complaints about state/provider performance with person-centered planning, services plans and HCBS settings requirements.

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

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

- Rhode Island must submit to CMS an assurance and analysis (1) at the time the state submits for readiness review, (2) on an annual basis and no later than 180 days after the end of the contract year, and (3) any time there has been a significant change that would affect the adequacy of capacity and services and with the submission of the associated contract. The assurances and analyses require an amendment to the existing Managed

Care contract by July 1, 2026. The state must also include specific contract language regarding provider incentive payments by July 1, 2026. Contract amendments are currently being drafted to reflect the new requirements.

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

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

Nursing Facility Minimum Staff Ratios and Cost Reporting

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

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

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

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

On December 2, 2025, CMS issued an interim final rule repealing numerical staffing requirements and the 24/7 RN mandate.[2] The repeal (effective February 2, 2026):

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

[2] Federal Register: Medicare and Medicaid Programs; Repeal of Minimum Staffing Standards for Long-Term Care Facilities

- Removes the 24/7 RN onsite requirement; and restores the prior policy requiring an RN to be available for at least 8 consecutive hours/day, 7 days/week, and to serve as a director of nursing full-time (except when waived).
- Removes the 3.48 hours per resident per day total nursing care requirement, inlcuding removal of the 0.55 hours per resident per day RN and 2.45 hours per resident per day nurse aide minimums.

The change follows:

- Legislative moratorium: Public Law 119-21 (July 2025) imposed a 10-year enforcement moratorium on the 2024 standards unbtil September 30, 2034.
- Court rulings: A federal court vacated the 24/7 RN and hours per resident per day requirements, finding CMS exceeded its authority under the Social Security Act.
- Policy and industry concerns: CMS cited recruitment challenges, especially in rural and tribal areas, and potential facility closures as key factors.

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

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

3. **Please provide an update on the timeline for extending the managed care contracts after June 30, 2026.**

   Medicaid was approved to exercise the remaining option year on the managed care contracts, extending through June 30, 2027. Medicaid was also granted an additional two option years, providing an approved extension period through June 30, 2029.

All Programs – Rate and Caseload Changes

1. **Please fill out the table for the specific rate and caseload changes that impact the separate programs, as has been included in testimony in the past ("Tab 3" attached file), so that the totals can be shown in the aggregate and by program.**

   See **Attachment 8**.

2. **Please provide an update on the approval and use of high-cost drug therapies. Please include information on other states covering the drugs, the current incidence of beneficiaries being prescribed them, and how those therapies are being approved.**

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

   See notes on GLP-1 use and expenditures under "GLP-1 Coverage" on page 14.

3. **Please fill out Tab 3a to update initiatives in the FY 2026 enacted budget and the FY 2027 savings assumed for the pharmacy containment proposal. Provide expenses/savings by program for:**
   a. **Community Health Workers – Tab 3b**
   b. **Pharmacy containment – Tab 3c**

c. **E-Consults – Tab 3d**
    i. **Please provide an update on how the Executive Office is tracking who is receiving the benefit and any savings resulting from the visit.**
d. **Equifax's The Work Number – 3e & 3f**

The workbook is completed as requested.

4. **For the Governor's recommended budget, "Tab 4" includes the proposals to include and exclude from the EOHHS estimate when providing current law caseload estimates. Please provide the updated value of each initiative based on the updated May testimony.**

   The workbook is completed as requested.

Long-Term Care

1. **Please provide fee-for-service nursing home expenses and methodology.**
   a. **For FY 2026, please note expenses through September 2025 and those starting October 1, 2025, under the new Patient-Driven Payment Model.**

      Claims paid through September for nursing facility and hospice services in the FFS program total $78.6 million, which reflect dates of service in July and August 2025. PDPM was implemented on October 1, 2025, for dates of services beginning October 1. Claims paid in November and December, which are for dates of service in October and November, respectively, totaled $80.0 million. 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.

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

      See Nursing and Hospice Care section of testimony.

2. **Please provide nursing home and hospice days from FY 2025 to date. Also, due to the inherent lag please provide final nursing home and hospice days by month going back to FY 2019.**

   The data is available in the model provided to the conferees (historical data are retained in file, within hidden rows).

3. **Please provide an update on all current LTSS activities, including most current initiatives.**

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

   3b - LTSS Update.pptx

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

Information on LTSS applications is available on the transparency portal.[3] As of April 18, 2026, the chart below shows a total of 182 overdue LTSS applications.

	Not Overdue			Overdue			Total
	Client	State	Total	Client	State	Total	Grand Total
SNAP Expedited	133	203	336	70	117	187	523
SNAP Non-Expedited	644	707	1,351	133	73	206	1,557
CCAP	66	127	193	6	48	54	247
GPA - Burial	0	16	16	0	3	3	19
SSP	16	14	30	1	1	2	32
GPA	60	29	89	5	4	9	98
*RIW	186	106	292	25	25	50	342
Undetermined Medical	472	206	678	277	384	661	1,339
Medicaid - MAGI	14	14	28	44	62	106	134
Medicare Premium Payments	325	185	510	44	157	201	711
Medicaid Complex	35	128	163	48	438	486	649
LTSS	43	406	449	11	171	182	631
Grand Total	1,994	2,141	4,135	664	1,483	2,147	6,282

**This is an estimate of pending applications for RI Works and is subject to change.*

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

Nursing home per diems are comprised of the following components:

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

  With the transition from a RUG-based methodology to PDPM, the direct care rate was rebased to achieve budget neutrality. From this rebased rate, the 5.3% inflationary increase enacted by

[3] April-2026-DHS-Monthly-House-Oversight-Report-final.pdf

the 2025 General Assembly was applied. The Direct Care component is adjusted by a PDPM weight, to account for patient acuity. (For example, a patient on a ventilator would receive a higher rate than someone not on a ventilator). The PDPM weight acts as a multiplier on the base rate. This rate is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.

- A Provider Base Rate which is the sum of the components below:
    - Other direct care reimburses for other direct care expenses such as recreational activity expenses, medical supplies, and food. This component is the same for all facilities. As a result of the FY 2024 Rate Review, this component was increased 25.5% to $84.09. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
    - Indirect care reimburses facilities for all other nursing facility operating expenses, like administration, housekeeping, maintenance, and utilities. This component is the same for all facilities. It is updated annually, pursuant to RIGL §40-8-19. (2)(vi), or other inflationary adjustment set by the General Assembly.
    - Fair rental value is facility specific and was determined as of 7/1/2012 based on a formula included in the current Principles of Reimbursement. Updated annually, pursuant to the State Plan which requires Medicaid to use the IHS Markit Healthcare Cost Review. The 10/1/2025 increase was 2.5%.
    - A per diem tax is facility specific and based on real estate, property taxes, and fire tax paid, and the Medicaid census days. Updated annually based on information from the BM-64 Cost Reports.

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

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

Patient Share Adjustment

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

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

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

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

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

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

7. **Please provide an update on the implementation of Conflict Free Case Management (CFCM), including an update on the implementation of CFCM specific to the IDD population. Please consult with BHDDH so that testimony regarding the status of CFCM for the IDD population is consistent across all agencies.**
   a. **a. Is the system fully operational through WellSky in FY 2026? If not, what is the projected timeframe for implementation?**
      The system is live. An update included in response to question 3.
   b. **For FY 2026, the November 2025 CEC testimony projection included 12,036 eligibles with staggered dates based on available monthly case management with 5,154 beneficiaries receiving CFCM services by June. This excludes 768 DD beneficiaries who receive case management through BHDDH staff. For FY 2027 the estimate assumed 6,270 beneficiaries would receive services by June 2027 with 1,899 DD beneficiaries and 4,371 non-DD beneficiaries with 576 beneficiaries being managed by BHDDH FTEs.**
      i. **Please update this information and include how many individuals are receiving case management services from DHS staff, BHDDH staff, or the certified agencies. Agencies include: Access Point, Bethel Behavioral Associates, CareLink, Child and Family, East Bay Community Action Program, Healthcare Connect, Revive Therapeutic Services, Seven Hills, Tri-County Community Action Agency, and Westbay Community Action Program.**

Case management is not provided by DHS staff; BHDDH has 16.0 case managers providing services, in addition to 2.0 case manager supervisors. The estimate assumes 768 members are managed by BHDDH staff.

Agencies include: Access Point, Bethel Behavioral Associates, Bethel of South County, CareLink, Child and Family, East Bay Community Action Program, Healthcare Connect, Revive Therapeutic Services, Rhode Island Parent Information Network (RIPIN), Seven Hills, Tri-County Community Action Agency, and Westbay Community Action Program.

CFCM Implementation Timeline

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

SFY 26 Nov. Estimate vs. SFY 26 May Revised Estimate

Item	**Enacted**	**Nov CEC**
Total Eligible	12,590 eligible with staggered start dates based on available monthly case management.	12,601 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	5,154 (3,519 non-DD clients; 1,635 DD clients)	5,180 (3,809 non-DD clients; 1,371 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators*	200 people will shift from Independent Facilitators each month from Feb. 2026 through May 2026, so there will be none by June-end 2026.)	CFCM model excludes members receiving services from Independent Facilitators; 703 actual members through March, which estimate assumes will grow to 778 by the end of June 2026.
FMAP	57.20%	57.20%
Rate	$170.87 Per Month	$170.87 Per Month
Amount in Medicaid Budget	$8,293,175	$8,047,806

SFY 27 May. Estimate

Item	**Nov. CEC**

Total Eligible	12,677 eligible with staggered start dates based on available monthly case management.
Total Billing by SFY End	6,462 (4,049 non-DD clients; 2,413 DD clients)
BHDDH FTEs	CFCM model excludes 768 DD clients managed by 16 FTEs
Independent Facilitators (IFs)	200 people will shift from Independent Facilitators to a community provider billing the CFCM rate each month from July 2026 through October 2026.
FMAP	57.73%
Rate	$170.87 Per Month
Amount in Medicaid Budget	$12,582,525

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

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

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

Managed Care

1. **Please provide estimates for Managed Care, broken down by RIte Care, RIte Share and fee-for-service for FY 2026 and FY 2027.**

   See **Managed Care** section of testimony.

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

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

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

The table below provides a brief schedule of in-plan services. The exhibit is found in the SFY 2026 final rate certification dated April 25, 2025, and is consolidated from **Attachment A** "Schedule of In-Plan Benefits" in the MCO Medicaid Managed Care Services contracts.

Figure 3: Medicaid Managed Care Benefit Package

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

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

Please see **Attachment A** on page 184 of Tufts Health Plan's contract, for a more in-depth example of in-plan services, available on EOHHS' website.[4] All MCO contracts have the same structure so there is no differentiation between Tuft's contract compared to the others. Please refer to Amendment 19 for the health plans most up to date MCO contract. Note, Amendment 20 was signed by both parties (MCOs and EOHHS) on April 10, 2026. This contract is yet to be posted as of 4/20/2026.

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

3. **Please provide the monthly capitation rate(s) for RIte Care.**
    a. **If FY 2026 or FY 2027 is different from the rate assumed in November 2025, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs. Also, where the testimony cites a percent-based caseload or cost inflator, please ensure that the specific cost impacts are also provided.**

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

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

The three adjustments below were incorporated into FY 2026 MCO contracts in Amendment 20. Any FY 2027 impact is captured within the draft rates used for the May CEC.

- *Primary Care Assessment.* A $4.15 PMPM add was included into capitation related to the enacted Primary Care Assessment.
- *FQHC Rate Adjustment for WellOne*. The FQHC submitted a rate review request of which the state granted a rate increase dating back to state fiscal year 2025. Inflation was recalculated for FY 2026 applying the applicable increase to the updated base.
- *SUD Residential Inflationary Adjustment*. Inflation of select procedure codes dictated by our State Plan was not included within the FY 2026 rates and was updated in Amendment 20. Unamended FY 2026 rates were previously consistent with the OHIC Rate Review. This inflation is currently requested to be removed in SFY 2027 due to inclusion of these rates in the OHIC Rate Review.

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

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

5. **Please provide any updates to what was provided in November testimony for the separate payments by the managed care plans to the Accountable Entities from FY 2019 through FY 2025.**

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

   Please see the spreadsheet below with incentive payments made through SFY 2025. Please note, SFY 2025 payments were updated and this reflects final incentive payments made through the program.

   Please also see the second file that shows shared savings (or loss) payments made by the plans to the accountable entities based on TCOC results each year. Please note, these payments are on a two-year lag due to claims run out and reporting timelines. Program Year 6, FY 2024, is the latest year with TCOC payments. FY 2025 TCOC results will be finalized at the end of FY 2026 (file remains same as included for November 2025 CEC).

   QA Attachment_Update

   QA Attachment_TCOC Sl

6. **GLP-1 Coverage: Please identify the current monthly drug costs for covering individuals for GLP-1 weight loss treatment by program. *[Added to file per email on 4/17/26]***
   a) Approximately how many individuals have prescriptions per month?

   GLP-1 drugs have been provided in Medicaid coverage for several years for both Type 2 diabetes and weight loss. Total expenditures in FY 2026 are projected at $54.0 million. The highest

percentage of total paid expenditures is attributed to the expansion population (47.3%), followed by RiteCare (29.0%), RHP (19.6%), and FFS/FIDE (<5%).

Growth in GLP-1 drug expenditures for weight loss are expected to continue increasing in Medicaid. In SFY 2025, there was approximately $11 million in all-funds expenditure on claims volume of 24,980 prescriptions written on drugs explicitly indicated for obesity (Wegovy and Zepbound – see following table for more detail on approved uses). This is more than double the SFY 2024 expenditures of approximately $5 million on 13,510 prescription claims for obesity. Together, Wegovy and Zepbound are on pace for an anticipated $18.5 million in spend for FY 2026. Please note, while there may be off label obesity use of other GLP-1s, this is not discernable from expenditure data. Figure 1 provides additional detail on total expenditures, users, and per treatment cost by year, for all uses.

The portion of composite capitation dedicated to weight loss GLP-1 drugs was initially $3.88 PMPM for FY 2026; however, in the final rate certification this was adjusted to $5.91 PMPM after review of emerging experience. Medicaid's actuarial consultant included $8.21 PMPM in the SFY 2027 capitation rates. This portion was derived based on applying a high utilization increase trend of 40 percent for obesity GLP-1s (though a lower increase than SFY 2025 into SFY 2026), while anticipating a cost reduction in the individual drugs (not related to the BALANCE model).

The budget initiative submitted in the FY 2027 Governor's Recommended budget assumed $20.3 million in all-funds savings; updated for the recommended SFY 2027 capitation rates, this is revised downward to $20.2 million.

Table. GLP-1 Agonists Approved for Type 2 Diabetes and Obesity

GLP-1 Agonists Approved for Type 2 DM			GLP-1 Agonists Approved for Obesity		
Brand Name	**Generic Name**	**Other Indications**	**Brand Name**	**Generic Name**	**Other Indications**
Mounjaro	Tirzepatide		Zepbound	Tirzepatide	moderate to severe obstructive sleep apnea
Ozempic	Semaglutide	CV event risk reduction - T2DM; kidney disease progression and CV death risk reduction - T2DM patients with CKD	Wegovy	Semaglutide	CV event risk reduction in obese or overweight patients with established CVD; metabolic dysfunction-associated steatohepatitis (stage F2-F3 fibrosis)
Rybelsus	Semaglutide (oral)	CV event risk reduction - T2DM at high risk			
Trulicity	Dulaglutide	CV event risk reduction - T2DM patients with established CVD or multiple CV risk factors			
Victoza	Liraglutide	CV event risk reduction - T2DM with established CVD			
Byetta	Exenatide				

Per KFF, as of January 2026, thirteen state Medicaid programs cover GLP-1s for obesity. California, New Hampshire, Pennsylvania, and South Carolina all ended obesity coverage for GLP-1s between 2025 and 2026. North Carolina rescinded coverage in 2025 that was later reinstated by a governor's order. Several states, such as Massachusetts, have limited or are limiting growth by implementing

further restrictions on use for obesity. In 2024, GLP-1 drugs comprised a 1 percent share of nationwide Medicaid prescriptions, but 8 percent share of nationwide Medicaid drug spend.

Figure 1. GLP-1 Drugs, Total Paid Amount, Total Users, and Cost Per Month

	2023	2024	2025	2026 Est.	3 Year CAGR (%)	FY25 → FY26 %
Paid Amount						
GLP-1 Drugs	**$ 27,416,556**	**$ 33,683,792**	**$ 44,671,461**	**$ 53,990,808**	25%	21%
OZEMPIC	$ 6,049,150	$ 11,627,529	$ 20,732,491	$ 21,468,392	53%	4%
WEGOVY	$ 2,445,988	$ 4,309,892	$ 7,483,494	$ 10,021,969	60%	34%
MOUNJARO	$ 387,451	$ 2,387,336	$ 5,617,855	$ 9,534,869	191%	70%
ZEPBOUND		$ 671,304	$ 3,402,119	$ 8,481,920	n/a	149%
TRULICITY	$ 14,773,895	$ 12,268,971	$ 5,682,786	$ 3,190,372		
RYBELSUS	$ 1,510,641	$ 1,700,076	$ 1,486,767	$ 1,232,670		
SAXENDA	$ 1,476,738	$ 215,638	$ 234,597	$ 59,020		
VICTOZA 2-PAK	$ 436,878	$ 331,822	$ 19,336	$ 1,596		
VICTOZA 3-PAK	$ 335,816	$ 171,224	$ 12,014	$ -		
(Average) Monthly Users						
GLP-1 Drugs	**2,322**	**2,707**	**3,440**	**3,937**	19%	14%
OZEMPIC	555	987	1,679	1,733	46%	3%
WEGOVY	152	272	473	600	58%	27%
MOUNJARO	34	179	412	698		
ZEPBOUND		55	268	638		
TRULICITY	1,276	1,003	463	258		
RYBELSUS	139	146	124	102		
SAXENDA	95	15	16	12		
VICTOZA 2-PAK	49	38	3	1		
VICTOZA 3-PAK	23	13	1			
Total Paid Amount	**$ 28,802,066**	**$ 37,591,754**	**$ 48,731,053**	**$ 57,929,460**	**26%**	**19%**
Total (Average) Monthly Use	**4,227**	**4,594**	**5,228**	**5,673**	**10%**	**9%**
Cost per Month of Treatment						
GLP-1 Drugs	**$ 984**	**$ 1,037**	**$ 1,082**	**$ 1,114**	4%	3%
OZEMPIC	$ 909	$ 982	$ 1,029	$ 1,031		
WEGOVY	$ 1,341	$ 1,322	$ 1,318	$ 1,392		
MOUNJARO	$ 952	$ 1,113	$ 1,136	$ 1,138		
ZEPBOUND		$ 1,022	$ 1,057	$ 1,107		
TRULICITY	$ 965	$ 1,019	$ 1,022	$ 1,030		
RYBELSUS	$ 906	$ 972	$ 997	$ 1,004		
SAXENDA	$ 1,294	$ 1,198	$ 1,228	$ 1,230		
VICTOZA 2-PAK	$ 749	$ 731	$ 586	$ 532		
VICTOZA 3-PAK	$ 1,226	$ 1,064	$ 707	$ -		

b) Has EOHHS applied for participation in the new CMS BALANCE Model?

Rhode Island Medicaid submitted a Notice of Intent (NOI) to explore participation in January 2026. The application window for state participation opened on March 9, 2026 and close on July

31, 2026. States may begin participation starting May 1, 2026, but must begin no later than December 2026.

c) How would this affect current costs and coverage?

Medicaid's Director of Pharmacy is working with CMS and the participating drug manufacturers to understand the impact of the state's participation. The model savings are set up as supplemental rebates and discounted prices; participating would result in significant rebates compared to the status quo. Given the lack of insight into current rebates attributed specifically to GLP-1s and finalization of prices once participating in the model, Medicaid is unable to provide a detailed fiscal analysis on the impact of participating.

d) What are the state or federal approval requirements for participation?

State participants must comply with the following legal, policy, operational, and system requirements to support the Balance model:

- Have, or obtain, the necessary authority for states to participate in the model, including CMS approval of a SPA to enter into a Supplemental Rebate Agreement(SRA);
- Establish a model drug access policy consistent with the CMS-manufacturer negotiated Medicaid Key Terms, or any CMS-approved variations;
- Ensure that applicable Medicaid plan policies align with model requirements for both FFS and Managed Care;
- Execute a CMS-authorized model SRA incorporating the CMS-manufacturer negotiated Medicaid Key Terms;
- Meet minimum requirements as specified in the State Agreement; and.
- Submit reports to CMS on model implementation and overall model operations, as required.

Please note, to participate in the model, coverage for obesity is required. See the Request for Application for more detail.[5]

Rhody Health Partners

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

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

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

2. **If FY 2026 or FY 2027 rates are different from the prior capitation rate included in the November 2025 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

[5] https://www.cms.gov/priorities/innovation/files/balance-state-medicaid-rfa.pdf

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

Rhody Health Options

3. **Please provide estimates for Rhody Health Options for FY 2026 and FY 2027. Please delineate those aspects of managed care programs not covered under a payment capitation system.**
    a. **Please provide the monthly capitated payment for the different groups enrolled in Rhody Health Options.**

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

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

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

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

    FIDE SNP is included in the monthly managed care enrollment report distributed by Medicaid and we will look to update the separate Gainwell reports.

5. **If FY 2026 or FY 2027 rates are different from the prior capitation rate included in the November 2025 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

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

Hospitals

1. **Please provide separate inpatient and outpatient estimates for hospital services in FY 2026 and FY 2027.**
    a. **Please provide an update on the Long-Term Behavioral Health Unit rate increase and any progress being made by the community hospitals in opening new units.**

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

2. **Please provide inpatient and outpatient days from FY 2025 to date. Also, due to the inherent lag please provide final inpatient and outpatient hospital days by month going back to FY 2019.**

    These data are available in the model provided to the conferees (historical data are retained in file, within hidden rows).

3. **What is the projected DSH allotment over the next several federal fiscal years? Please cite the source.**

See **Hospitals – DSH** section of testimony

4. **Please provide an update to the Hospital State-Directed Payment Program, including any changes to assumptions about Medicaid match rates and how changes in HR 1 impact this payment for FY 2026 and FY 2027?**
    a. **Please provide an update on if the plan included in the FY 2026 enacted budget has received federal approval yet. If not, what is the impact on the program?**

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

    Total SDP Appropriation:

    - For SFY 2026, the November CEC forecast of $331.3 million in all funds financing is consistent with the enacted budget. This includes $324.7 million for payments to hospitals and $6.6 million for the premium tax paid by the MCOs. While consistent with the enacted budget, this represents a shift of $0.6 million from payments to hospitals to the MCO tax.
    - For FY 2027, the May CEC forecast equates the enacted all funds amount from the previous fiscal year ($331.3 million), inclusive of tax liability, and calculates the GR amount by applying the FFY 2027 federal Medicaid match rates and utilization mix across eligibility groups. This calculation produces a GR appropriation of $98.8 million, a reduction of $0.7 million from enacted.

    Determination of Medicaid Matching Rates:

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

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

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

5. **For the phase-down of the 6% provider tax threshold to 3.5% by FY 2032 for expansion states, including Rhode Island, please provide the cumulative revenue impact by fiscal year and, if possible, by hospital or hospital network. Please provide any relevant updated federal guidelines.**

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

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

Pharmacy

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

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

Medicaid Expansion

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

   See **Expansion** section of testimony.

2. **If the FY 2026 or FY 2027 capitation rates are different from the November 2025 estimate, please document the change according to contributing factors such as medical expense trends, risk/claims adjustment assumptions, and administrative costs.**

   See the **Expansion** section of testimony.

   The three adjustments below were incorporated into FY 2026 MCO contracts in Amendment 20. Any FY 2027 impact is captured within the draft rates used for the May CEC.

   - *Primary Care Assessment.* A $4.15 PMPM add was included into capitation related to the enacted Primary Care Assessment.
   - *FQHC Rate Adjustment for WellOne*. The FQHC submitted a rate review request of which the state granted a rate increase dating back to state fiscal year 2025. Inflation was recalculated for FY 2026 applying the applicable increase to the updated base.

- *SUD Residential Inflationary Adjustment*. Inflation of select procedure codes dictated by our State Plan was not included within the FY 2026 rates and was updated in Amendment 20. Unamended FY 2026 rates were previously consistent with the OHIC Rate Review. This inflation is currently requested to be removed in SFY 2027 due to inclusion of these rates in the OHIC Rate Review.

Other Medical Services

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

   See **Other Services** section of testimony.

2. **Please provide the methodology that calculates the projected Medicare Part A and B premium costs in FY 2026 and FY 2027.**

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

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

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

   See **Other Services** section of testimony.

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

   See **Other Services** section of testimony.

   For purposes of testimony, BHDDH Medical Services includes payments to behavioral health providers for certain clients not enrolled in managed care. Most of the incurred costs are for aged, blind, and disabled Duals, but it will also include some spending on behalf of some children with special health care needs remaining in FFS. Spending on these providers for Expansion-eligible clients or MAGI-based children and families would fall under Expansion FFS or Core FFS.

   BHDDH Medical Services included spending on IHH/ACT at community mental health organizations (CMHO), but with the implementation of CCBHC Demonstration, Medicaid is differentiating between CCBHC services and non-CCBHC services.

The non-CCBHC that Medicaid has still designated as "BHDDH Medical Services" include any remaining IHH and ACT services at EBCAP and Elwynn, but approximately 90% of the remaining dollars are for MHPRR services for those not enrolled in managed care. For the appropriate funding sources, the following types of providers are mapped to the "BHDDH Medical Services" categorization.

PR_TYP_CDE	PR_TYP_DSC
060	Substance Abuse Rehab
061	CMHC/Rehab Option
066	BHDDH Behavioral Health Group
108	Centers of Excellence
109	Peer Recovery Services
123	CCBHC

4. **What are the state-only costs in FY 2026 and FY 2027?**

   State-only costs are shown below.

Budget Line	Description	FY 2026	FY 2027
Managed Care	Cover all Kids	$20,000,000	$15,000,000
Managed Care	Abortion Coverage	$1,000,000	$1,000,000

5. **Please provide an update on the Program Integrity initiative and projected savings assumed.**

   See **FY 2026 Budget Initiatives** section of testimony.

Behavioral Health

1. **Please provide an update on the expenses for Certified Community Behavioral Health Clinics (CCBHC) by program.**
   a. **Please include any information on third-party liability billings and payment collections.**

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

   Medicaid estimates $150.2 million in FY 2026, an increase of $7.8 million from November 2025 Caseload. This increase is due to the budgeting for anticipated quality bonus payments for FY 2026 and FY 2027. Subject to appropriations, the state can make payments up to 5.0% of underlying Medicaid CCBHC payments, assuming the CCBHC meet the quality payment benchmarks prospectively set by the SAMHSA and/or the State. For purposes of the revised forecast, EOHHS has included quality bonus payments equivalent. The payment associated with

CY 2025 is anticipated to be made in second half of FY 2027 but was included in the FY 2026 as we anticipate accruing—subject to appropriation—for the future liability.

Overall, the enhanced FMAP provides $15.2 million GR savings in FY 2026. For FY 2027, Medicaid estimates $159.6 million, an increase of $9.4 million compared to the revised estimate for FY 2026. This includes a Quality Bonus Payment of $4.0 million associated with CY2025 activities, to be awarded sometime in early CY 2027 (i.e., Q3 or Q4 of SFY 2027). Given uncertainty around performance and total amount of award, it is unlikely that EOHHS will accrue for this in the current fiscal year. The enhanced FMAP will provide $16.2 million GR savings in FY 2027.

With respect to TPL, Medicaid is the payer of last resort; however, due to monthly PPS-2 payments that greatly exceed commercial reimbursements, EOHHS pays the full PPS-2 rate to the CCBHC and retroactively recoupments for any payments collected from commercial payers for Medicaid clients with TPL. Medicaid anticipates continuing this retroactive recoupment through at least end of DY2 (September 30, 2026) with $3.0 million in collections assumed in SFY 2026 and SFY 2027.

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

	SFY 2025:	SFY 2026:			SFY 2027:			
	Final	Nov CEC	Current	Surplus/ (Deficit)	Nov CEC	Current	Surplus/ (Deficit)	FY26 → FY27
Managed Care								
RC Core	$ 15.473.478	$ 21.438.674	$ 20.137.385	$1.3 M	$ 22.853.187	$ 22.478.406	$0.4 M	$2.3 M
RC CSHCN	$ 3,939,598	6,104,508	5,442,221	0.7 M	6,357,745	5,759,853	0.6 M	0.3 M
RHP	28,991,308	38,094,352	39,591,264	(1.5 M)	41,058,958	42,701,337	(1.6 M)	3.1 M
Expansion	22,825,747	31,330,970	31,146,932	0.2 M	30,821,127	32,690,965	(1.9 M)	1.5 M
RHO II	0	10,070,368	10,094,012	(0.0 M)	20,938,541	21,675,437	(0.7 M)	11.6 M
Subtotal	$ 71,230,130	$ 107,038,873	$ 106,411,815	0.6 M	$ 122,029,558	$ 125,305,998	(3.3 M)	18.9 M
Fee For Service								
Other Services	$ 34,885,072	$ 35,449,856	$ 39,783,743	($4.3 M)	$ 31,944,160	$ 29,784,519	$2.2 M	($10.0 M)
Managed Care	679,773	800,000	2,278,993	(1.5 M)	800,000	2,382,688	(1.6 M)	0.1 M
Expansion	1,439,594	2,100,000	1,045,046	1.1 M	2,100,000	1,092,596	1.0 M	0.0 M
TPL Collections	(2,100,000)	(3,000,000)	(3,000,000)	0.0 M	(3,000,000)	(3,000,000)	0.0 M	0.0 M
Subtotal	$ 32,785,072	$ 35,349,856	$ 40,107,783	(4.8 M)	$ 31,844,160	$ 30,259,802	1.6 M	(9.8 M)
Quality Payment			3,669,012	(3.7 M)	3,513,446	3,984,515	(0.5 M)	0.3 M
Grand Total	**104,015,202**	**142,388,729**	**150,188,610**	**(7.8 M)**	**157,387,164**	**159,550,316**	**(2.2 M)**	**9.4 M**
Additional GR Relief		***13,990,176***	***15,150,767***		***15,981,439***	***16,148,451***		1.0 M

2. **Please provide enrollment and costs expected to be incurred in FY 2026 and FY 2027, for the following programs and their relationship with the CCBHC payments. Please indicate the costs to programs individually.**
    a. **MHPRR**
    b. **IHH, ACT, OTP Programs**
    c. **Behavioral Health Link Program**
    d. **Centers of Excellence**
    e. **Peer Supports Programs**
    f. **Housing Stabilization Program**

Please note that Medicaid added "CCBHC" to the list of individual programs included in response. The exhibit below shows expenditures by program in FY 2024 and FY 2025 (by quarter)—along with estimates for FY 2026 and FY 2027. The OHIC rate review and the CCBHC program had a significant impact on spending in FY 2025.

Please note that the prior period expenditures reflect actual provider payments and do not include any adjustment for IBNR or missing data; nor do these expenditures include the additional administrative costs paid to the managed care plans and included in the overall cost of the program.

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

Significantly, between FY 2024 and FY 2026 with the full annualization of both the OHIC-mandated rate increases for behavioral health providers and implementation of the CCBHC demonstration program, spending for specific BH providers supporting the state's BH safety net has increased by $115 million, over 50%—from $228.0 million in FY 2024 to an estimated $344.4 million in FY 2027.

Please note that for CCBHC spending in Table 2 below reflects actual or estimates of direct provider payments for Medicaid eligible clients. Not included are quality payments less TPL collections or the associated managed care related (i.e., actual PMPM included in premiums paid to the MCOs that is inclusive of administrative component and risk margin and directly tied to actual enrollment).

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

Paid		FY 2024	FY 2025	FY 2026 Est.	FY 2027 Est.
CCBHC	CCBHC PPS-2 (T1041)		$96,428,182	$131,284,027	$143,566,128
	Assertive Community Treatment (H0040)	$16,227,665	$3,903,957		
	Integrated Health Home (H0037)	$28,682,052	$6,963,159		
	Housing_Stabilization (H0044)	$388,263	$111,547		
	Peer Support_Program(H0038)	$155,849	$25,990		
	Other BH/SUD Services	$11,156,764	$2,681,696		
CCBHC Total		**$56,610,593**	**$110,114,531**	**$131,284,027**	**$143,566,128**
OHIC	Assertive Community Treatment (H0040)	$1,542,398	$1,815,992	$1,833,801	
	Integrated Health Home (H0037)	$2,921,767	$3,158,025	$2,960,654	
	BH Link (S9485)	$928,872	$1,118,087	$1,535,232	$1,573,613
	MHPRR (H0019)	$18,306,046	$25,981,848	$27,131,057	$27,809,333
	Opioid Treatment Program (H0037 - Provider Type 060)	$585,276	$1,023,742	$1,037,392	$1,063,327
	Peer Support_Program(H0038)	$409,772	$245,826	$418,529	$428,992
	Other BH/SUD Services	$135,554,396	$150,566,623	$149,472,823	$153,209,644
OHIC Total		**$160,248,527**	**$183,910,143**	**$184,389,488**	**$184,084,909**
Other	Housing_Stabilization (H0044)	$487,894	$1,542,874	$2,061,468	$2,113,005
	Other BH/SUD Services	$10,788,084	$14,473,835	$14,265,096	$14,621,723
Other Total		**$11,275,978**	**$16,016,708**	**$16,326,564**	**$16,734,728**
Grand Total		**$228,135,098**	**$310,041,382**	**$332,000,079**	**$344,385,765**
% Managed Care		**85.76%**	**78.10%**	78.00%	78.00%