



Federal Compliance Advisory Group

Federal Policy Changes Report: Findings, Options, and Considerations to Become Compliant with Federal Changes

Medicaid Program, Supplemental Nutrition
Assistance Program, and Health
Insurance Marketplace

October 30, 2025

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EXECUTIVE SUMMARY

Background on House Resolution-1

On July 4, 2025, President Trump signed a budget reconciliation bill, called House Resolution-1 (H.R.-1), which became Public Law 119-21. A reconciliation bill can pass with a simple majority vote and thus bypasses the filibuster rules in the Senate and makes changes to federal spending. H.R.-1 makes sweeping changes to federal funding across various programs that have significant implications for states. H.R.-1 enacted several policy changes affecting health and human services programs including but not limited to the Medicaid, Supplemental Nutrition Assistance Program (SNAP), and Health Insurance Marketplace.

Figure 1: H.R.-1 Impacts on Health and Human Services Programs

IMPACT AREA	NATIONAL ESTIMATES
Federal Medicaid Spending	The Kaiser Family Foundation (KFF) estimates that federal spending on Medicaid will decrease by \$911 billion over 10 years. ¹
Health Insurance Coverage	CBO estimates that 11.8 million people will lose health insurance over 10 years, including 1.4 million people without proper immigration status that will not be covered by programs solely funded by states. ²
Federal Food Assistance	The CBO estimates that H.R. 1's SNAP provisions will result in \$185.9 billion less in federal spending over 10 years. ³

Notes:

1. [The Impact of H.R. 1 on Two Medicaid Eligibility Rules](#)
2. [Estimated Effects on the Number of Uninsured People in 2034 Resulting from Policies Incorporated within CBO's Baseline Projections and H.R. 1](#)
3. [Supplemental Nutrition Assistance Program \(SNAP\) and Related Nutrition Programs in P.L. 119-21: An Overview](#)

Federal Compliance Advisory Group

The Rhode Island General Assembly passed a FY26 budget requirement for EOHHS related to the federal budget. EOHHS, under the direction of the Governor, was instructed to convene an advisory working group to assist in the review and analysis of potential impacts of any federal actions related to Medicaid programs. The advisory working group was to include, at a minimum, the Secretary of Health and Human Services, Director of the Office of Management and Budget, and Designees from State agencies, businesses, healthcare, public sector unions, and advocates. In response, the Secretary of Health and Human Services appointed 38 members to the Federal Compliance Advisory Group (FCAG) on Tuesday, July 29, 2025.

Figure 2: FCAG Sectors Represented by Membership



As a public meeting, the FCAG met a total of four times prior to submission of this report with the following areas of focus: (1) July—Kickoff, (2) August—SNAP, (3) September—Medicaid, and (4) October—Health Insurance Marketplace. A fifth meeting to review what was submitted in this report and to evaluate the process of the FCAG is scheduled for early November.

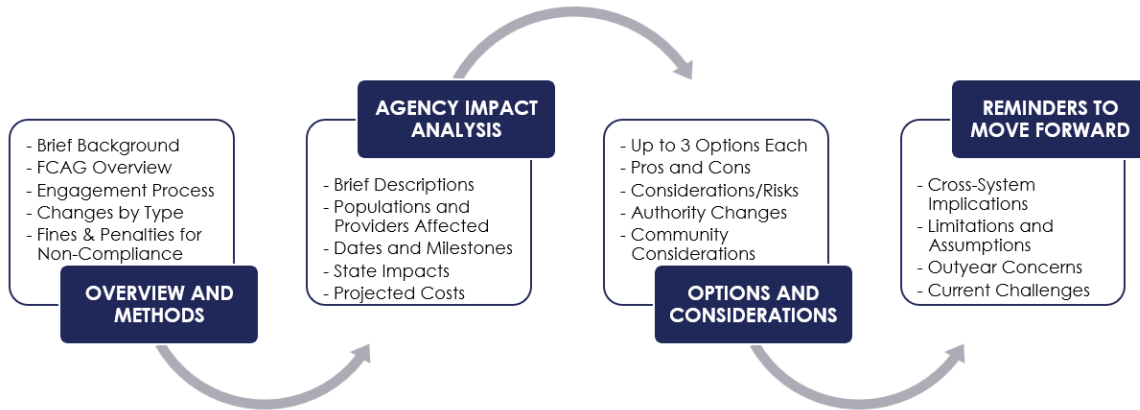
Figure 3: FCAG Meeting Materials

MEETING	KEY TOPIC(S) COVERED	MATERIALS
July 29, 2025	H.R.-1 and Rhode Island's Fiscal Climate	Slide Deck ; OMB Deck
August 19, 2025	SNAP Changes	Slide Deck
September 9, 2025	Medicaid Changes	Slide Deck
October 7, 2025	Health Insurance Marketplace Changes	Slide Deck
November 5, 2025	FCAG Report and Process Evaluation	In Development

Report Components

No later than October 31, 2025, EOHHS was directed to provide a report from the FCAG to the Governor, Speaker of the House, and President of the Senate that contains the projected impacts of Federal policy changes and options for compliance for Rhode Island. This includes options for Governor or General Assembly consideration that may be needed to address federal funding changes that specifically impact Rhode Island's Medicaid program. The Secretary, in partnership with the Governor's Office, OMB, and the FCAG expanded the review and report to include SNAP and the Health Insurance Marketplace given the breadth of changes affecting these core health and human services programs. As such, the methods, impacts, options to consider, and reminders to move forward across these programs are included in this report.

Figure 4: Summary of Report Contents



Overall Findings

Upon Secretariat and FCAG review of H.R.-1, significant costs are projected for the State based on the federal policy changes affecting Medicaid, SNAP, and the Health Insurance Marketplace. Additionally, several other notable impacts on partners, providers, and beneficiaries were identified through agency review and community feedback. Lastly, several considerations for federal compliance were identified for Rhode Island across the various categories of changes.

Cost Projections Summary

The cost projections, both on impact of, and for coming into compliance with the Federal policy changes is significant for Rhode Island. Upon initial analysis (some without federal guidance) by the agencies, costs by program were calculated for the next several years and beyond. Costs related to other options to come into compliance are summarized in the Agency-Specific Sections of this report. All costs projected and represented in the figures within this report reflect millions of dollars.

Figure 5: Federal Policy Change Cost Projections by Program¹

FUNDING SOURCE IMPACT TYPE	FY26 IMPACT (\$ Millions)	FY27 IMPACT (\$ Millions)	OUTYEAR IMPACT ² (\$ Millions)	STATUS
EOHHS: Medicaid Program (H.R.-1 Changes)				
All Funds	\$3.5	(\$103.8)	(\$315.3)	Enacted
General Revenue	\$1.2	(\$23.7)	(\$40.4)	
Federal Funds	\$2.3	(\$80.1)	(\$275.0)	
DHS: Supplemental Nutrition Assistance Program (H.R.-1 Changes)				
All Funds	(\$26.9)	(\$3.0)	(\$1.3)	Enacted
General Revenue	\$0.6	\$16.5	\$23.2	
Federal Funds	(\$27.5)	(\$19.5)	(24.5)	
HSRI: Health Insurance Marketplace (H.R.-1 and CMS Rule Changes)				
All Funds	\$2.2	\$6.7	\$10.6	Enacted
General Revenue ³	\$1.9	\$6.0	\$9.6	
Federal Funds	\$0.3	\$0.7	\$1.0	

Notes:

1. Fiscal year impacts are presented from the perspective of the state budget. A positive amount in General Revenue reflects a new state expenditure or required investment, while a negative amount in Federal Funds reflects a reduction in available federal revenue. The All Funds total represents the net fiscal impact across both funding sources.
2. Represents FY28 but is subject to change due to Federal Mid-Term Elections.
3. Includes General Revenue and Restricted Receipt.

Other Notable Impacts

In review of cost and impact analysis, public comment, and compliance options, several other notable impacts have been identified. These impacts range from concerns about uncompensated care, specific geographic impacts, safety net resources, and increased errors resulting from change implementation.

Key Considerations for Compliance

Many specific federal policy changes can be grouped into common types of changes with similar impacts to be considered. These categories of changes are comprised of a varying number of specific policy changes. For each category, there are several options for Rhode Island to explore. Each option is presented with a brief description, advantages, disadvantages, implementation risks, other key considerations, authority-related changes, and community feedback.

Figure 6: Summary of Options for Compliance by Category

PROGRAM	CATEGORY OF CHANGES	# POLICIES	# OPTIONS
Medicaid	Eligibility and Benefits	9	5
	Finance Changes	7	5
	Program Integrity	4	0
	Delivery System Reform	2	0
	Low-Impact H.R.-1 Provisions	8 ¹	0
SNAP	Eligibility	3	7
	Benefits	1	2
	Finance Changes	3	6
	No Impact H.R.-1 Provisions	1	0
Health Insurance Marketplace	Affordability: Broad-Based	1	3
	Affordability: Specific Populations	3	2
	Enrollment Barriers	4	4
	Operational Challenges	Many	0
	Low-Impact H.R.-1 Provisions	1 ¹	0

Note:

1. These changes are in the relevant categories but will not be addressed in detail.

Staying Engaged and Educated

EOHHS launched a webpage specifically for the FCAG and federal policy changes on the EOHHS website that includes key source documents from national partners. Additionally, a landing page for beneficiaries about changes is available on the Stay Covered website—and links to a variety of other pages at DHS and HSRI for more information. To stay engaged and educated on the latest changes, an email address was created and remains available to add individuals to the Interested Parties list, to send in questions that are answered and updated on the Frequently Asked Questions page, and to request a presentation on this work at an existing partner convening.

Figure 7: Key Links and Resources

RESOURCE	LINK
FCAG Webpage	https://eohhs.ri.gov/initiatives/federal-compliance-advisory-group
FCAG Public Notices	https://bit.ly/FederalComplianceAdvisoryGroup
Medicaid Changes	https://staycovered.ri.gov/about-medicaid/updates-news
SNAP Changes	<ol style="list-style-type: none"> 1. https://dhs.ri.gov/programs-and-services/supplemental-nutrition-assistance-program-snap 2. https://staycovered.ri.gov/updates-news/snap-updates
Marketplace Changes	https://healthsourceri.com/stayconnected/
Stay Covered RI	https://staycovered.ri.gov/
FCAG Inquiries	OHHS.FederalPolicyTracking@ohhs.ri.gov

INTRODUCTION AND OVERVIEW

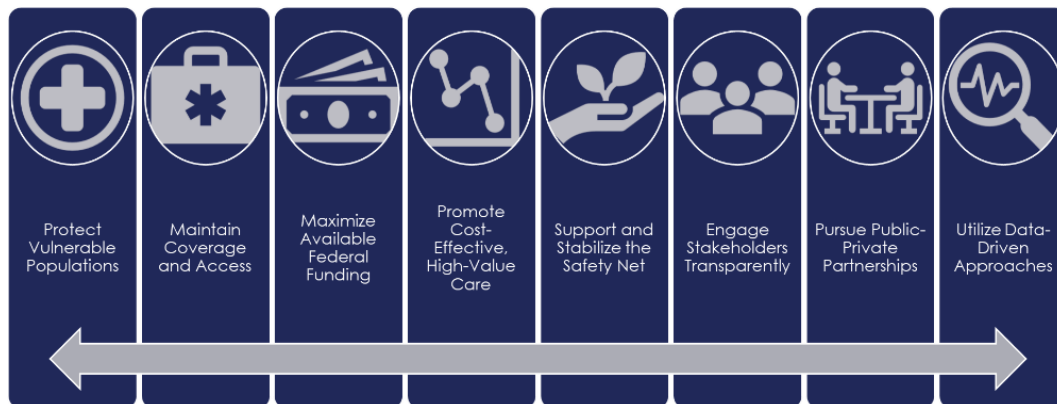
Secretary's Directive

Prior to the passage of H.R.-1, the Secretary of Health and Human Services assigned internal staff to track, assess, and monitor federal policy changes occurring through Executive Orders, Agency Directives, and related guidance changes—including challenges in court. Upon passage of H.R.-1, the EOHHS Secretary determined the need to expand the review of changes beyond just Medicaid and included both SNAP and the Health Insurance Marketplace through partnerships with DHS and HSRI. At this time, EOHHS assembled an internal Steering Committee to staff, prepare for, and facilitate the FCAG—including development of this report and engagement opportunities.

Guiding Principles

The FCAG adopted guiding principles to guide appointed member and community feedback efforts. Having established guiding principles assisted with framing discussions, maintaining a collective focus on key considerations, and developing critical questions for facilitating public comment during the three gallery walk exercises on major federal policy changes by program. These guiding principles represent eight approaches to balance in Rhode Island when analyzing impacts from and reviewing potential options for compliance with the Federal policy changes.

Figure 8: FCAG Guiding Principles



Community and Staff Engagement Processes

Community and staff engagement were put at the center of FCAG processes. All FCAG meetings were held as public advisory meetings. Each meeting included public comment—with the latter three meetings also including both in-person and virtual gallery walks during which participants reviewed policy materials and added comments or ideas to help obtain potential solutions from community partners.

Figure 9: Gallery Walk¹ Facilitation Questions

KEY PROMPTS FOR ADVISORY GROUP AND PUBLIC COMMENT	
<input type="checkbox"/>	What should we consider for a potential safety net when this change takes effect?
<input type="checkbox"/>	How could we leverage community assets or build capacity to navigate the change?
<input type="checkbox"/>	What other creative budget savings or revenue generating ideas should we consider together?
<input type="checkbox"/>	Which populations or communities must we prioritize for potential supports and outreach?
<input type="checkbox"/>	What other system, technology, people, or process changes should we consider?

Note:

1. Gallery Walks are interactive feedback sessions where participants review posted materials and share written comments or ideas. They promote engagement and collective problem-solving. FCAG used posters and sticky notes for in-person sessions and Mural Board for virtual participation.

Read-ahead materials were sent prior to each FCAG meeting and posted online. Further, for each set of program changes—Medicaid, SNAP, and Health Insurance Marketplace, a call for community impact statements and creative proposals was issued through the release of three surveys. Each survey was made available in English, Spanish, and Portuguese. A Speaker's Bureau was also staffed for this effort, and presentations were made widely available. Lastly, staff brainstorm sessions and/or staff surveys were held across the three agencies affected by these changes—EOHHS/Medicaid, DHS, and HSRI. A full list of community-generated themes can be found in the Appendices.

Figure 10: Community Engagement Outcomes

TYPE	DESCRIPTION	RESPONSES
Gallery Walks	Virtual Gallery Walk Comments—All Meetings	72
	In-Person Gallery Walk Comments—All Meetings	285
Surveys	SNAP Survey—All Languages	15
	Medicaid Survey—All Languages	7
	Health Insurance Marketplace Survey—All Languages	7
	State Agency Staff Survey—All Agencies	29
Presentations	Speaker's Bureau Presentations—All Audiences	17
Meetings	FCAG Attendees—All Meetings (Online and Virtual)	636
Email	FCAG Interested Parties—All Members	362

Changes At-A-Glance

Medicaid Program Changes

H.R.-1 included a total of 22 federal policy changes affecting the Medicaid program. For Rhode Island, these policy changes apply locally. Most of the eligibility and benefit changes will impact the Medicaid Expansion population (low-income, non-elderly adults with no children with incomes up to 138% of Federal Poverty Level). Details are subject to change based on guidance provided by CMS. The remaining policy changes group into four main categories:

- **Eligibility and Benefits Changes**
- **Finance Changes**
- **Program Integrity Changes**
- **Delivery System Reform Changes**

The impact levels listed below, low – medium – high, were assigned generally based on the level of complexity for implementation, as well as the relative impact on beneficiaries, providers, and state expenditures.

Figure 11: Medicaid Changes At-A-Glance

Section No.	Short Name	Effective Date	Required Changes Identified					Impact Level
			State Authority ¹	Systems & Tech	Agency Operations	Overall Budget	Consumer Behavior	
CATEGORY 1: ELIGIBILITY AND BENEFITS								
71101	MSP Streamlining Rule	7/2025	X					Low
71102	Medicaid/CHIP/BHP Streamlining Rule	7/2025	X					Low
71107	Eligibility Redeterminations	12/2026	X	X	X	X	X	Med
71108	Home Equity Limits	1/2028	X	X		X		Low
71109	Alien Medicaid Eligibility	10/2026	X	X	X	X	X	High
71112	Retroactive Coverage	1/2027	X	X	X	X	X	High
71113	Disqualified Entity Payment Ban	7/2025		X	X	X	X	Med
71119	Community Engagement Reqs.	12/2026	X	X	X	X	X	High
71121	HCBS Coverage and Eligibility (Optional)	7/2028	X	X	X	X	X	Low
CATEGORY 2: FINANCE CHANGES								
71110	Emergency Medicaid FMAP CAP	10/2026						Low
71114	Expansion FMAP Incentive Sunset	1/2026						Low
71115	Provider Tax Uniformity and Caps	7/2025	X			X		High
71116	State-Directed Payment Standards	7/2025	X		X	X		High

Section No.	Short Name	Effective Date	Required Changes Identified					Impact Level
			State Authority ¹	Systems & Tech	Agency Operations	Overall Budget	Consumer Behavior	
71117	Provider Tax Waivers	7/2025	X			X		Low
71118	Demonstration Budget Neutrality	1/2027	X					High
71120	Expansion Population Cost-Sharing	10/2028	X	X	X	X	X	High
CATEGORY 3: PROGRAM INTEGRITY CHANGES								
71103	Duplicate Enrollment Reduction	10/2029	X	X				Low
71104	Deceased Beneficiary Removal	1/2027	X	X				Med
71105	Deceased and Expelled Provider Removal	1/2028	X	X				Med
71106	Erroneous Payment Recovery	10/2029		X	X	X		Med
CATEGORY 4: DELIVERY SYSTEM REFORM CHANGES								
71111	LTC Staffing Standards	7/2025						Low
71401	Rural Access to Care	12/2025						None

Note:

1. State authority is any State Plan Amendment (SPA), state regulation, or state legislative action required.

Medicaid Repercussions and Risks of Non-Compliance

There are no defined repercussions noted in the sections of H.R.-1. Non-compliance with sections would fall under existing non-compliance repercussions or new repercussions outlined through federal regulations. Generally, non-compliance with CMS regulations results in corrective action plans (CAPs), holds on authority requests (e.g., state plan amendments), and ultimately the withholding or return of state Federal Medicaid Assistance Percentage (FMAP).

Eligibility determinations not aligned with the federal Department of Health & Human Services (HHS) rules count as "erroneous excess payment" under the CMS quality reviews. Historically, states were not required to return significant funds resulting from Payment Error Rate Measurement (PERM) error rate findings. Under H.R.-1, eligibility decisions and payments not aligned with new HHS rules will count as "erroneous excess payment" with quality reviews beginning October 1, 2029. Any audit conducted by the United States Secretary of Health and Human Services can count towards the 3% error rate allowable under current statute and regulation, and, at the Secretary's option, audits conducted by the State. US HHS may reduce federal financial participation to states for identified improper payment errors related to payments made for ineligible individuals and overpayments made for eligible individuals and expands the definition of improper payments to include payments where insufficient information is available to confirm eligibility.

Supplemental Nutrition Assistance Program (SNAP) Changes

H.R.-1 included a total of eight policy changes affecting the Supplemental Nutrition Assistance Program (SNAP). For Rhode Island, only seven of these eight policy changes apply as Section 10104: Internet Expense Restrictions has not been implemented locally. Of the remaining policy changes, they group into three main categories:

- **Eligibility Changes**
- **Benefit Changes**
- **Finance Changes**

Figure 12: SNAP Changes At-A-Glance

Section No.	Short Name	Effective Date	Required Changes Identified					Effort Level
			State Authority	Systems & Tech	Agency Operations	Overall Budget	Consumer Behavior	
CATEGORY 1: ELIGIBILITY CHANGES								
10102	Work Requirements	10/2025	X	X			X	Medium
10103	SUA Allowances	10/2025	X	X	X		X	High
10108	Non-Citizen Eligibility	10/2025	X	X	X		X	High
CATEGORY 2: BENEFIT CHANGES								
10101	Thrifty Food Plan	10/2027	X				X	Low
CATEGORY 3: FINANCE CHANGES								
10105	Error Rate Matching	10/2027		X	X	X	X	High
10106	Administrative Cost Sharing	10/2026			X	X		Medium
10107	SNAP-Ed Grant	10/2025				X	X	Low
CATEGORY 4: LOW-IMPACT CHANGES								
10104	Internet Expenses	N/A	N/A	N/A	N/A	N/A	N/A	None

SNAP Repercussions and Risks of Non-Compliance

Eligibility decisions not aligned with new FNS rules also count as “error cases” in quality reviews. Each “error case” contributes toward the 6% PER maximum threshold and the new provisions that can increase error rates upon implementation include:

- Thrifty Food Plan COLA adjustment;
- SUA restricted to elderly/disabled and Heat + Eat removal;
- ABAWD expansions (work requirements); and
- Immigration-related caseload reductions.

For the Payment Error Rate (PER), if two consecutive years are above the national PER average there is a \$2.5M penalty assessed to Rhode Island for which 50% is to be reinvested in program and 50% paid to FNS. Additional state cost-share penalties will begin on October 1, 2027 (FFY28). States with a PER above 6% must contribute state funds toward SNAP benefit issuance. Penalties are based on the PER from three years earlier, starting October 1, 2028 (e.g., FY26 for FY29). In RI, each 5-percentage-point increase equates to roughly \$17.1 million in added state cost. Exception (also known as the Alaska exception): If the FFY25 PER x 1.5 exceeds 20%, implementation is delayed until FFY29. FFY26 PER x 1.5 exceeds 20% again, implementation is delayed until FFY30.

Health Insurance Marketplace Changes

H.R.-1 included a total of seven policy changes affecting Health Insurance Marketplaces. For Rhode Island, all seven of these policy changes apply locally with six medium or high impact changes listed in the table below and one lower impact change, health savings account (HSA) eligibility for bronze plans, listed in HSRI's summary of all federal changes. Additionally, the lack of extension of enhanced Advanced Premium Tax Credits (APTC), and some items from the Marketplace Integrity and Affordability Rule have significant impacts. The federal policy changes that affect Rhode Island can be grouped into four main categories:

- **Affordability Changes-Broad Based**
- **Affordability Changes-Specific Populations**
- **Enrollment Barriers**
- **Operational Challenges**

Figure 13: Health Insurance Marketplace Changes At-A-Glance

Section No.	Short Name	Effective Date	Required Changes Identified					Effort Level
			State Authority	Systems & Tech	Agency Operations	Overall Budget	Consumer Behavior	
CATEGORY 1: AFFORDABILITY CHANGES (BROAD-BASED)								
N/A	Expiring Enhanced APTC	1/2026		X	X	X	X	High
CATEGORY 2: AFFORDABILITY CHANGES (SPECIFIC POPULATIONS)								
71302	No APTC 5-Year Bar	1/2026		X	X	X	X	Medium
71301	No APTC Immigration	1/2027		X	X	X	X	Medium
71119	No APTC Work Requirements	1/2027		X	X			Medium
CATEGORY 3: ENROLLMENT BARRIERS								
71304 / Rule	No APTC for income SEPs	10/2025 1/2026		X	X		X	Low
Rule	Short Open Enrollment	OE 2027		X	X	X	X	High
71303	Pre-Enrollment Verification	1/2028		X	X	X	X	High
71305	No limit APTC Recapture	1/2026			X		X	Low
CATEGORY 4: OPERATIONAL CHALLENGES								
Various	Various	Various		X	X	X		Medium
CATEGORY 5: LOW-IMPACT CHANGES								
71307	Expanded HSA Compatibility	1/2026						None

Repercussions and Risks of Non-Compliance

H.R.-1 has no specific repercussions for Affordable Care Act (ACA) Health Insurance Marketplaces for non-compliance. Broadly, ACA Marketplaces are subject to audits and annual reviews. Findings of non-compliance are a risk and addressed during those routine activities.

MEDICAID PROGRAM

Overview of Approach

The impact analysis for each section is primarily based on the State's interpretation of H.R.-1, any available CMS guidance as of October 20, 2025, and relevant Medicaid enrollment and price assumptions as of September 2025. Given the absence of federal guidance, several assumptions were made to determine the population and fiscal impacts. All population and fiscal impact estimates are subject to change based on federal guidance and changes to overall enrollment and expenditures adopted at the biannual Caseload Estimating Conference. Each section below summarizes the following:

- The current state of the topic or program being changed under H.R.-1;
- What is changing under H.R.-1;
- Anticipated populations, providers, and partners directly affected, such as through potential termination or who must take some action;
- Key effective and implementation dates; and
- Summary of direct and/or indirect state impacts, including impact on benefit spend and operations.

As Medicaid Enterprise System (MES) modernization (e.g., adoption of modular architectures, data infrastructures) to the Medicaid Management Information System (MMIS) moves forward, consideration of impact on the multi-vendor bids, scope of work, and implementation should be considered. Figure 14 summarizes all projected Medicaid costs: benefit expenditure impact, personnel resources required, operating information technology expenses required for system changes, contracted services required for technical support, and revenue impact.

Overarching Human Capital Resources Needs for Compliance

Systems and Project Management

Expanded project management capacity will be required to coordinate multi-system initiatives across the Medicaid Management Information System (MMIS) and the eligibility system. Several H.R.-1 initiatives will span multiple systems and business processes, requiring complex planning, design, development, testing, implementation, and integration within the timelines mandated by legislation and forthcoming CMS guidance. The systems team will also produce oversight reporting and outcome metrics for these initiatives. Several initiatives, like work requirements, increased frequency of redeterminations, and the addition of new external data sources, will operate across multiple systems and require ongoing coordination and management to support auditors, finance, and data resolution needs. Capacity may be met through a mix of permanent staff, contractors, consultants, or interagency support, depending on implementation timelines and fiscal guidance.

Customer Resolution and Eligibility Operations

Additional customer-resolution capacity (e.g., Human Services Policy and System Specialists) will be needed to reconcile issues between RI Bridges and the MMIS; manage all aspects of health plan enrollment and disenrollment; process requests for Medicare premium assistance; and research inquiries from providers such as nursing homes, assisted living, and home care agencies with applications pending over 90 days. Medicaid anticipates a direct workload increase for this team due to changes in eligibility processes—including work requirements, redeterminations every six months for the Medicaid Expansion population, and retroactivity for LTSS eligibility.

Finance and Federal Reporting

Additional capacity will be required to interpret and implement complex payment and tax-related changes, and to sustain enhanced federal reporting of enrollment and expenditures to EOHHS's federal partners. Several of the major H.R.-1 provisions directly affect Medicaid finances and payment structures. These functions will require specialized expertise in financial analysis, strategic planning, monitoring, and evaluation, which may be provided through a combination of in-house staff and contracted subject-matter experts.

Coordination and Stakeholder Management

Dedicated coordination capacity will be needed within the Medicaid Special Projects and Stakeholder Relations group to manage cross-agency implementation efforts and maintain alignment with federal partners and external stakeholders on all compliance-related initiatives.

Resource projections and associated cost assumptions are summarized in Figure 14.

Capacity may be fulfilled through a combination of permanent positions, temporary or contracted expertise, and interagency collaboration, aligned to implementation timelines and available fiscal resources.

Figure 14: Summary of Projected Medicaid Costs¹

Cost Type	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 1: ELIGIBILITY AND BENEFITS										
Benefits	(\$0.2)	(\$0.7)	(\$26.6)	(\$111.3)	(\$54.8)	(\$333.1)	(\$54.8)	(\$333.1)	(\$54.8)	(\$333.1)
Personnel			\$0.2	\$0.5	\$0.2	\$0.5	\$0.2	\$0.5	\$0.3	\$0.5
Operating (IT)	\$1.3	\$4.0	\$1.5	\$4.6						
Contracted Services	\$0.1	\$0.2	\$0.3	\$0.5	\$0.1	\$0.2	\$0.2	\$0.3	\$0.2	\$0.3
CATEGORY 2: FINANCE CHANGES										
Benefits					\$12.2	\$12.2	\$20.4	(\$2.0)	\$38.7	(\$3.3)
Personnel			\$0.2	\$0.4	\$0.2	\$0.4	\$0.2	\$0.4	\$0.2	\$0.4
Operating (IT)			\$0.0	\$0.1	\$0.8	\$2.6	\$0.2	\$0.7		
Contracted Services			\$0.3	\$0.6	\$0.3	\$0.6	\$0.3	\$0.6	\$0.3	\$0.7
Revenue Impact					\$12.2		\$31.9		\$60.3	
CATEGORY 3: PROGRAM INTEGRITY CHANGES										
Benefits										
Personnel			\$0.2	\$0.3	\$0.2	\$0.3	\$0.2	\$0.3	\$0.2	\$0.3
Operating (IT)			\$0.0	\$0.2	\$0.2	\$0.7	\$0.4	\$1.1	\$0.2	\$0.7
Contracted Services										
CATEGORY 4: DELIVERY SYSTEM REFORM CHANGES										
Benefits										
Personnel										
Operating (IT)										
Contracted Services										
TOTAL	\$1.2	\$3.5	(\$23.7)	(\$103.8)	(\$40.1)	(\$315.3)	(\$32.8)	(\$331.2)	\$(14.8)	(\$333.7)

Note:

1. Fiscal year impacts are presented from the perspective of the state budget. A positive amount in General Revenue reflects a new state expenditure or required investment. The All Funds total represents the net fiscal impact across both general revenue and federal funds. Positive numbers may also indicate lost state revenue.

Impact Analysis and Compliance Considerations

In this section, a summary of cost impacts by category and change is presented. This is followed by a description of the specific changes within the categorical type. Where applicable, options for compliance are presented related to the specific changes for Rhode Island to contemplate.

MEDICAID CATEGORY 1 – ELIGIBILITY AND BENEFITS

Figure 15: Summary of Benefit Impacts for Medicaid Category 1 Provisions

Section	(\$ Millions)										
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030		
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF	
CATEGORY 1: ELIGIBILITY AND BENEFITS CHANGES											
MSP Streamlining Rule											
Medicaid/CHIP/BHP Streamlining Rule											
Eligibility Redeterminations											
Home Equity Limits											
Alien Medicaid Eligibility			(\$21.6)	(\$61.6)	(\$28.8)	(\$82.1)	(\$28.8)	(\$82.1)	(\$28.8)	(\$82.1)	
Retroactive Coverage											
Disqualified Entity Payment Ban	(\$0.2)	(\$0.7)									
Community Engagement Requirements			(\$5.0)	(\$49.7)	(\$26.0)	(\$251.0)	(\$26.0)	(\$251.0)	(\$26.0)	(\$251.0)	
HCBS Coverage and Eligibility (Optional)											
TOTAL	(\$0.2)	(\$0.7)	(\$26.6)	(\$111.3)	(\$54.8)	(\$333.1)	(\$54.8)	(\$333.1)	(\$54.8)	(\$333.1)	

Section 71101: MSP Streamlining Rule

Program Description:

The Streamlining Medicaid, Medicare Savings Program (MSP) Eligibility Determination and Enrollment'' (88 Fed. Reg. 65230) final rule, published on September 21, 2023, aims to simplify the enrollment process for the program. It specifically established automatic MSP eligibility to all qualifying Medicare beneficiaries without requiring a separate state

application and required states to use Medicare Part D Low-Income Subsidy (LIS) information to determine MSP eligibility.

Program Change:

This section delays implementation, administration, and enforcement of CMS's eligibility and enrollment rule pertaining to dual eligibles effective July 4, 2025, through September 30, 2034. Only those provisions not yet in effect are subject to this delay.

Populations, Providers, and Partners Affected:

This delay impacts individuals who are eligible for the MSP (also known in RI as the Medicare Premium Payment Program). These individuals will not benefit from enhancements that would have made it easier to enroll, and consequently fewer people will be enrolled in MSP than would have enrolled if the regulation were not delayed. However, this delay does not affect the status quo; enrollment procedures will remain as they are currently rather than improving.

Effective Date and Key Milestones:

This change delays implementation of the CMS rule until September 30, 2034.

State Impacts:

- **Direct:** None.
- **Indirect:** As a result of the delay, Medicaid no longer needs to identify the resources for compliance.

Section 71102: Medicaid, CHIP, BHP Streamlining Rule

Program Description:

The Medicaid Program: Streamlining the Medicaid, Children's Health Insurance Program, and Basic Health Program Application, Eligibility Determination, Enrollment, and Renewal Processes (89 Fed. Reg. 22780) final rule, published on April 2, 2024, aims to simplify eligibility and enrollment processes. This rule aligns enrollment and renewal requirements for most individuals in Medicaid; establishes beneficiary protections related to returned mail; creates timeliness requirements for redeterminations of eligibility; makes transitions between programs easier; eliminates access barriers for children enrolled in CHIP by prohibiting premium lock-out periods, benefit limitations, and waiting periods; and modernizes recordkeeping requirements to ensure proper documentation of eligibility determinations.

Program Change:

Effective July 4, 2025, through September 30, 2034, prohibits HHS from implementing, administering, or enforcing the rule relating to eligibility and enrollment for Medicaid and CHIP (but does not affect Basic Health Programs). Only those provisions not yet in effect as of July 4, 2025, are subject to this delay.

Populations, Providers, and Partners Affected:

This delay impacts most Medicaid and CHIP beneficiaries as they will no longer benefit from the simplified enrollment processes that were required, but it does not affect the status quo.

Effective Date and Key Milestones:

This change delays implementation of the CMS rule until September 30, 2034.

State Impacts:

- **Direct:** None.
- **Indirect:** As a result of the delay, Medicaid no longer needs to identify the resources for compliance.

Section 71107: Eligibility Redeterminations

Program Description:

Medicaid currently reviews eligibility once per year. Redeterminations are conducted annually to determine if an individual is still eligible through income and other financial information or through a request to beneficiaries for the required information to verify eligibility.

Program Change:

H.R.-1 changes the frequency of redeterminations for the adult expansion population or those receiving minimum essential coverage through a waiver program to once every six months. Members of Tribes are not subject to the six-month eligibility check requirement.

Populations, Providers, and Partners Affected:

This change will impact approximately 84,000 adult expansion beneficiaries who will be required to undergo additional redeterminations. The anticipated impact from this policy is minimal as EOHHS currently uses Post-Eligibility Verification to check for income changes quarterly. Other requirements of HR-1, such as community engagement, may necessitate active rather than passive renewals. In that case, the impact of biannual redeterminations will be greater. However, because this interaction is captured under the community engagement discussion, EOHHS is not accounting for a major impact on enrollment for Section 71107.

Managed care organizations will experience increased administrative burden in their efforts to support outreach and reminders related to renewals and will likely face both administrative and financial challenges as member churn increases. Churn will also impact providers, whose patients will be more likely to experience coverage gaps that impact provider reimbursement.

Effective Date and Key Milestones:

This change is effective for redeterminations scheduled on or after December 31, 2026. Guidance on this provision is anticipated to be issued by December 31, 2025.

State Impacts:

- **Direct:** Will require Rhode Island Bridges system changes and additional staff for the Department of Human Services. It is not expected to have major impact on enrollment status, and subsequently expenditures, given the state already verifies income on a quarterly basis, apart from failure to complete the additional renewal requirements. No benefit impact is provided given significant efforts will be made to ensure administrative-related terminations do not occur. State regulations and likely SPA will need to be updated. There will be cross-agency impact on DHS and HSRI.
- **Indirect:** It is possible that an increase in churn occurs from procedural disenrollments and therefore disruptions in care/services provided and billing/reimbursement to providers.

Compliance Options for Consideration

[Applies to Sections 71101, 71102, 71107]

Option 1: Maintain the expansion population and the state would absorb additional implementation costs.

Advantages:

- Approximately 80,000 beneficiaries will retain Medicaid coverage.

Disadvantages:

- Will require state investment.

Implementation Risks:

- There will be changes required to the eligibility system as well as a potential backlog for verification tasks. Managed care organizations will experience increased administrative burden in their efforts to support outreach and reminders related to renewals and will likely face both administrative and financial challenges as member churn increases. Churn will also impact providers, whose patients will be more likely to experience coverage gaps that impact provider reimbursement.

Authority Change Needed:

- TBD.

Community Feedback:

- Invest in customer-facing and eligibility staff training and work to simplify mailings and forms (or have explainers).
- Increase walk-in centers for members who have technology barriers.
- Leverage community partners for application assistance and transition supports for those losing care to Free Clinics.
- Prioritize people with disabilities and older adults for outreach by expanding targeted navigator services

Option 2: Eliminate the Expansion population and coordinate with HSRI on alternative exchange-based options for this population.

Advantages:

- Eliminates implementation costs and allows the State to come into compliance with Federal requirements quickly.

Disadvantages:

- Would result in over 80,000 beneficiaries losing Medicaid coverage, which will significantly increase uninsured rates and uncompensated care. Any alternative exchange-based option will require significant state investment if the state does not want to shift all costs to beneficiaries. Households under 100% FPL will not qualify for Advance Premium Tax Credits so coverage would be very costly for the individual or, should the state seek to defray the cost of premiums, be significantly costly to pay for (over \$600 million). Additionally, individuals in this income range would not qualify for Cost Sharing Reductions, leaving enrollees with significant out of pocket costs and annual deductibles in the thousands.

Implementation Risks:

- Potential confusion with beneficiaries and providers.
- Loss of 90/10 match.
 - States cannot reduce expansion eligibility to 100% of the FPL and retain the enhanced 90/10 match for the remaining population.
 - Federal law does not allow partial repeal of the Medicaid Expansion. States must either maintain the entire expansion group or remove it completely. Any reduction in eligibility would eliminate the enhanced 90/10 federal match for the entire population.

Authority Change Needed:

- Yes, requires SPA to remove the authority for the expansion population. Likely Rhode Island General Law (RIGL) and regulation changes needed as well.

Community Feedback:

- Invest in customer-facing and eligibility staff training and work to simplify mailings and forms (or have explainers).
- Increase walk-in centers for members who have technology barriers.
- Leverage community partners for application assistance and transition supports for those losing care to Free Clinics.
- Prioritize people with disabilities and older adults for outreach by expanding targeted navigator services.

Section 71108: Home Equity Limits

Program Description:

States have a maximum allowable value to attribute to an individual's home when calculating the value of the individual's resources for purposes of determining eligibility for nursing facility services or other Long-Term Care (LTC) services; this is known as the home equity limit. Federal law has historically permitted states to choose a home equity limit within a range set by CMS; CMS adjusts the value annually on January 1 and Rhode Island uses the minimum Home Equity Limit allowable under CMS guidelines. Rhode Island Medicaid's home equity limit for CY 2025 is \$730,000.

Program Change:

This new requirement caps the permissible home equity value at \$1 million for individuals seeking eligibility for long-term care services and prohibits the use of asset disregards from being applied to waive home equity limits.

Populations, Providers, and Partners Affected:

There is no near-term impact as Rhode Island's current limit is below the H.R.-1 maximum.

Effective Date and Key Milestones:

This change will be effective on January 1, 2028.

State Impacts:

- **Direct:** No current impact.
- **Indirect:** None.

Compliance Options for Consideration

[Applies to Section 71108]

No Options: There are no alternative options for compliance.

Section 71109: Alien Medicaid Eligibility

Program Description:

Noncitizens with a “qualified” immigration status are eligible for full Medicaid benefits. However, note that with the exceptions defined under [eCFR :: 42 CFR 435.4](#) definitions and terms, qualified noncitizens still must meet the five-year bar before being eligible for benefits. In addition, qualified noncitizen veterans and active-duty military and their lawfully residing spouses and dependent children and un-remarried widow(ers) are not subject to the five-year bar.

Rhode Island has also adopted the state option to cover children under age 21 and pregnant (and post-partum) individuals who are lawfully present in the U.S., without a five-year bar. The scope of “lawfully residing” includes qualified noncitizens as well as others who are lawfully present (e.g., those with temporary protected status, individuals applying for asylum, individuals with specific immigration status for less than a year, etc.).

Program Change:

This section says that regardless of any provisions to the contrary in the applicable section of law, only “aliens lawfully admitted for permanent residence as an immigrant as defined by sections 101(a)(15) and 101(a)(20) of the Immigration and Nationality Act, excluding, among others, alien visitors, tourists, diplomats, and students who enter the United States temporarily with no intention of abandoning their residence in a foreign country,” certain Cuban and Haitian immigrants, and Compact of Free Association (COFA) migrants. The change means that many “qualified” individuals, - such as refugees, asylees, humanitarian parolees, victims of trafficking, individuals subject to battery and other cruelty, conditional entrants, etc. will need to adjust their status to lawfully permanent resident (LPR) (i.e., obtain a green card) before they will be eligible for full Medicaid. These changes do not affect the state’s obligation to provide Emergency Medicaid to otherwise eligible individuals, regardless of immigration status.

Absent CMS guidance, several areas of uncertainty remain. One area is 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 is also unclear whether LPRs who have been exempt from the five-year bar will become subject to the five-year bar under H.R.-1. The option to cover lawfully present children and pregnant/postpartum individuals is also understood to remain in place. Pending clarification from CMS, the impact analysis assumes that all such individuals will become subject to the five-year bar and that children and pregnant/postpartum individuals will not be impacted.

Populations, Providers, and Partners Affected:

Implementation of section 71109 will impact approximately 9,000 individuals who currently have full or limited Medicaid benefits, through managed care or fee-for-service, in Rhode Island. This estimate is based on limited data from the Federal Verification Hub (FVH), which is used to verify citizenship and immigration status for Medicaid applicants. 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. Medicaid assumes these estimates will change once formal federal

guidance is issued and once the FVH dataset is updated by the federal government; until then, this should be interpreted cautiously. Currently, available FVH data are incomplete for certain individuals who are otherwise considered qualified, resulting in uncertainty regarding final eligibility determinations, as noted above. This estimate assumes 75% of potential closures – those with missing data and therefore cannot determine their status as of October 1, 2026 – will ultimately close.

Effective Date and Key Milestones:

This change will be effective on October 1, 2026.

State Impacts:

- **Direct:** Anticipated impacts include a reduction in benefits paid through the state due to current beneficiaries losing coverage, offset moderately by an increase in emergency Medicaid spending. These changes could require the state to incur potentially significant costs to update eligibility systems, if the FVH is not updated by next fall and CMS nevertheless requires states to implement on time. There is likely to be substantial public concern and confusion, which will increase call volume for EOHHS, DHS, and HSRI, and it will be necessary to spend significant staff time on training and education about new rules. Similarly, DHS staff costs for appeals of denials and terminations will likely increase. Regulatory and State Plan modifications are highly likely.
- **Indirect:** Anticipated impacts include increases in uncompensated care due to reduction in coverage.

Compliance Options for Consideration

[Applies to Section 71109]

Option 1: Modify the “Cover All Kids” eligibility pathway to include those over 21.

Advantages:

- Any beneficiaries subject to losing coverage due to the “qualified alien” definition change would be covered regardless of immigration status. Limits the amount of uncompensated care resulting from individuals who lose coverage.

Disadvantages:

- This will require significant addition of state-only funds, \$40 million in SFY 2027 and \$53.3 million annualized based on current estimates.

Other Considerations:

- It cannot be implemented through current systems. We will need to move this program outside of the Medicaid program, including the MMIS and Managed Care Contracts, pending CMS guidance.

Implementation Risks:

- Claims data integration will no longer exist if separate systems are required.

Authority Change Needed:

- Yes, would require changes to RIGL and likely to state regulations.

Community Feedback:

- Concern regarding data privacy and security of personal information.
- Some providers may be more burdened than others.

- Use this as an opportunity to revamp uncompensated care in RI.
- Tremendous investment and need for community involvement and outreach.
- Strengthen charity care access for uninsured.

Section 71112: Retroactive Coverage

Program Description:

Current federal rules allow for up to three months of retroactivity for Medicaid coverage. Rhode Island only has retroactive coverage for disabled people, those over 65, people applying for LTSS, pregnant individuals, and infants under age 1.

Program Change:

This new requirement will change retroactive coverage as follows: (1) traditional Medicaid population to the two months preceding enrollment; (2) expansion population to the month preceding enrollment; and (3) CHIP to the two months preceding enrollment.

Populations, Providers, and Partners Affected:

Pregnant individuals, LTSS, Katie Beckett, Sherlock, Ticket to Work, dual eligibles, and any other individuals over age 65 and/or who are applying on the basis of a disability will be impacted. LTC providers and network including the Aging and Disability Resource Center (ADRC), DHS LTC social case work staff, and community-based providers who assist individuals with Medicaid applications will all need to adjust the cadence and speed of their work. Nursing facilities in particular will need to make significant adjustments to its operations to ensure residents' applications are submitted earlier, to avoid the risk of uncompensated care or access lapses.

Effective Date and Key Milestones:

This change will be effective on January 1, 2027.

State Impacts:

- **Direct:** System design and modification work on the RIBridges system will have to occur to enable this change in retroactive coverage. There will be minimal impact to DHS as these changes do not impact the 90-day review period once the application is submitted for DHS purposes.
- **Indirect:** Significant impact on providers, especially LTC providers, that do not submit applications for and on behalf of their patients in a timely manner. Ultimately this could also have a fiscal impact on providers who, depending on timing of application submission, may not get fully reimbursed retroactively.

Community Feedback:

- Use state funds to cover the gap or create a state-funded insurance problem-solving program for clients in need.
- Prioritize enrollees connecting to Federally Qualified Health Centers (FQHCs) and hospitals.
- Advocate for Federal flexibility on the one-month limit for expansion populations and/or explore administrative simplification.

Compliance Options for Consideration

[Applies to Section 71112]

No Options: There are no alternative options for compliance.

Section 71113: Disqualified Entity Payment Ban

Program Description:

The Hyde Amendment prohibits federal funds from being used to pay for abortions, except in specific circumstances such as to save the life of the woman or in cases of rape or incest. In Rhode Island, providers that offer abortions outside of those permitted by the Hyde Amendment are not reimbursed with federal funds; Medicaid beneficiaries are eligible for such services funded with state dollars only. Providers that offer both abortion services and other Medicaid-covered services can be reimbursed for any non-abortion service using both federal and state dollars.

Program Change:

For the one-year period following date of enactment of this legislation, prohibits federal match for items and services provided by prohibited entities that, as of the first day of the first quarter beginning after date of enactment of this legislation:

- Are 501(c)(3) entities under the Internal Revenue Code of 1986;
- Are essential community providers that are primarily engaged in family planning services, reproductive health, and related medical care;
- Provides for abortions other than those provided if the pregnancy is the result of an act of rape or incest or to save the life of the pregnant woman; and
- Received directly or through its affiliates as part of a nationwide health care provider network over \$800,000 in total federal and state expenditures under title XIX of the Social Security Act in FY 2023.

This change restricts use of federal funds for any service provided by the entities above, including for non-abortion services.

Populations, Providers, and Partners Affected:

This change impacts Planned Parenthood of Southern New England (PPSNE) and their patients (over 2,300 Medicaid beneficiaries served in SFY 2025).

Effective Date and Key Milestones:

These changes were effective as of July 4, 2025, for the one-year period following date of enactment of this legislation; however, the Mass District Court granted a Motion for a Preliminary Injunction against the United States that was lifted by the 1st U.S. Circuit Court of Appeals on September 11, 2025. Medicaid was not required to comply with this section when the Preliminary Injunction was in place.

State Impacts:

- **Direct:** Anticipated impacts resulting from this requirement include reduced Medicaid payments to impacted providers and federal funding to the State for non-abortion services provided by Planned Parenthood. SFY 2026 projections for these services are \$0.7 million all funds. As of September 11, 2025, Medicaid suspended payment to impacted providers and issued a memo to all contracted plans, directing them to suspend payment to impacted providers per federal law. Please note, Medicaid anticipates impacted beneficiaries may receive care from other providers if not able to be served by PPSNE and thus overall expenditures may not change.

- **Indirect:** This will have, if required, a significant operational impact on the Medicaid program from a contract and financing perspective. MCOs will also have to assist beneficiaries in finding other preventive care services within primary care community. This may be a challenge given the current limited primary care capacity in the state. This change will ultimately have an impact on access to reproductive and preventative care for Medicaid beneficiaries who can no longer be served by impacted providers for all services

Compliance Options for Consideration

[Applies to Section 71113]

Option 1: Create, outside of Medicaid, a state only funded, direct legislative grant for the one provider who supplies these benefits.

Advantages:

- This would be status quo for beneficiaries and would not impact their care in any way. Advantageous and viable option for Planned Parenthood to continue to operate and provide the breadth of services they provide today to Medicaid beneficiaries.

Disadvantages:

- Additional budgetary costs to implement, approximately \$0.7 million in SFY 2026, with changes annually to account for inflation and changes in caseload.

Other Considerations:

- Requires ability to pay for services provided outside of Medicaid.

Implementation Risks:

- None.

Authority Change Needed:

- Yes, a line-item appropriation would likely be required in the enacted budget.

Community Feedback:

- Identify alternative funds to maintain services.
- Conduct outreach to explain where services can be obtained and invest in mobile OBGYN services for rural areas.
- Partner with clinics and FQHCs to increase family planning capacity and with hospitals for on-demand care options.

Section 71119: Community Engagement Requirements

Program Description:

Federal law has historically prohibited conditioning Medicaid eligibility on meeting a work requirement, however several states were allowed to waive this condition under 1115 waivers. Rhode Island Medicaid does not currently have a work requirement in place for beneficiaries.

Program Change:

This section imposes work or community engagement requirements for certain Medicaid beneficiaries to work, participate in a work program, and/or participate in community

service for at least 80 hours a month, or be in school at least half time. People can also comply based on monthly income that is not less than 80 times the federal minimum hourly wage or has averaged 80 times the federal minimum hourly wage per month over the past six months. The requirement generally applies to adult expansion or an expansion-like waiver category. HR-1 includes a list of mandatory exemptions including: Medicare enrollees, foster youth, former foster youth, pregnant/postpartum individuals, parents/caretakers of children age 13 and under, disabled individuals, people eligible for Indian Health Services, veterans with rated disabilities, individuals participating in an SUD or AUD treatment program, individuals who are incarcerated or released in the past 90 days, individuals who already meet SNAP/TANF work requirements, and people who are medically frail (states likely have the ability to define "medically frail").

Populations, Providers, and Partners Affected:

This change will impact approximately 90,000 existing beneficiaries covered under the expansion or an expansion-like waiver category. Based on the total number of people enrolled in the respective eligibility categories and using existing eligibility and claims data as a proxy for how many people are estimated to be exempt and how many people are estimated to be compliant today, Medicaid anticipates that approximately 24,600, primarily expansion beneficiaries, will be at risk for disenrollment due to this requirement. This estimate assumes 75% of those not identified as exempt or already meeting the requirement from the proxy claims analysis, will be at risk for disenrollment due to this requirement either through no response to any information request, general noncompliance, or subsequent increase in income that put an individual over income for Medicaid eligibility. The 75% assumption is based on experience in other states, as described in [RWJ Foundation and National Association of Medicaid Directors, "H.R.-1: Impacts and Considerations" \(July 2025\)](#), and on local factors such as Rhode Island's high minimum wage relative to the federal minimum wage.

Effective Date and Key Milestones:

These changes are effective as of December 31, 2026. The Health and Human Services Secretary can exempt a state from compliance through December 2028 if the state demonstrates a good faith effort (GFE); it is Medicaid's understanding that GFE exemptions will be limited. Key milestones include the federal issuance of an interim final rule by June 1, 2026. The process by which beneficiaries demonstrate if they meet one of the exemption or compliance criteria is not yet determined. The finalized process is reliant on federal guidance.

State Impacts:

- **Direct:** Anticipated impacts of this requirement include a reduction in benefits paid through the State and increased IT and personnel costs. Significant operational, procedural, and administrative changes for Medicaid, DHS, HSRI, and potentially DLT, including changes in authority and promulgated regulations. Community and public outreach plan will be needed.
- **Indirect:** Anticipated impacts of this requirement include potential increase in appeals and fair hearings, an increase in the number of uninsured and thus increase in uncompensated care at hospitals. Potential back log in overall Medicaid and other benefit application processing due to the complexity of the new requirement across the board. Assessment of the impact on managed care is unknown except for their inability to assist the state in determining beneficiary compliance with these new requirements. There will likely be a disruption in eligibility and increase in churn which may have a downstream impact on providers and managed care organizations. Community based partners/organizations will likely see an uptick in cases and/or

requests for assistance with Medicaid application process and overall assistance with navigating healthcare system.

Compliance Options for Consideration

Option 1: Work with CMS to determine if it is possible to align work requirements for SNAP and Medicaid.

Advantages:

- Harmonizing work requirements across programs reduces implementation challenges, including IT programming costs and worker training.

Disadvantages:

- Using SNAP's more stringent work requirements for Medicaid recipients may create additional compliance challenges as there are differences in the structure of the SNAP medical exemptions and self-attestations.

Other Considerations:

- The State could mitigate the impact of enhanced work requirements by partnering with employers and nonprofit entities to establish volunteer programs that meet both SNAP and Medicaid eligibility criteria.
- SNAP's medical exemption framework and self-attestation process differ significantly from Medicaid's. For example, individuals who qualify as medically frail under Medicaid may not meet SNAP's medically unfit standard, and SNAP does not allow self-attestation for medical exemptions.

Implementation Risks:

- Medicaid work requirement implementation carries risks such as coverage loss. This can lead to worsening health outcomes. Additionally, implementation can cause strain on community health systems and hospitals as well as administrative burdens for beneficiaries and the state.

Authority Changes Needed:

- Potential SPA changes and amended state Medicaid regulations.

Option 2: Eliminate the Expansion population and coordinate with HSRI on alternative exchange-based options for this population.

Advantages:

- Eliminates implementation costs and allows the State to come into compliance with Federal requirements quickly.

Disadvantages:

- Would result in over 80,000 beneficiaries losing Medicaid coverage, which will significantly increase uninsured rates and uncompensated care. Any alternative exchange-based option will require significant state investment if the state does not want to shift any costs to beneficiaries. Households under 100% FPL will not qualify for Advance Premium Tax Credits so coverage would be very costly for the individual or, should the state seek to defray the cost of premiums, be significantly costly to pay for (over \$600 million). Additionally, individuals in this income range would not qualify for Cost Sharing Reductions, leaving enrollees with significant out of pocket costs and annual deductibles in the thousands.

Implementation Risks:

- Potential confusion with beneficiaries and providers.
- Loss of 90/10 match (Note, states cannot reduce expansion eligibility to 100% of the FPL and retain the enhance 90/10 match for the remaining population).

Authority Change Needed:

- Yes, requires SPA to remove the authority for the expansion population. Likely Rhode Island General Law (RIGL) and regulation changes needed as well.

Community Feedback:

- Additional targeted outreach, communications, and engagement supports will be needed to assist consumers in navigating the changes as noted by expressed concerns about impacts on disabled individuals, non-English speakers, caregivers, immigrants, and homeless navigating changes.
- Additional supports and resources will be helpful to assist consumers in meeting these new requirements, including a centralized list of qualifying volunteer and employment options and provision of childcare supports to adults with families who now need to meet these requirements. Also support in options available for beneficiaries' losing coverage.
- Simplification of documentation is necessary to navigate these changes effectively, without increasing errors, to meet requirements for consumers, employers, and volunteer organizations.
- Create a toolkit for providers, FQHCs, MCOs, Hospitals, etc. to have a unified approach to ensuring beneficiaries we serve maintain eligibility. Also grants to the community to assist Medicaid beneficiaries.
- Increase funding for job training and opportunities.

Section 71121: HCBS Coverage and Eligibility (Optional)

Program Description:

Rhode Island's Global 1115 Demonstration Waiver includes authority for LTSS Home and Community-Based Services (HCBS). CMS refers to these Demonstration services as "1915(c)-like" services and "1915(i)-like services," because the underlying authority comes from sections 1915(c) and 1915(i) of the Social Security Act. These authorities allow individuals to get LTSS HCBS if 1) they have an "institutional" level of care need - meaning that if they did not get HCBS, they would need care in a Nursing Facility or Intermediate Care Facility; or 2) they have a "High" level of care need that would not require an institutional setting, but which does require HCBS.

Program Change:

This is a new option available to states that permits HHS to approve a state's request for a standalone 1915(c) waiver that does not require participants to be subject to a determination that, but for the provision of HCBS, those individuals would require nursing home or Intermediate Care Facility/Intellectual and Developmental Disability level of care. As explained above, Rhode Island already has authority to provide HCBS to such individuals, under the state's Global 1115 Demonstration Waiver.

Populations, Providers, and Partners Affected:

None, because Rhode Island already has the relevant coverage in place.

Effective Date and Key Milestones:

This option is available for states effective July 1, 2028.

Compliance Options for Consideration

[Applies to Section 71121]

No Options: There are no alternative options for compliance because Rhode Island already has the relevant coverage in place.

MEDICAID CATEGORY 2 – FINANCE CHANGES

Figure 16: Summary of Benefit Impacts for Medicaid Category 2 Provisions

Section	(\$ Millions)										
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030		
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF	
CATEGORY 2: FINANCE CHANGES											
Emergency Medicaid FMAP											
Expansion FMAP incentive Sunset											
Provider Tax Uniformity and Caps ¹					\$12.2	\$12.2	\$31.9	\$31.9	\$60.3	\$60.3	
State Directed Payment Standards							(\$11.4)	(\$32.5)	(\$21.6)	(\$61.8)	
Provider Tax Waivers											
Demonstration Budget Neutrality											
Expansion Population Cost-Sharing							(\$0.2)	(\$1.4)	(\$0.0)	(\$1.8)	
Total					\$12.2	\$12.2	\$20.4	(\$2.0)	\$38.7	(\$3.3)	

Section 71110: Emergency Medicaid FMAP Cap

Program Description:

States are required to provide limited services to treat emergency conditions for individuals who except for their immigration status would otherwise be eligible for Medicaid. This is known as emergency Medicaid and primarily reimburses hospitals for the costs of emergency care provided to these individuals. Rhode Island claims the standard FMAP for emergency Medicaid services.

Program Change:

This section prohibits states from using the expansion FMAP of 90% for emergency Medicaid.

Populations, Providers, and Partners Affected:

This change has no impact on populations or providers.

Effective Date and Key Milestones:

This change is effective October 1, 2026.

State Impacts:

This change has no impact on the state. Medicaid does not currently claim at the enhanced matching rate for any individuals served by emergency Medicaid.

Section 71114: Expansion FMAP Incentive Sunset

Program Description:

The American Rescue Plan Act (ARPA) provided a temporary 5% FMAP enhancement to states that opted to expand Medicaid after March 11, 2021.

Program Change:

Removes the temporary percentage point enhanced FMAP for states that opted to expand Medicaid after March 11, 2021, that was enacted by the American Rescue Plan Act.

Populations, Providers, and Partners Affected:

None.

Effective Date and Key Milestones:

This change is effective for states expending funding for the expansion population after January 1, 2026.

State Impacts:

There is no impact from this change as Rhode Island expanded Medicaid prior to March 11, 2021.

Compliance Options for Consideration

[Applies to Section 71106, 71110, 71114]

No Options: There are no alternative options for compliance.

Section 71115: Provider Tax Uniformity and Caps

CMS Guidance Forthcoming: Guidance on Section 71115 is forthcoming; program details and compliance requirements are subject to change pending federal clarification.

Program Description:

States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, health care related taxes (or "provider taxes"), and local government funds. Provider taxes are a significant source of state revenue and governed by federal regulations. Federal regulations identify nineteen (19) specific classes of health care services and providers. Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

Generally, taxes must be broad based, uniformly imposed, and not in violation of hold harmless provisions. This means taxes must be imposed on at least all health care items or services in the class, be the same amount for every provider furnishing the items or services within the class and not redistribute Medicaid payments to hold taxpayers harmless for the cost of the tax. States can request waivers from broad based and uniform requirements but hold harmless provision cannot be waived.

Rhode Island currently has taxes or assessments on four (4) federal provider classes: nursing facilities, inpatient hospital services, outpatient hospital services, and services of managed care organizations. There are five individual taxes or assessments assessed on services of managed care organizations; Gross Premium Tax (RIGL §44-17-1; §42-14-5(c), Children's

Health Account Assessment (RIGL §42-7.4-3; § 42-12-29; §42-7.4-2), Child Immunization Assessment (RIGL §42-7.4-3; § 23-1-46; §42-7.4-2), Adult Immunization Assessment (RIGL §42-7.4-3; §23-1-46; §42-7.4-2), and the newly enacted Primary Care Assessment (RIGL §42-7.4-3; §42-7.4-2).

The following table includes a summary of the percentage of revenue assessed and total collections for SFY 2025, by federal provider class.

Figure 17: Percentage of Revenue and Collections for SFY2025

Federal Provider Class Taxed	Percentage of Revenue	Total Collections (SFY 2025) (\$ Millions)
Nursing facility services	5.5%	\$44.1
Inpatient hospital services	5.81%	\$227.6
Outpatient hospital services	5.83%	
Services of managed care organizations (including health maintenance organizations, preferred provider organizations)	4.69% (estimated aggregate across all five assessments) ¹	\$167.0 ²

Notes:

1. Estimated using 100% of gross premium revenues. This assumes self-insured and third-party administrators are considered for federal compliance.
2. Include estimate for the new primary care assessment enacted in the SFY 2026 budget.

Program Change:

This section makes changes to the hold harmless threshold. New taxes enacted on or after July 4, 2025, have a hold harmless threshold of 0% beginning October 2026. For existing taxes, non-expansion states may continue using the applicable percent of net patient revenue for the provider class, while expansion states must use the lower of that percentage or gradually reduced thresholds starting in FY 2028 (5.5% in 2028, down to 3.5% in 2032). Taxes on nursing facility services are exempt from this change.

Populations, Providers, and Partners Affected:

This change will impact the total amount of taxes paid by providers, specifically hospitals and health insurers.

Effective Date and Key Milestones:

These changes are effective upon enactment for prohibition of new or increased taxes and the reduction of the hold harmless threshold begins on October 1, 2027 (SFY 2028). Table below shows the threshold limit by SFY.

State Impacts:

- **Direct:** Anticipated impact is a reduction in state revenues starting in SFY 2028. The following table shows the estimated cumulative revenue impact by year. For example, the total impact by SFY 2032 is an estimated reduction of \$150.9 million in state revenue.
- **Direct:** The changes to provider taxes under H.R.-1 will also increase operational costs due to increased work for Medicaid’s actuary and a dedicated finance FTE for navigating, implementing, and providing the required oversight of these taxes moving

forward to ensure continued compliance. RIGL will need to be updated to reflect the phase down requirements.

- **Direct:** Medicaid must work with CMS on compliance, especially for the assessments on MCO services. Assessing compliance for these is complex and subject to CMS guidance given the variable rate basis (percent of premiums vs per member assessment) and inclusion of self-insured or third-party administrators for some assessments. The MCO services revenue impact below is estimated using 100% of gross premium revenues, which may change based on CMS guidance.

Figure 18: Provider Tax Estimated Revenue Impact

SFY	Threshold (%)	Hospital Licensing Fee ¹ (\$ Millions)	MCO Services Taxes ² (\$ Millions)	Total (\$ Millions)
2028	5.5%	(\$12.2)	NA	(\$12.2)
2029	5.0%	(\$31.9)	NA	(\$31.9)
2030	4.5%	(\$51.7)	(\$8.6)	(\$60.3)
2031	4.0%	(\$71.5)	(\$32.9)	(\$104.4)
2032	3.5%	(\$91.3)	(\$59.6)	(\$150.9)

Notes:

1. Assumes constant base year.
2. Assumes 5% inflation in revenues annually.

- **Indirect:** A reduction in state revenue will create downstream budgetary impacts, requiring the Administration and General Assembly to determine whether to offset the shortfall through alternative revenue sources or to implement corresponding expenditure reductions.

Compliance Options for Consideration

[Applies to Section 71115]

Option 1: Lower hospital SDP payments to align with Hospital Licensing Fee (HLF) reductions.

Advantages:

- Reduces impact of state revenue reduction.

Disadvantages:

- Reduces state directed payments (SDP) to hospitals.

Other Considerations:

- Will interact with other sections of H.R.-1, 71116 and 71117.

Implementation Risks:

- None.

Authority Change Needed:

- None.

Option 2: Work with CMS to understand if any of the MCO provider taxes in place could remain above the hold harmless thresholds.

Advantages:

- Would allow the state to continue with the same level of MCO tax funding.

Disadvantages:

- This would require the taxes to pass CMS' 75/75 test, where the state proves that more than 75% of the taxpaying providers do not receive more than 75% of the cost of the tax back. This requires significant administrative effort; would require additional actuarial support and use majority of the required FTE, as well as additional FTEs as this effort is underway. As of December 2024, no state had a tax approved above the hold harmless threshold, signaling the challenges with approval.

Other Considerations:

- Assumes that this 75/75 test will continue to be an option moving forward. This will not be known until CMS updates its regulations.

Implementation Risks:

- None.

Authority Change Needed:

- Currently under review.

Community Feedback:

- Work closely with primary care hospitals and hospital industry.
- Look for new revenue streams or explore ability to phase in tax reductions for certain providers to mitigate impact.
- Develop a contingency plan for provider solvency in partnership with other State efforts.

Sections 71116: State-Directed Payment Standards

CMS Guidance Forthcoming: *Guidance on Section 71116 is forthcoming; program details and compliance requirements are subject to change pending federal clarification.*

Program Description:

States are generally not permitted to direct how MCOs pay their contracted providers. However, subject to CMS approval, states may use "state directed payments" (SDPs) to require MCOs to pay providers certain rates, make uniform rate increases, or to use certain payment methods. A 2024 rule on access to care in Medicaid managed care codified the upper limit for SDPs as the average commercial rate for inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center, which is generally higher than the Medicare payment ceiling used for other Medicaid fee-for-service supplemental payments.

Rhode Island Medicaid has over 20 SDPs, valued at more than \$470 million, not inclusive of minimum fee schedules. All SDP approvals, except for minimum fee schedules that do not require a preprint submission to CMS, are available online: [Approved State Directed Payment Preprints | Medicaid](#). Minimum fee schedule SDPs are available in the Medicaid MCO Contracts, available online: <https://eohhs.ri.gov/providers-partners/medicaid-managed-care>.

Program Change:

This section caps the total SDP payment value at 100% of Medicare for expansion states and at 110% of Medicare for non-expansion states. When a Medicare rate is not available, the payment rate cannot exceed the rate under the Medicaid state plan. Previously approved payments, as defined by CMS guidance, 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 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).

Effective Date and Key Milestones:

This section is effective upon enactment and prevents payments approved after May 1, 2025, in excess of the new limits from taking effect. For “grandfathered in” payments, the phasedown of 10% begins with the first rating period beginning on or after January 1, 2028 (SFY 2029).

State Impacts:

- **Direct:** To assess impacts, the state needs to understand which payments are “grandfathered in” and which payments may exceed Medicare. Most Rhode Island SDPs are set at Medicare levels or below. One exception is the hospital (inpatient and outpatient) separate payment term SDP where the state directs the MCOs to pay hospitals at a percentage of the average commercial rate. The most recent approval (SFY 2025) was valued at \$281 million, increasing payments to hospitals to equal 81% of the average commercial rate. The SFY 2026 SDP is valued at \$325 million and currently under CMS review.
- The state is awaiting a CMS decision on its “grandfathered in” status for this SDP. Based on the “[Section 71116 SDP Letter](#),” it is the agency’s opinion that both the SFY 2025 and SFY 2026 hospital separate payment term SDP are “grandfathered in,” meaning the SFY 2026 value of \$325 million will be allowable until the SFY 2029 rating period when a 10% annual reduction will be applicable until it reaches Medicare levels. This opinion is based on the applicable rating period beginning within 180 days of enactment of section 71116 and the submission meets preprint status criteria #5, that a completed preprint was submitted to CMS prior to July 4, 2025.
- When asked if CMS agreed with the state’s conclusion, CMS indicated they will include language in their standard adjudication letter (preprint approval provided to states upon review completion) to provide preliminary feedback on CMS’s initial assessment of the impact of section 71116, including whether a preprint is likely eligible for the grandfathering period. They also indicated that final implementation and decision will depend on the contents of a final rule, meaning the state may not have a final approval on the SFY 2026 preprint value for some time. This puts the current year \$44 million payment increase over SFY 2025 at risk, or at minimum, at risk of a delay. These payments are made quarterly, and Medicaid waits for approval prior to payment.
- CMS has not released guidance on acceptable methods to calculate the percentage of Medicare for hospital services. The methodology used significantly influences the result. When applying a cost to charge ratio methodology, which is used by CMS for Upper Payment demonstrations that compare Medicaid to Medicare payments, the state’s current hospital SDP (SFY 2026) is \$298 million over 100% of Medicare (CMS UPL

demonstrations, which compare Medicaid payments to Medicare, use this methodology). This is provided for context and included in the fiscal impact summaries but should be interpreted cautiously as the state is awaiting guidance and proposes to evaluate other more rigorous methods. Also, the base data used in this preliminary analysis is hospital self-reported Medicare and Medicaid data that will require updating.

- Apart from the hospital separate payment term SDP, there are rates resulting from the Office of the Health Insurance Commissioner Social and Human Services rate review process that now exceed Medicare, primarily behavioral health rates. CMS indicated they are considering changes to the total payment rate limit for SDPs for other services beyond inpatient hospital services, outpatient hospital services, nursing facility services, or qualified practitioner services at an academic medical center. The value of the payments over Medicare is estimated at \$3.3 million all funds, including \$1.0 million in general revenue. This estimate is not included in the summary impact given the lack of guidance at this time.
- To comply with the changes, Medicaid will require additional funding for its actuary, which includes funding to use the actuary's proprietary diagnostic related group (DRG) repricing tool to more accurately estimate how the hospital separate payment term SDP aligns with Medicare. Ideally, this work would begin in the current SFY.
- **Indirect:** Base data used for the analysis is hospital self-reported Medicare and Medicaid data, which is imperfect and likely requires follow up.

Compliance Options for Consideration

[Applies to Section 71116]

Option 1: Set hospital minimum fee schedule to Medicare equivalent.

Advantages:

- Streamlines administrative oversight while maintaining compliance and paying hospitals maximum allowable.

Disadvantages:

- Will likely reduce overall payments to hospitals, assuming they are currently paid above Medicare.

Other Considerations:

- None.

Implementation Risks:

- None.

Authority Changes Needed:

- Yes, this would require a change to the state plan and Rhode Island General Laws.

Community Feedback:

- Explore revenue generating proposals or taxes.
- Review and repeal ineffective tax incentive programs, for example, the film tax credit.
- Consider a State-grandfathering of current payments and advocate for a longer phase-down.
- Review which providers are most at risk of closure due to payment cuts and examine other supplemental payment programs for cost efficiencies.

Section 71117: Provider Tax Waivers

Program Description: States are permitted to finance the non-federal share of Medicaid spending through multiple sources, including state general funds, provider taxes, and local government funds. Provider taxes are a significant source of state revenue and governed by federal regulations. Federal regulations identify 19 specific classes of health care services and providers. Taxes that pertain to each class must apply to all items and services within the class, regardless of whether the items and services are furnished by or through a Medicaid-certified or licensed provider.

Generally, taxes must be broad based, uniformly imposed, and not in violation of hold harmless provisions. This means taxes must be imposed on at least all health care items or services in the class, be the same amount for every provider furnishing the items or services within the class and not redistribute Medicaid payments to hold taxpayers harmless for the cost of the tax. States can request waivers from broad based and uniform requirements but hold harmless provision cannot be waived.

Rhode Island's taxes on inpatient hospital services and outpatient hospital services both have approved waivers of the uniformity provision from CMS. The waivers were approved after demonstrating compliance with federal regulations on how a state can demonstrate the proposed tax structure is generally redistributive. The table below described the approved rates in place on outpatient and inpatient services, by tier.

Figure 19: Rhode Island Outpatient and Inpatient Tax Rates

Tier	Criteria	Outpatient Rate	Inpatient Rate
(i)	High Medicaid/uninsured cost hospitals and independent hospitals	2.66	2.63
(ii)	Medicare-designated low volume hospitals and rehabilitative hospitals	1.33	1.31
(iii)	State-government owned and operated hospitals	5.25	5.25
(iv)	All other facilities	13.3	13.12

Program Change:

H.R.-1 modifies the methodology for determining whether taxes are generally redistributive, meaning any taxes that are not uniform or broad based must meet new guidance set by CMS. This change specifies that a provider tax shall not be considered generally redistributive if the tax rate is lower for providers with a lower volume or percentage of Medicaid taxable units or the tax rate on Medicaid taxable units is higher than the tax rate imposed on non-Medicaid taxable units.

CMS posted a proposed rule on Health Care-Related Taxes in May 2025: [Federal Register :: Medicaid Program; Preserving Medicaid Funding for Vulnerable Populations-Closing a Health Care-Related Tax Loophole Proposed Rule](#). While this was posted prior to H.R.-1 enactment, it does offer additional insight into what the new criteria may entail.

Populations, Providers, and Partners Affected:

This change may impact the taxes imposed on hospital services, paid by all hospitals in the state.

Effective Date and Key Milestones:

This change is effective upon enactment and provides a transition period of up to three fiscal years at the discretion of the Secretary of HHS. Based on the proposed rule, if impacted, Rhode Island would need to submit a health care-related tax waiver proposal that complies (or otherwise modify the tax) with an effective date no later than the start of the first SFY beginning at least one year from the final rule effective date (most likely SFY 28). This aligns with the changes in Section 71115.

State Impacts:

- **Direct:** There may be revenue impacts on the state if required to change the structure of the current tax on hospital services. The current structure's tiers (i) and (ii) are the criteria that may be challenged by CMS, given the state assesses hospitals with high Medicaid volume a rate of 2.66%, compared to the tier (ii) rate of 1.33%. Medicaid will have to work closely with CMS once they issue guidance or promulgate rules, along with the Hospital Association of Rhode Island, the administration, and the general assembly on a solution if required.
- **Direct:** As described under section 71115, the changes to provider taxes under H.R.-1 will also increase operational costs due to increased work for Medicaid's actuary and a dedicated finance FTE for navigating, implanting, and providing the required oversight of these taxes moving forward.
- **Indirect:** A change in state revenue would have downstream impact on programs as the administration and general assembly will have to identify how to fill any revenue gap. Any change to the tax structure will also have a significant impact on the state's hospitals.

Section 71118: Demonstration Budget Neutrality

Program Description:

Under long-standing policy and practice, Section 1115 demonstration waivers must be "budget neutral" to the federal government over the course of the waiver. Federal costs under an 1115 waiver may not exceed what they would have been for that state without the waiver. Typically, budget neutrality calculations are determined on a per enrollee basis— per enrollee spending over the course of the waiver (usually 5 years) cannot exceed the projected per enrollee spending calculated in the "without-waiver baseline."

Budget neutrality calculations and the use of "savings" when expenditures decrease on account of the waiver are negotiated between states and CMS and the Office of Management and Budget).

Program Change:

Codifies in statute the requirement that HHS must determine an 1115 demonstration waiver is budget neutral. The Chief Actuary of CMS must certify that the waiver amendment will not result in an increase to Federal expenditures. Requires the Secretary to determine the methodology for applying savings in extensions if applicable.

Populations, Providers, and Partners Affected:

None/Limited.

Effective Date and Key Milestones:

This section is effective on January 1, 2027.

State Impacts:

- **Direct:** While this is codifying current policy, Medicaid has experienced enhanced oversight of budget neutrality reporting in recent weeks including during waiver negotiations.
- **Indirect:** If overall budget neutrality cap is limited, could impact proposals in future waiver renewals.

Compliance Options for Consideration

[Applies to Section 71117, 71118]

No Options: There are no alternative options for compliance.

Section 71120: Expansion Population Cost-Sharing

Program Description:

States have the option to require cost sharing for certain beneficiaries and services within limits. Excluded services include emergency, family planning, pregnancy and preventive and cost-sharing is generally limited to nominal amounts but may be higher for those with income above 100% of the federal poverty level (FPL). Out-of-pocket costs cannot exceed 5% of family income. Rhode Island does not impose any cost-sharing requirements on Medicaid beneficiaries.

Program Change:

This section requires states to implement cost-sharing for expansion adults with incomes greater than 100% of the FPL. The amount of cost-sharing must be more than \$0 and cannot exceed \$35 per item or service, and total aggregate cost-sharing may not exceed 5 percent of the individual's or family's income. Current cost sharing limits on prescription drugs would remain in place (for people at or below 150% FPL, maximum \$4 for preferred drugs and \$8 for non-preferred drugs).

Certain services are excluded, including primary care, prenatal care, pediatric care, emergency room care (except for non-emergency care provided in emergency rooms), or services provided in an FQHC, CCBHC, or rural health clinic. States may permit providers to require payment of cost sharing obligations as a condition for provision of care. A provider may reduce or waive cost sharing on a case-by-case basis.

Services impacted include pharmacy, inpatient hospital, office visits (primarily specialty), and non-emergency emergency services.

Populations, Providers, and Partners Affected:

This change will affect approximately 11,000 expansion adults with incomes at or about 100% of the FPL, based on current eligibility data projected to SFY 2029 (assuming reductions due to other H.R.-1 changes). Copays are generally collected at point of service by the provider, with Medicaid revenues reduced by the copay amounts. Managed care organization and providers who offer impacted services would experience operational impacts and potentially revenues impacts.

Effective Date and Key Milestones:

These changes are effective as of October 1, 2028.

State Impacts:

- **Direct:** Anticipated impacts include a reduction in benefit expenditures due to cost-share and offsetting utilization; the estimated reduction range represents a minimal copay at the low end of the allowable range to the maximum allowed copays, along with 5% utilization reductions anticipated for pharmacy, non-emergency ED, and office visits. Other assumptions in this impact analysis include projections of SFY 2029 overall utilization, SFY 2029 expansion population enrollment, percentage of those beneficiaries at or above 100% FPL, and share of total utilization that will apply to those at or above 100% FPL.
- **Direct:** Given the limited population impacted and low utilization for many of the services amongst the impacted population, copay collections are anticipated to be minimal from a state fiscal perspective, however, have meaningful impacts on beneficiaries, providers, and operations. See the table below for a summary of the potential annualized benefit expense reduction by copay service. The overall range, assuming an October 1, 2028, implementation date is \$1.4 million to \$5.0 million all funds, including \$0.2 million to \$0.5 million in general revenue.
- **Direct:** There are also direct impacts on the MMIS system to update technology and claims processing to apply, track and enforce cost sharing requirement for a specific Medicaid population and set of services. This is estimated at \$0.4 million all funds, including \$0.04 million in general revenue. Managed care contract amendment to establish new requirements and reporting related to cost sharing and limitations. Regulatory impact and likely State Plan template to be completed.

Figure 20: Copay Service Ranges

Copay Service	Low End Copay (\$)	High End Copay (\$)	Estimate Range, Annualized (\$ Millions)
Pharmacy	\$1	\$4	(\$0.8 - \$1.4)
Inpatient	\$1	\$35	(\$0.0 - \$0.3)
Office Visits ¹	\$1	\$35	(\$0.7 - \$4.6)
Non-Emergency ED	\$1	\$35	(\$0.2 - \$0.4)
Total All Funds			(\$1.8 - \$6.6)
Total General Revenue			(\$0.2 - \$0.6)

Note:

1. Includes other outpatient hospital services and excludes: FQHCs, CCBHCs, ancillary services, non-emergency transportation, nursing facility care, HCBS services.

- **Indirect:** Managed Care organization need to implement IT and claims processing changes on their end to enable these changes. Provider and member education to inform of new requirement and to help minimize confusion since this requirement does not apply to all Medicaid populations and services.

Compliance Options for Consideration

[Applies to Section 71120]

Option 1: Implement state infrastructure for copay collection.

Advantages:

- Reduces administrative burden and revenue impact on providers.

Disadvantages:

- Increases administrative burden on state and requires additional state funding.

Other Considerations:

- None.

Implementation Risks:

- None.

Authority Change Needed:

- Yes, likely Rhode Island General Law (RIGL) and regulation changes needed as well.

Community Feedback:

- Access to care concerns. Rhode Island does not currently impose a cost sharing (copay) on beneficiaries. Copays are generally collected at the appointment by the provider. Will providers deny service if the copay isn't paid at time of service?
- Implications on debt collection. How do we ensure access for beneficiaries regardless of ability to pay the cost share.
- People with chronic conditions may get sicker if they reduce/eliminate their office visits due to co-pays.
- Can state funds be used to fund cost-sharing.
- Maximize the annual out-of-pocket cap and exempt high-value services from copays.
- Focus education on the out-of-pocket cap and sliding scale options.

MEDICAID CATEGORY 3 – PROGRAM INTEGRITY CHANGES

Figure 21: Summary of Benefit Impacts for Medicaid Category 3 Provisions

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 3: Program Integrity Changes										
Duplicate Enrollment Reduction										
Deceased Beneficiary Removal										
Deceased and Expelled Provider Removal										
Erroneous Payment Recovery										
Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0

Sections 71103: Duplicate Enrollment Reduction

Program Description:

The Eligibility and Enrollment final rule issued in April 2024 requires states to leverage reliable data sources to update enrollee address information, effective June 2025.

Program Change:

Requires states to update enrollee address information using reliable data sources, including the National Change of Address Database and managed care entities. It also requires the Secretary to establish a system to share information with states for purposes of preventing individuals from being simultaneously enrolled in two states and requires states to submit monthly enrollee Social Security Numbers and other information to the system.

Effective Date and Key Milestones:

This section is effective on January 1, 2027.

Populations, Providers, and Partners Affected:

Medicaid beneficiaries, providers, DHS, HSRI, and community-based partners and organizations.

State Impacts:

- **Direct:** Anticipated impact of this requirement is that beneficiaries will no longer be enrolled in two states simultaneously which prevents managed care capitation payment for individuals that are not receiving services. Note that these cases are minimal, and this change not anticipated to have a benefit impact. Cross agency impact for DHS, HSRI and Medicaid system component to implement change. This process is already underway with the managed care organization and work on this has already commenced for Medicaid FFS. Likely modification will be needed to state regulations.
- **Indirect:** Beneficiaries with an unknown address, may be disenrolled, which could lead to an increased number of uninsured beneficiaries, increased Emergency Department usage, and uncompensated care/debt. Disruption of care, services, and billing/reimbursement to providers may result due to increased churn of members on and off Medicaid.

Community Feedback:

Additional targeted outreach, communications, and engagement supports will be needed to assist beneficiaries in navigating the changes as noted by expressed concerns about impacts on disabled individuals, non-English speakers, caregivers, and homeless navigating changes. Also, support in options available for beneficiaries' who may lose coverage.

Section 71104: Deceased Beneficiary Removal

Program Description:

Section 1902 of the Social Security Act (42 U.S.C. 1396a) outlines requirements for State Medicaid plans, including provisions for identifying deceased individuals to ensure timely termination of their benefits.

Program Change:

Requires state Medicaid programs to check the Social Security Administration's Death Master File on at least a quarterly basis to determine whether Medicaid enrollees are deceased and to disenroll individuals who are determined to be deceased from Medicaid coverage.

Populations, Providers, and Partners Affected:

None to Limited.

Effective Date and Key Milestones:

This section is effective on January 1, 2027.

State Impacts:

- **Direct:** Some technological costs to connect to the Death Master File. Potential need to update regulations.
- **Indirect:** None.

Section 71105: Deceased and Expelled Provider Removal

Program Description:

Section 1902 of the Social Security Act (42 U.S.C. 1396a) outlines requirements for State Medicaid plans, including provisions for identifying deceased individuals and providers, to ensure timely termination.

Program Change:

This provision requires states, as part of their provider and supplier enrollment, reenrollment, and revalidation processes, not less than quarterly while a provider is enrolled, to check the Death Master File to determine whether the provider or supplier is deceased.

Populations, Providers, and Partners Affected:

None to Limited.

Effective Date and Key Milestones:

This section is effective on January 1, 2028.

State Impacts:

- **Direct:** Anticipated impacts because of this requirement are mostly cross agency. Medicaid, DHS, and HSRI will be impacted from an IT/Systems perspective to establish needed connectivity to DMF. Note that these cases are minimal given existing systems in place and therefore this change not anticipated to have a benefit impact. One-time system funding required.
- **Indirect:** As MES modernization (adoption of modular architectures, data infrastructures to the Medicaid Management Information System (MMIS) moves forward consideration of impact on the multi-vendor bids, scope of work, and implementation should be highly considered.

Compliance Options for Consideration

[Applies to Section 71103, 71104, 71105]

No Options: There are no alternative options for compliance.

Section 71106: Erroneous Payment Recovery

Program Description:

Every three years, Rhode Island is required to participate in a Payment Error Rate Measurement (PERM) program audit, which identifies improper payments (do not meet statutory, regulatory, or administrative requirements) and calculates an error rate. Rhode Island's FY 2023 error rate was 8.84% overall for Medicaid and 1.84% for CHIP. Following each PERM cycle, EOHHS creates corrective action plans for all PERM error findings and those are prioritized in the system governance procedures in place.

In the years between PERM audits, the Medicaid Eligibility Quality Control (MEQC) program conducts case-level reviews, as required by CMS. Failure to meet MEQC program requirements, including the submission of complete MEQC case level reports and CAPs, leaves the state at risk of receiving a disallowance if its future PERM eligibility improper payment rate is above the 3% threshold.

Federal law directs CMS to recoup federal funds for erroneous payments made for ineligible individuals and overpayments for eligible individuals if the state's eligibility "error rate" exceeds 3 percent. CMS may waive the recoupment for PERM audit findings if the Medicaid agency has taken steps to demonstrate a "good faith" effort to get below the 3 percent allowable threshold. Rhode Island has never been subject to significant recoupments for error rates above the threshold.

Program Change:

This section makes changes to how HHS responds to certain erroneous excess payments under Medicaid, increasing fiscal exposure to states. It expands the definition of "erroneous excess payment," gives the Secretary the option to allow state-conducted audit findings to be considered in determining a state's error rate and puts new limits on the amounts of penalties the Secretary may waive through good faith effort.

Populations, Providers, and Partners Affected:

This change does not have a direct impact on any Medicaid population or provider group.

Effective Date and Key Milestones:

These changes are effective as of October 1, 2029. Key milestones include: The next PERM audit in 2026, followed by 2029. Based on the effective date, Rhode Island assumes the changes will impact Review Year 2029, with findings likely delivered in SFY 2030.

State Impacts:

- **Direct:** This change directly increases the state’s fiscal exposure. For example, assuming FFY 2026 expenditures are consistent with the projected SFY 2026 estimate and applying FFY 2023 PERM Audit results, the expenditure variance would be \$47.6 million; without a waiver, the state would be expected to return these funds to CMS.
- **Direct:** There is also a significant anticipated impact on both the Medicaid system and compliance/program integrity teams, inclusive of MMIS vendor impact.
- **Direct:** Cross-agency impact on DHS as result of MEQC audit reviews (Medicaid Eligibility Quality Control) as well as the Payment Error Rate Measurement (PERM) audit. Internal impact on the MEQC unit from a procedural/operational perspective.
- **Indirect:** Anticipate indirect impact on overall state budget if significant federal funding needs to be returned. There would also be a significant administrative burden if funding must be returned, given the need to correct reporting of federal funding on the CMS 64 report using prior period adjustments.

CATEGORY 4 – DELIVERY SYSTEM REFORM CHANGES

Figure 22: Summary of Benefit Impacts for Medicaid Category 4 Provisions

Section	(\$ Millions)										
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030		
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF	
CATEGORY 4: Delivery System Reform Changes											
LTC Staffing Standards (RI Has State-Specific Rules)											
Total	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0

Section 71111

Program Description:

CMS 3442-F final rule from the Centers for Medicare & Medicaid Services (CMS) aimed to establish minimum nurse staffing standards for long-term care (LTC) facilities and mandate 24/7 registered nurse (RN) presence.

Program Change:

Prohibits implementation on the final staffing rule for nursing facilities.

Effective Date and Key Milestones:

This section is effective upon enactment.

State Impacts:

- **Direct:** Only the minimum staff elements of the rule are delayed. Elements of the rule related to compensation reporting for direct care workers and support staff at the individual facility level by Medicaid agencies remain in place. The moratorium gives nursing home providers more time to evaluate and adjust their staffing models before federal minimum standards are enforced. Rhode Island has its own state law for minimum staffing in nursing facilities.
- **Indirect:** None.

SUPPLEMENTAL NUTRITION ASSISTANCE PROGRAM

Overview of Approach

Outlined here are projected impacts of Federal changes to SNAP under H.R.-1 and identified mitigation strategies aligned with Rhode Island's SNAP Payment Error Rate (PER) Improvement Plan, emphasizing shared responsibility for quality, accessibility, and program integrity. Foundational to the SNAP analysis and options is DHS' "Work In Motion" foundational strategy.

Work in Motion: Strengthening Quality, Accountability, and Shared Ownership of Accuracy

The Department has shifted from designing compliance "options" to implementing an agencywide reform strategy that directly addresses the root causes of SNAP payment errors identified through the PER review and federal plan submission. This strategy focuses on early detection, continuous feedback, staff empowerment, and transparency, turning what were once corrective actions into sustained management practices across DHS offices.

Embedding Quality Assurance and "Find-and-Fix" as Core Operations

To reduce the state's exposure to federal sanctions and elevate accuracy as a shared goal, DHS has strengthened its Quality Assurance (QA) Framework and embedded "Find-and-Fix" reviews within daily operations. Every case review now functions as a learning opportunity—tracking not only whether an error occurred but why it occurred and how to prevent it in the future. Supervisors and senior eligibility technicians conduct targeted accuracy checks focused on the most error-prone areas identified in the PER analysis, including: (1) Shelter calculation and SUA application; (2) Wages, earnings, and income verification; and (3) Household composition and living arrangements. This real-time feedback loop ensures corrective actions are not just retrospective but proactive, allowing workers to identify and correct errors before affecting payment accuracy.

Targeted Training and Micro-Learning for High-Risk Areas

Recognizing that shelter calculation and deduction errors remain among the top three federal error categories, DHS has implemented Shelter Calculation PER Guardrails within its QA model. Supervisors now perform monthly micro-reviews of shelter-deduction cases, while new micro-learning modules on shelter rules, vendor-paid utilities, and shared housing scenarios are being rolled out statewide. These refreshers are short, targeted, and data-informed—directly addressing the conditions that drive repetitive error patterns. Results from these reviews are reported through the QA Collaborative Dashboard, reinforcing shared accountability and surfacing office-level trends in need of additional coaching.

Shifting from Enforcement to Engagement: Coaching for Accuracy

DHS has reframed traditional compliance monitoring into engagement-driven performance coaching, designed to build staff confidence and encourage continuous improvement. Instead of treating case corrections as disciplinary, supervisors now use motivational coaching techniques and data dashboards to recognize progress and reinforce accurate performance. Staff are working to see accuracy as a collective outcome—where policy, systems, and operations work in alignment to make "the easy way the right way." This approach has begun shifting culture across local offices, replacing punitive oversight with collaborative accountability and peer mentoring.

Transparency and Shared Accountability

To sustain this shift, DHS is developing a Transparency and Accountability Dashboard that tracks monthly progress toward key federal metrics—payment accuracy, timeliness, and corrective action implementation. The dashboard, shared internally through leadership briefings and the QA

Collaborative, makes progress visible to staff and provides early warning of potential error trends. The same data will also be used to inform quarterly updates to federal partners, reinforcing Rhode Island's commitment to transparency, integrity, and continuous improvement.

Expanding Data Integration and Error Prevention

These initiatives are closely aligned with parallel technology efforts, including: (1) Integration of automated wage-matching and income-verification systems to reduce manual data entry; (2) Expansion of automated SUA verification through data exchange with energy providers and LIHEAP; and (3) Deployment of Smart Policy Hub tools to ensure consistent statewide policy interpretation and decision support. Together, these enhancements build a system of shared accountability where accuracy is embedded in every level—from data input to benefit issuance.

Results-Oriented Culture and Next Steps

DHS's internal PER Action Teams continue to track performance, deliver coaching, and refine training based on observed case trends. By integrating QA, staff engagement, and data transparency into everyday operations, the Department is transforming error reduction from a compliance requirement into an organizational value. The work in motion is not simply about lowering the PER—it's about sustaining a culture where every employee, at every level, owns a part of Rhode Island's commitment to program integrity and customer trust.

Impact Analysis and Compliance Considerations

In this section, a summary of cost impacts by category and change is presented. This is followed by a description of the specific changes within the categorical type. Where applicable, options for compliance are presented related to the specific changes for Rhode Island to contemplate.

Overarching Resource Needs for SNAP H.R.-1 Compliance and PER Mitigation Compliance

Implementation of the SNAP provisions under H.R.-1 and the corresponding mitigation strategies outlined in this report will require targeted investment in personnel, technology, and operational capacity. DHS anticipates the need for dedicated Interdepartmental Project Managers to oversee system modifications in RIBridges and coordinate complex, cross-program dependencies between SNAP, Medicaid, and RI Works. These positions will ensure alignment across eligibility, reporting, and work-requirement systems, supporting timely design, testing, and implementation consistent with federal mandates. Additional Human Services Policy and System Specialists are needed to strengthen the Quality Assurance (QA) Framework, lead "Find-and-Fix" case reviews, and manage increased workload related to new eligibility terminations, appeals, and customer inquiries. DHS will also require expanded IT and data integration capacity to automate utility verification, standardize wage-matching, and embed Smart Policy Hub tools to sustain accuracy and compliance. Finally, sustained investment in training, staff development, and the Office of Program Integrity is essential to maintain a skilled workforce capable of managing the operational and fiscal risks introduced by H.R.-1, including expanded state cost-sharing requirements. These resources are foundational to achieving the dual goals of federal compliance and long-term reduction of Rhode Island's Payment Error Rate (PER).

Figure 23: Summary of Projected SNAP Costs¹

Cost Type	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	FF	GR	FF	GR	FF	GR	FF	GR	FF
CATEGORY 1: ELIGIBILITY CHANGES										
Benefits		(\$27.1)		(\$1.8)		(\$0.1)				
Personnel										
Operating (IT)	\$0.6	\$1.1	\$0.1	\$0.2	\$0.1	\$0.2				
Contracted Services										
CATEGORY 2: BENEFIT CHANGES										
Benefits										
Personnel										
Operating (IT)										
Contracted Services										
Revenue Impact ²										
CATEGORY 3: FINANCE CHANGES										
Benefits		(\$1.5)	\$9.3	(\$10.8)	\$13.0	(\$14.5)	\$13.0	(\$14.5)	\$13.0	(\$14.5)
Personnel			\$5.9	(\$5.9)	\$7.7	(\$7.7)	\$7.7	(\$7.7)	\$7.7	(\$7.7)
Operating (IT)			\$1.0	(\$1.0)	\$1.7	(\$1.7)	\$1.7	(\$1.7)	\$1.7	(\$1.7)
Contracted Services			\$0.2	(\$0.2)	\$0.7	(\$0.7)	\$0.7	(\$0.7)	\$0.7	(\$0.7)
TOTAL	\$0.6	(\$27.5)	\$16.5	(\$19.5)	\$23.2	(\$24.5)	\$23.1	(\$24.6)	\$23.1	(\$24.6)

Notes:

1. For SNAP, costs are presented as General Revenue (GR) and Federal Funding (FF), and not as All Funds (AF).
2. Financial Impacts of Category 2: Benefit Changes cannot be measured at this time.

CATEGORY 1 – ELIGIBILITY CHANGES

Figure 24: Summary of Benefit Impacts for Medicaid Category 1 Provisions

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	FF	GR	FF	GR	FF	GR	FF	GR	FF
CATEGORY 1: ELIGIBILITY CHANGES										
Work Requirements		(\$12.6)		(\$0.8)		(\$0.1)				
SUA Allowances		(\$13.0)		(\$0.6)						
Non-Citizen Eligibility		(\$1.5)		(\$0.4)						
Total		(\$27.1)		(\$1.8)		(\$0.1)				

Section 10102: Work Requirements

Program Description:

Under federal SNAP law, able-bodied adults without dependents (ABAWDs) must meet specific work requirements to receive benefits beyond three months in a 36-month period. Prior to H.R.-1, this requirement applied to individuals aged 18 through 54, with certain exemptions and limited state waiver authority. Volunteering or participation in an approved education/training program may also satisfy the requirement, provided participation is verified and meets the required hours. H.R.-1 amends Section 6(o) of the Food and Nutrition Act to expand the population subject to the time-limited benefit and narrow the exceptions. As of July 4, 2025, individuals aged 18 through 64 are subject to the ABAWD time limit unless they meet one of the modified exceptions outlined below. While individuals aged 60 to 64 remain exempt from the general work registration and SNAP Employment and Training (E&T) requirements, they are still subject to the ABAWD time limit unless another exception applies.

Program Changes:

Modified Exception Criteria: Effective July 4, 2025, State agencies must apply the following exception standards:

- Parent or Caretaker of a Dependent Child Under Age 14: Previously under 18 but now adults with children aged 14–17 are subject to the time limit unless they meet another exception.
- Removal of Fiscal Responsibility Act (2023) Temporary Exceptions: Veterans, homeless individuals, and those aging out of foster care no longer qualify for automatic exemption.
- New Exceptions for Native Populations: Adds exemptions for Indians, Urban Indians, and California Indians as defined under 25 U.S.C. §1603 and §1679. State agencies must verify these statuses per 7 CFR 273.2(f) and 273.24(l).

State agencies must screen all work registrants for these criteria at application and recertification and update client notices to inform individuals aged 55 through 64 that they are now subject to the ABAWD time limit. Both written and oral explanations of work requirements must be provided. A 120-day Quality Control variance exclusion applies for misapplication of the new exception criteria through November 1, 2025, after which all cases are fully subject to QC review.

Changes to Waiver Criteria: H.R.-1 revises Section 6(o)(4) of the Act to limit state requests for ABAWD waivers to areas with unemployment rates exceeding 10 percent. The former criterion allowing waivers based on a “lack of sufficient jobs” is eliminated. FNS will no longer approve or renew waivers under that standard. Special provisions apply to Alaska and Hawaii, where FNS may approve waivers for areas with unemployment rates 150 percent above the national average or grant temporary “good faith” exemptions through December 31, 2028, for states demonstrating implementation barriers. No other states qualify for these exceptions. All active ABAWD waivers issued under the previous “lack of sufficient jobs” criterion must be terminated within 30 days of this memorandum unless scheduled to expire by November 2, 2025. FNS strongly encourages states not to seek waivers and instead focus on connecting ABAWDs to employment, education, or volunteer pathways that satisfy the work requirement. No QC variance period applies to waiver implementation.

Populations, Providers, and Partners Affected:

- *Households:* Approximately 5,300 new Rhode Island cases become subject to work requirements, and around 4,000 lose previous exemptions. Additional adults aged 55–64 and parents of older teens will enter the ABAWD population.
- *Tribal and Indigenous Members:* Now eligible for new federal exceptions if verified per 25 U.S.C. §1603 and §1679.
- *Community Providers:* Increased demand anticipated for SNAP Employment & Training (E&T) navigation, childcare access, and food pantry support for newly restricted households.

Effective Date and Key Milestones:

July 4, 2025: Implementation of all modified exception and waiver criteria by July 4, 2025. End of 120-day QC variance period for exception application by November 1, 2025. Completion of policy manual, notice, and system updates and integration with RIBridges for expanded screening by FY26.

State Impacts:

- **Direct:** Increased system modification costs, eligibility training, and notice redesign. Potential benefit reductions from expanded ABAWD population.
- **Indirect:** Reduced food purchasing power for affected households, greater reliance on food pantries and community feeding networks, and heightened casework complexity for workers verifying tribal status or dependent age.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, the Department will embed these federal changes within the Quality Assurance (QA) Framework and “Find-and-Fix” process. Each system and policy update will include pre-implementation accuracy checks and post-implementation reviews to identify and correct emerging errors in real time. Findings will inform training and policy transmittals to maintain federal compliance and reduce PER exposure.

Compliance Options for Consideration

[Applies to Section 10102]

Option 1: Integrated Work-Requirement Platform and “One Front Door” Compliance Hubs

Description:

- Establish a single, unified platform connecting SNAP and Medicaid work-requirement rules under one policy and technology framework. Modeled on Tua Path or similar tools, it would interface with RIBridges to exchange data without rebuilding core systems. The platform would include both a customer-facing portal for real-time reporting and a worker portal for compliance tracking. Community “Front Door” Hubs would support customers with reporting, exemptions, and referrals.
- Create a centralized, multi-lingual, and disability accessible online repository across agencies and partners (e.g., DHS, DLT, Commerce, DBR, Secretary of State, OPSC, DOA, Universities, 211) of eligible volunteer, education, and work opportunities (adjusting hours for the RI minimum wage) as well as exemption hubs (i.e., organizations who folks can access for assistance in meeting exemptions).

Advantages:

- Streamlines reporting across programs and reduces duplication; improves accuracy and timeliness through digital verification; simplifies customer experience through a multilingual, mobile-friendly interface; reduces manual entry for staff; and aligns with PER reduction goals.

Disadvantages:

- Requires significant upfront investment and new governance structures; complex integration across systems; some participants will still need assisted-digital or paper options.

Other Considerations:

- Pilot in high-volume offices before statewide rollout; design for accessibility and mobile use; integrate with workforce and education systems; use Smart Policy Hub for training and communication alignment.

Implementation Risks:

- Interface or training gaps could cause reporting errors or inconsistent processes; data-sharing challenges could affect accountability.
- Local organizations who serve as hubs will likely need volunteer capacity support.

Authority Changes Needed:

- Interagency MOUs for data sharing, procurement authority for modular technology, and potential regulatory updates for shared compliance tracking.

Community Feedback:

- Broad support for a single, transparent system with reminders, plain-language notices, childcare/transportation resources, and real-time visibility for customers and partners.

Option 2: Voluntary Referral to the Vocational Rehabilitation (VR) Program

Description:

- Create a voluntary referral pathway linking SNAP and Medicaid recipients with disabilities to the Office of Rehabilitation Services (ORS) for vocational guidance, job training, and employment supports. Participants identifying work barriers due to disability may also be referred to ORS Disability Determination for SSI/SSDI evaluation.

Advantages:

- Leverages existing ORS and DLT partnerships; aligns financial eligibility; expands access to employment supports; promotes interagency coordination and long-term self-sufficiency.

Disadvantages:

- VR serves only individuals meeting its disability criteria and is not an entitlement program; capacity limits may restrict service availability.

Other Considerations:

- Participation must remain voluntary; messaging should emphasize choice and clarify that VR is optional and not tied to benefit eligibility. Outreach should guide those unable to work toward SSI/SSDI as appropriate.

Implementation Risks:

- Potential surge in referrals could slow processing; unclear messaging could cause confusion about voluntary participation.

Authority Changes Needed:

- None—existing law allows referrals for VR and SSI/SSDI services.

Community Feedback:

- Broad support for a voluntary, choice-driven model that connects individuals with disabilities to work supports while maintaining program integrity and informed consent.

Option 3: Volunteer and Peer-Led “SNAP-Ed Lite” Network

Description:

- Establish a volunteer- and peer-led “SNAP-Ed Lite” network to sustain nutrition education after the loss of federal SNAP-Ed funding. Trained volunteers, interns, and peers would deliver short, practical sessions in community settings and through virtual Work-Requirement Hubs, allowing participants to earn volunteer credit while promoting healthy eating and budgeting skills.

Advantages:

- Maintains statewide nutrition education at low cost; integrates with Work-Requirement Hubs and Eat Well, Be Well (EWBW); supports peer mentoring and community engagement; fosters cross-agency collaboration and skill-building.

Disadvantages:

- Requires ongoing volunteer coordination and quality control; instructional consistency may vary; volunteer availability may fluctuate.

Other Considerations:

- Develop a DOH/DHS-endorsed curriculum and short certification; integrate sessions with the Work-Requirement Portal for attendance tracking; recruit volunteers through colleges, Food Bank, and partners; explore small stipends or grants for sustainability.

Implementation Risks:

- Inconsistent standards or messaging without supervision; variable volunteer capacity; risk of misperception as a mandatory activity.

Authority Changes Needed:

- Internal policy to define volunteer criteria and authorize participation as a qualifying work activity.

Community Feedback:

- Strong support for sustaining nutrition education through volunteer networks that link with EWBW and Work-Requirement Hubs; viewed as empowering, community-driven, and aligned with self-sufficiency goals.

Section 10103: Standard Utility Allowances

Program Description:

Section 10103 of H.R.-1 changes how households can qualify for the Standard Utility Allowance (SUA) in the Supplemental Nutrition Assistance Program (SNAP). Currently, households that receive a minimum amount of heating or cooling assistance—often through the Low Income Home Energy Assistance Program (LIHEAP) or similar programs—are allowed to claim a standardized SUA deduction. This deduction simplifies reporting, reduces administrative burden, and often increases eligibility for the excess shelter expense deduction, resulting in higher SNAP benefits. The SUA provides a proxy for utility costs, avoiding the need for households to provide individual utility bills and for staff to manually verify them.

Program Change:

H.R.-1 eliminates the SUA for households that do not include an elderly or disabled member. These households must instead submit actual utility bills to demonstrate costs in order to qualify for an excess shelter deduction. This change removes automatic access to the SUA for many households, making eligibility for shelter deductions more difficult and often reducing SNAP benefits for non-elderly, non-disabled households. It also increases administrative complexity for eligibility staff, who must verify and calculate actual expenses.

Populations, Providers, and Partners Affected:

- *Households:* Low-income families without an elderly or disabled member are most affected. Many will experience reduced SNAP benefits, particularly renters and working families who previously qualified through LIHEAP participation.

- *State Agencies:* DHS eligibility staff will face increased workload due to the need for manual verification of utility bills, which introduces more opportunities for payment errors.
- *Community Providers:* Food pantries and community-based organizations may see increased demand from households experiencing reduced SNAP benefits.
- *Energy Assistance Providers:* Coordination between LIHEAP administrators and DHS may diminish in importance, as LIHEAP participation will no longer trigger the SUA for most households.

Effective Date and Key Milestones:

This provision takes effect November 1, 2025, aligned with the broader set of federal SNAP eligibility changes under H.R.-1. During FY 2025–FY 2026, DHS will modify eligibility system logic in RIBridges, update policy manuals, and train staff on manual utility expense verification to prepare for implementation. The new rules for the Standard Utility Allowance (SUA) will be applied to all new applications and recertifications effective November 1, 2025. New eligibility rules related to immigration status, work registrants, and ABAWDs are scheduled for February 1, 2026. Pending federal clarification—particularly regarding non-citizen eligibility categories and verification protocols—DHS has adjusted implementation of these provisions to ensure that all technology supports, legal notice requirements, and stakeholder engagement activities are completed before rollout. Monitoring of the Payment Error Rate (PER) impact will continue throughout FY 2026, as shelter deduction errors remain a major driver of Rhode Island’s SNAP error rate.

State Impacts:

- **Direct:** Reduction in SNAP benefits for affected households, requiring updated IT systems and staff retraining. Increased processing time and risk of errors in shelter calculations. DHS and RI Energy will explore data-sharing agreements to automate verification and reduce manual errors in shelter and utility calculations.
- **Indirect:** Reduced household food purchasing power will negatively affect grocery retailers. Increased strain is anticipated on food pantries and emergency food networks. Community partners may need to expand outreach to help families gather utility documentation.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, these changes will be monitored through the Department’s strengthened Quality Assurance (QA) Framework and “Find-and-Fix” case review process. Each new policy or system change will include a pre-implementation accuracy check and a post-implementation review to identify emerging errors and implement corrective actions in real time. Findings from these reviews will be shared through the statewide QA Collaborative, ensuring that results directly inform staff training, policy transmittals, and community-partner communications. Embedding this continuous feedback loop across policy, operations, and technology modernization efforts ensures that eligibility, benefit, and administrative changes strengthen program accuracy, reduce the state’s PER exposure, and maintain full compliance with federal oversight expectations.

Compliance Options for Consideration

[Applies to Section 10103]

Option 1: Utility Data-Match + Simple Proofs Pathway

Description:

- Automate verification of household utility costs through mandatory data-sharing with major energy providers and LIHEAP, replacing the current opt-out and manual proof process. DHS would receive regular, secure data feeds confirming active utility accounts or assistance, with a simple proof pathway (single bill or landlord statement) for unmatched cases.

Advantages:

- Reduces caseworker workload and shelter-calculation errors; replaces manual entry with standardized, automated verification; ensures full data exchange across systems; enables proactive cross-checks and future integration with other utilities.

Disadvantages:

- Requires upfront interface development, vendor participation, and privacy agreements; partial manual review may continue until full integration.

Other Considerations:

- Begin with RI Energy and LIHEAP as pilot partners; test batch uploads and validation scripts; track automation coverage and error-rate reductions.

Implementation Risks:

- Early data-feed inconsistencies or limited vendor readiness could delay full rollout; staff retraining needed for new workflows.

Authority Changes Needed:

- Amend data-sharing agreements to remove customer opt-out; issue policy establishing automated match as the primary verification method; update DHS-2 and related forms to authorize data exchange.

Community Feedback:

- Strong support for automation to reduce paperwork, improve accuracy, and ensure equitable SUA deductions statewide.

Option 2: Public/Private Seasonal Hardship & Energy-Efficiency Supports (Non-SNAP Funds)

Description:

- Create a public/private Seasonal Hardship and Energy-Efficiency Support Program to help renters and low-income households losing SUA eligibility or facing higher utility costs. The program would offer one-time annual payments or in-kind supports to prevent shutoffs and improve home efficiency, funded through discretionary or TANF resources and partnerships with utilities, weatherization programs, and philanthropies.

Advantages:

- Offsets loss of SUA benefits; prevents shutoffs and promotes stability; uses capped, flexible funding without creating ongoing obligations; combines relief with energy-efficiency education.

Disadvantages:

- Funding is limited and non-entitlement based; requires interagency coordination and potential temporary staffing for seasonal administration.

Other Considerations:

- Leverage discretionary, TANF, and partner funds; cap assistance at \$150–\$250 per household; prioritize renters, elderly, and non-heating households; integrate eligibility through RIBridges and Utility Data-Match (Option 1); align outreach with LIHEAP and weatherization partners.

Implementation Risks:

- Delayed funding or vendor setup could slow launch; limited resources may restrict reach; strong fiscal controls needed to manage one-time funds.

Authority Changes Needed:

- Legislative or budget authorization for a Seasonal Hardship Fund using existing resources; approval for capped payments and interagency coordination.

Community Feedback:

- Broad support for bundled emergency and efficiency assistance; partners emphasized early outreach, clear messaging, and targeting households most at risk.

Section 10108: Non-Citizen Eligibility

Program Description:

Section 10108 of H.R.-1 significantly narrows SNAP eligibility for non-citizens who are legally present in the United States under certain immigration categories. Under current law, a range of legally present non-citizens are eligible for SNAP, including refugees, asylees, survivors of trafficking or domestic violence, and other humanitarian entrants. These groups qualify based on urgent humanitarian considerations or conditions set forth in federal asylum and refugee law. The statute maintains SNAP eligibility for:

- U.S. citizens and nationals;
- Lawful permanent residents (with limited exceptions);
- Cuban and Haitian entrants and;
- Migrants lawfully residing under the Compacts of Free Association (COFA) with Micronesia, the Marshall Islands, and Palau.

All other legally present non-citizens—such as those granted conditional entry, humanitarian parole, or protection as survivors of domestic violence or trafficking—will no longer be eligible for SNAP benefits.

Program Change:

H.R.-1 eliminates SNAP eligibility for broad categories of legally present immigrants who are not included in the limited statutory list. This represents one of the most restrictive eligibility provisions in SNAP's history, reversing longstanding humanitarian protections. For Rhode Island, this change would terminate eligibility for individuals who have qualified for benefits

through asylum, refugee, or humanitarian parole status, unless they fall within the narrow list of exempt groups.

Populations, Providers, and Partners Affected:

- *Households:* An estimated 2,300 Rhode Islanders will lose SNAP eligibility entirely. These include asylum seekers, survivors of trafficking or domestic violence, and other humanitarian entrants currently receiving assistance.
- *Community Providers:* Food pantries, refugee resettlement agencies, and community-based nonprofits will face increased demand as SNAP households lose access to benefits.
- *State Agencies:* DHS will need to reconfigure eligibility systems, train staff, and implement changes in RIBridges to ensure compliance. Staff will also need to manage increased appeals and inquiries from affected households.
- *Advocacy and Legal Partners:* Immigrant support organizations and legal aid providers will likely see increased casework as families seek to understand or contest their loss of benefits.

Effective Date and Key Milestones:

This provision is effective November 1, 2025, aligning with the broader implementation of SNAP eligibility restrictions under H.R.-1. DHS is still awaiting formal FNS guidance about implementation. FY2025: System modifications, policy guidance, and staff training in FY25. Termination of eligibility for affected groups at new applications and recertifications in November 2025. Ongoing monitoring of caseload reductions, appeals, and community impact in FY26 and beyond.

State Impacts:

- **Direct:** Loss of SNAP eligibility for approximately 2,300 Rhode Islanders, requiring updates to eligibility rules in RIBridges and training for staff. Potential for increased administrative workload related to notices, case closures, and appeals. DHS will coordinate with DCYF and the Office of Refugee Resettlement to identify interim supports for affected households.
- **Indirect:** Increased food insecurity for immigrant households, rising demand at community food providers, and potential public health impacts. Providers may face financial strain as they absorb additional need. Rhode Island's refugee resettlement and immigrant-serving organizations will need to expand emergency assistance, advocacy, and support services.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, these changes will be monitored through the Department's strengthened Quality Assurance (QA) Framework and "Find-and-Fix" case review process. Each new policy or system change will include a pre-implementation accuracy check and a post-implementation review to identify emerging errors and implement corrective actions in real time. Findings from these reviews will be shared through the statewide QA Collaborative, ensuring that results directly inform staff training, policy transmittals, and community-partner communications. Embedding this continuous feedback loop across policy, operations, and technology modernization efforts ensures that eligibility, benefit, and administrative changes strengthen program accuracy, reduce the state's PER exposure, and maintain full compliance with federal oversight expectations.

Compliance Options for Consideration

[Applies to Sections 10108]

Option 1: Public and Private Food Assistance Bridge for Newly Ineligible Groups

Description:

- Create a temporary, state-funded Food Assistance Bridge Program to support humanitarian and mixed-status households losing SNAP eligibility under new federal non-citizen rules. Benefits would mirror SNAP purchasing rules, issued through existing EBT systems, and funded through discretionary or TANF dollars, with capped benefits and limited enrollment to ensure fiscal control.

Advantages:

- Maintains food access for vulnerable populations; uses existing systems to minimize costs; provides a time-limited, scalable safety net; reinforces the State's humanitarian commitments while ensuring fiscal predictability.

Disadvantages:

- Requires new state funding; limited by annual appropriations; may face administrative complexity in tracking eligibility across systems.

Other Considerations:

- Fund through discretionary and TANF sources; restrict eligibility to specific humanitarian categories; offer flat monthly or capped annual benefits; administer via RIBridges and EBT; include sunset clause and quarterly evaluation.

Implementation Risks:

- Funding volatility, eligibility confusion, and potential public scrutiny; administrative overlap if data matching is incomplete.

Authority Changes Needed:

- Legislative authorization to establish a State Food Assistance Fund and define eligibility, benefit levels, and allowable funding sources.

Community Feedback:

- Strong support from advocates for a capped, state-funded bridge to maintain food access for humanitarian populations while preserving fiscal discipline.

Option 2: Community Service Exchange Models (Non-Benefit)

Description:

- Establish community-based, voluntary service models allowing legally present non-citizens ineligible for SNAP—such as recent LPRs and humanitarian parolees—to earn food access through structured volunteer work (e.g., at food pantries or community gardens). Participants receive food credits or vouchers redeemable for groceries. The program would operate outside federal benefit rules in partnership with food banks, CBOs, and faith-based groups.

Advantages:

- Expands food access for ineligible non-citizens while remaining federally compliant; promotes dignity, community engagement, and self-sufficiency;

leverages existing food bank and agriculture networks without new entitlement spending.

Disadvantages:

- Limited reach and dependent on community capacity; may be uneven across regions; requires clear messaging to avoid confusion with work requirements.

Other Considerations:

- Ensure trauma-informed design; partner with food banks, gardens, and mutual-aid networks; coordinate outreach with the Food Assistance Bridge (Option 1); fund through discretionary or private resources—not federal benefits.

Implementation Risks:

- Potential confusion about voluntariness; sustainability tied to donations and local capacity; inconsistent availability statewide.

Authority Changes Needed:

- None—program can proceed under existing authority with DHS guidance for partnerships and reporting.

Community Feedback:

- Strong support for voluntary, culturally sensitive exchange models that foster inclusion, strengthen local food systems, and address hunger among excluded populations.

CATEGORY 2 – BENEFITS CHANGES

Figure 25: Summary of Impacts for SNAP Category 2 Provisions

Note: Financial Impacts of this provision cannot be measured at this time.

Section 10101: Thrifty Food Plan

Program Description:

Section 10101 of H.R.-1 modifies how the Thrifty Food Plan (TFP) is calculated and updated. The TFP represents the cost of a nutritionally adequate, low-cost diet and is the foundation for determining the maximum SNAP allotment. USDA sets the maximum benefit level for a four-person household based on the monthly cost of the TFP and adjusts benefits for households of other sizes. Under current law, USDA must:

- Annually adjust the TFP to account for inflation using the Consumer Price Index (CPI-U).
- Reevaluate the contents of the TFP every five years, considering updated food prices, nutritional guidance, consumption patterns, and food composition data (a requirement added by the 2018 Farm Bill).

This process allows benefit levels to reflect both changes in food costs and evolving nutrition science.

Program Change:

H.R.-1 prohibits USDA from increasing the cost of the TFP based on reevaluations of the market basket of goods. Instead, benefit adjustments are limited strictly to annual inflation updates using the CPI-U. This eliminates USDA's authority to update SNAP benefit levels based on changes in dietary guidelines, food availability, or consumption patterns. The

practical effect is that maximum SNAP benefits will no longer keep pace with evolving nutritional standards or shifts in the cost of maintaining a healthy diet.

Populations, Providers, and Partners Affected:

- *Households:* All SNAP households are affected, as the TFP sets maximum benefit levels. Families may see reduced purchasing power over time, as benefits will lag behind the true cost of a healthy diet.
- *Retailers:* Grocery stores serving SNAP participants may see reduced sales due to lower SNAP benefit levels.
- *Community Providers:* Food banks and emergency food providers may face increased demand as benefits fail to cover the cost of adequate nutrition.
- *Public Health Partners:* Nutrition and health advocates are concerned that limiting updates to CPI-U undermines efforts to align SNAP with dietary guidelines and obesity prevention.

Effective Date and Key Milestones:

This provision is effective October 1, 2025 (FY26). CPI-U becomes the only allowable adjustment factor; USDA reevaluations no longer increase benefit levels in October 2025. Benefit levels grow more slowly, falling behind the real cost of healthy diets in FY26 and beyond.

State Impacts:

- **Direct:** Reduced SNAP benefits for Rhode Island households over time, resulting in decreased federal funds flowing into the state's economy. The CBO estimates that making TFP updates cost neutral will reduce future benefit levels by \$37 billion through FY2034.
- **Indirect:** Anticipated impacts include reduced spending at grocery retailers, increased demand for food pantries, and worsening food insecurity. Long-term health impacts may include higher prevalence of diet-related chronic conditions (e.g., diabetes, hypertension), leading to increased pressure on the state's public health and healthcare systems.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, these changes will be monitored through the Department's strengthened Quality Assurance (QA) Framework and "Find-and-Fix" case review process. Each new policy or system change will include a pre-implementation accuracy check and a post-implementation review to identify emerging errors and implement corrective actions in real time. Findings from these reviews will be shared through the statewide QA Collaborative, ensuring that results directly inform staff training, policy transmittals, and community-partner communications. Embedding this continuous feedback loop across policy, operations, and technology modernization efforts ensures that eligibility, benefit, and administrative changes strengthen program accuracy, reduce the state's PER exposure, and maintain full compliance with federal oversight expectations.

Compliance Options for Consideration

[Applies to Section 10101]

Option 1: Strengthen and Expand the Rhode Island Interagency Food and Nutrition Policy Advisory Council

Description:

- Formalize and expand Rhode Island's Interagency Food Access Council (IFAC) into a permanent, cross-agency body co-chaired by DHS and DOH to align statewide nutrition programs, policies, and data. The Council will coordinate SNAP, WIC, EWBW, School Meals, CACFP, and emergency food programs to address food insecurity and reduced Thrifty Food Plan (TFP) purchasing power.

Advantages:

- Reduces program silos; improves coordination across agencies and community partners; strengthens data-driven targeting; enhances eligibility alignment; attracts federal and philanthropic support; reinforces EWBW and nutrition-education efforts.

Disadvantages:

- Requires sustained leadership and coordination capacity; managing diverse agency priorities may be challenging.

Other Considerations:

- Charter the IFAC through Executive Order or statute; establish working groups on policy, equity, community distribution, and data; fund coordination through discretionary, USDA, CDC, and philanthropic sources; align with EWBW and SNAP-Ed Life initiatives; publish annual "State of Food Access" reports with equity reviews.

Implementation Risks:

- Inconsistent engagement or data-sharing; overlap with existing groups; limited funding for ongoing coordination.

Authority Changes Needed:

- Interagency MOU between DHS, DOH, and WIC; Executive or legislative authorization for funding and formal establishment.

Community Feedback:

- Broad support from food banks, health providers, and community partners, emphasizing transparency, data sharing, and sustained community representation

Option 2: Sustain and Expand the Eat Well, Be Well (EWBW) Rewards Program

Description:

- Continue and expand Rhode Island's first-in-the-nation statewide SNAP incentive program, which provides a 50% produce discount (up to \$25/month) automatically credited to EBT cards. All SNAP households are enrolled, with incentives redeemable at Stop & Shop and Walmart statewide. Sustaining EWBW requires ongoing state funding and formal authorization as a permanent nutrition incentive program.

Advantages:

- Preserves access to affordable produce for 90,000+ households; improves diet quality and public health; strengthens retail and agriculture partnerships; operates efficiently using existing EBT systems; delivers measurable, data-driven outcomes.

Disadvantages:

- Requires continued state appropriations; dependent on retailer compliance and technology upkeep.

Other Considerations:

- Establish dedicated funding through annual appropriations, public-health funds, or federal GusNIP matches; consider expanding the monthly cap to \$35 and adding farmers markets and small grocers; integrate nutrition education via HealthyRhode and SNAP-Ed Lite.

Implementation Risks:

- Funding loss would disrupt benefits; expansion may require new POS integration; outreach needed to sustain participation among diverse households.

Authority Changes Needed:

- Legislation to codify EWBW as a permanent state program with a dedicated fund and retailer agreements.

Community Feedback:

- Strong support from retailers, public-health partners, and advocates who view EWBW as a national model for linking food access, retail innovation, and health equity.

CATEGORY 3 – FINANCE CHANGES

Figure 26: Summary of Impacts for SNAP Category 3 Provisions

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	FF	GR	FF	GR	FF	GR	FF	GR	FF
CATEGORY 3: FINANCE CHANGES										
Error Rate Matching ¹										
Administrative Cost Sharing (DHS)			\$7.1	(\$7.1)	\$10.1	(\$10.)	\$10.1	(\$10.1)	\$10.1	(\$10.1)
Administrative Cost Sharing (EOHHS)			\$2.2	(\$2.2)	\$2.9	(\$2.9)	\$2.9	(\$2.9)	\$2.9	(\$2.9)
SNAP-Ed Grant		(\$1.5)		(\$1.5)		(\$1.5)		(\$1.5)		(\$1.5)
Total		(\$1.5)	\$9.3	(\$10.8)	\$13.0	(\$14.5)	\$13.0	(\$14.5)	\$13.0	(\$14.5)

Notes:

1. Financial Impacts of Error Rate Matching cannot be measured at this time.

Section 10105: Error Rate Matching

Program Description:

Section 10105 of H.R.-1 establishes a state benefit cost-sharing requirement for the Supplemental Nutrition Assistance Program (SNAP) based on each state's payment error rate (PER). Beginning in FY2028, states must contribute a portion of SNAP benefit costs, ranging from 0% to 15%, tied directly to their error rate performance. Currently, states contribute 0% of SNAP allotments. Under the new statute:

- A state with a PER below 6% will continue to contribute 0%.
- A state with a PER at least 6% but less than 8% must contribute 5%.
- A state with a PER at least 8% but less than 10% must contribute 10%.
- A state with a PER 10% or greater must contribute 15%.

For FY2028 only, states may elect to use either their FY2025 or FY2026 error rate to calculate the requirement. For FY2029 and thereafter, the state match is based on the PER from the third prior fiscal year. The statute also provides delayed implementation for states with extremely high error rates. If a state's error rate in FY2025 or FY2026, multiplied by 1.5, equals or exceeds 20%, the requirement is delayed until FY2029 or FY2030, respectively.

Program Change:

This section introduces a fundamental shift in state financing for SNAP, tying program costs directly to payment accuracy. Rhode Island, which reported PERs of 12.40% in FFY2023 and 12.29% in FFY2024, would currently fall into the 15% state match tier if performance does not improve. This represents a major fiscal exposure, as the state would be required to cover up to 15% of SNAP benefit costs in addition to its administrative obligations.

Populations, Providers, and Partners Affected:

This provision does not directly change household eligibility, but it affects the entire SNAP caseload (over 80,000 Rhode Island households) by shifting federal/state financing responsibilities.

- *State Government:* DHS must achieve and maintain a PER below 6% to avoid significant state general revenue costs.
- *Providers and Partners:* Community food providers may experience indirect impacts if reductions in state participation or constrained resources limit program reach.
- *Households:* While benefits are not reduced under this section, state fiscal stress could influence long-term policy or service delivery decisions.

Figure 27: Fiscal Impact by Error Rate Tier

Payment Error Rate	State Match	RI Cost Share (Est.) (\$ Millions)
Below 6.00%	0%	None
6.00—7.99%	5%	\$17.1
8.00—9.99%	10%	\$34.2
10.00 and Above	15%	\$51.3

Effective Date and Key Milestones:

These changes are effective beginning October 1, 2027 (FY28), with delayed implementation to FY29 or FY30 for states meeting the statutory high-error condition. Federal error rates finalized and option for state to elect which year to use for FY28 baseline in FY25—FY26. State preparations and corrective action implementation in FY27. Annual state match liability applied based on three-year lagged PER in FY28 and beyond.

State Impacts:

- **Direct:** Rhode Island faces substantial fiscal liability if its PER is not reduced below 6%. At current performance levels (12.29%), the state would be responsible for 15% of SNAP benefits issued, creating hundreds of millions in potential new state general revenue costs. IT investments, training, and staffing to improve accuracy will also require significant upfront resources.
- **Indirect:** Increased financial exposure could reduce available state resources for other social services, increase legislative scrutiny, and heighten the urgency of DHS's PER improvement strategies.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, these changes will be monitored through the Department's strengthened Quality Assurance (QA) Framework and "Find-and-Fix" case review process. Each new policy or system change will include a pre-implementation accuracy check and a post-implementation review to identify emerging errors and implement corrective actions in real time. Findings from these reviews will be shared through the statewide QA Collaborative, ensuring that results directly inform staff training, policy transmittals, and community-partner communications. Embedding this continuous feedback loop across policy, operations, and technology modernization efforts ensures that eligibility, benefit, and administrative changes strengthen program accuracy, reduce the state's PER exposure, and maintain full compliance with federal oversight expectations. DHS will also integrate PER and accuracy metrics into annual performance evaluations for supervisors and QA leads, ensuring individual accountability aligns with statewide performance goals under H.R.-1.

Other Considerations:

- DHS will explore a Performance-Based Accuracy Incentive Pilot for staff and supervisors, tying recognition and professional development opportunities to measurable improvements in payment accuracy and timeliness.
- DHS will also integrate PER and accuracy metrics into annual performance evaluations for supervisors and QA leads, ensuring individual accountability aligns with statewide performance goals under H.R.-1.
- Conduct an Equity Impact Review prior to finalizing each major policy or operational change to assess potential disparities and ensure equitable access for all SNAP households.

Compliance Options for Consideration

[Applies to Sections 10105]

Option 1: Establish a State PER Reserve and Embed Vendor Performance Clauses

Description:

- Create a state-funded Payment Error Rate (PER) Reserve to protect against federal sanctions during the transition to new thresholds and embed performance-based accountability clauses in key vendor contracts. The reserve would serve as a fiscal backstop for potential penalties, while vendor clauses link compensation to measurable accuracy outcomes, ensuring shared responsibility for reducing errors.

Advantages:

- Provides fiscal protection from federal cost-sharing reductions; aligns vendor payments with performance; promotes accountability and transparency; strengthens data-driven contract management.

Disadvantages:

- Requires initial funding and administrative setup; adds contract negotiation workload; poorly defined metrics could drive short-term compliance over long-term improvement.

Other Considerations:

- Fund the reserve with discretionary or unspent federal administrative funds (up to 1% of annual SNAP admin costs); draw only when sanctions exceed available appropriations; include annual reporting to OMB and the General Assembly. Embed SLAs in major contracts with measurable benchmarks (accuracy, timeliness, resolution rates) tracked through Vendor Scorecards and the PER Dashboard.

Implementation Risks:

- Delays in authorization could limit responsiveness; monitoring multiple vendors may strain staff; unclear metrics could reduce vendor participation.

Authority Changes Needed:

- Legislative or budget language authorizing the reserve; procurement policy updates for performance-based SLAs; internal DHS procedures for fiscal and vendor oversight.

Community Feedback:

- Broad support from fiscal and federal partners for a transparent, accountable model that ties fiscal readiness to vendor performance and shared responsibility for quality outcomes.

Option 2: Community PER Partners

Description:

- Launch a Community PER Partners micro-grant program funding community-based organizations to help prevent client-caused errors through education and outreach. Partners will use DHS-approved materials to teach clients how to report changes, submit documents, and complete renewals—reinforcing consistent messages across DHS and partner networks.

Advantages:

- Extends PER prevention into trusted community networks; reduces client-caused errors; builds capacity for accurate referrals; promotes transparency through shared dashboards; strengthens trust with diverse communities.

Disadvantages:

- Impact attribution may be difficult; requires DHS staff for training and monitoring; smaller partners may need technical assistance.

Other Considerations:

- Offer \$5K–\$25K micro-grants targeting major error drivers; provide standardized toolkits and allow culturally tailored outreach; track activities in the Customer Portal; fund through discretionary, administrative, or philanthropic sources; publish quarterly partner results in the PER Dashboard.

Implementation Risks:

- Uneven partner capacity, complex reporting, or inconsistent messaging could limit results.

Authority Changes Needed:

- Policy authorization for a Community Partnership Grant Program and procurement flexibility for micro-grants.

Community Feedback:

- Strong support for co-created materials, plain-language outreach, and recognition of community partners as key allies in reducing Rhode Island's PER.

Section 10106: Administrative Cost Sharing

Program Description:

Section 10106 of H.R.-1 reduces the federal share of SNAP administrative costs from 50% to 25% beginning in FY2027 and for each fiscal year thereafter. Currently, the U.S. Department of Agriculture (USDA) reimburses states for 50% of administrative expenses, including staffing, technology, training, and operational costs required to administer SNAP. This section increases the state share from 50% to 75%, representing a fundamental shift in how SNAP operations are financed. Unlike eligibility rules or benefit calculations, this change does not affect who qualifies for SNAP or the size of household benefits. Instead, it significantly increases the state's financial responsibility for running the program.

Program Change:

Under H.R.-1, the state share of SNAP administrative costs increases by 25 percentage points beginning October 1, 2026 (the start of FY2027). For Rhode Island, which currently relies on approximately 50% federal reimbursement, this change effectively doubles the state's out-of-pocket administrative costs for SNAP. This shift occurs simultaneously with Section 10105 (Error Rate Matching), which ties state contributions to benefit costs, creating a dual fiscal pressure:

- Section 10105: State match of SNAP benefit allotments if error rates exceed 6%.
- Section 10106: Increased state responsibility for SNAP administrative costs regardless of error rate.

Populations, Providers, and Partners Affected:

This provision primarily affects state government and its partners in SNAP administration:

- *State Government (DHS):* The agency must secure new state general revenue to cover the increased cost of eligibility determination, customer service, quality assurance, and IT systems.
- *Workforce and Labor Partners:* Additional state investment will be required to sustain staffing levels, training, and system improvements.
- *Vendors/Contractors:* System vendors, call center operators, and training providers may see expanded contracts as the state invests to sustain operations without federal support. *Households:* While benefits are not directly reduced, administrative challenges (e.g., staffing shortages, slower processing times) could affect service delivery if the state cannot meet increased costs.

Effective Date and Key Milestones:

The reduced federal reimbursement rate takes effect October 1, 2026 (FY27). FY26 is a Planning Year where DHS develops budget adjustments, decision packages, and staffing/systems mitigation plans. FY27 begins the Implementation Year where State share of administrative costs increases to 75%. FY28 and beyond is when there is ongoing state responsibility for 75% of administrative costs, in addition to benefit cost-sharing requirements under Section 10105.

State Impacts:

- **Direct:** Rhode Island must absorb an additional 25% of SNAP administrative costs. Based on FY2024 spending levels, this shift could represent tens of millions of dollars in new state general revenue obligations annually. Additional pressures include IT modernization, training, and workforce investments required to maintain compliance with federal accuracy standards.
- **Indirect:** The increased state share may create competition for limited state resources, potentially affecting other human services programs. Providers and community partners may face indirect strain if administrative challenges reduce SNAP's efficiency, leading to longer wait times for households or greater reliance on emergency food networks.
- **Quality Assurance and Error Prevention Alignment:** Consistent with the Rhode Island SNAP Payment Error Rate (PER) Improvement Plan, these changes will be monitored through the Department's strengthened Quality Assurance (QA) Framework and "Find-and-Fix" case review process. Each new policy or system change will include a pre-implementation accuracy check and a post-implementation review to identify emerging errors and implement corrective actions in real time. Findings from these reviews will be shared through the statewide QA Collaborative, ensuring that results directly inform staff training, policy transmittals, and community-partner communications. Embedding this continuous feedback loop across policy, operations, and technology modernization efforts ensures that eligibility, benefit, and administrative changes strengthen program accuracy, reduce the state's PER exposure, and maintain full compliance with federal oversight expectations.

Other Considerations:

Pair operational redesign with staff wellness and change-management supports, including stress-mitigation resources, peer debriefs, and training to sustain morale during cost-share transitions and increased performance demands.

Compliance Options for Consideration

[Applies to Section 10106]

Option 1: Facility & Operations Redesign ("Right-Size the Footprint")

Description:

- Transition DHS from a primarily walk-in model to a hybrid system emphasizing appointments, digital access, and centralized processing. The redesign consolidates underused offices, expands the Shepard Building as a flagship regional hub, and reinvests savings into technology, QA, and workforce modernization to improve accuracy, timeliness, and customer satisfaction.

Advantages:

- Reduces lease and maintenance costs through consolidation; expands appointment-based and virtual access; enhances customer experience via digital tools; reinvests savings into staff training and QA; improves workspace design and morale; supports sustainability goals.

Disadvantages:

- Requires upfront investment and careful labor coordination, temporary disruptions possible during transitions.

Other Considerations:

- Prioritize high-cost, low-traffic offices for consolidation; expand self-service kiosks and universal appointment scheduling; use savings for technology and hybrid-work improvements; align redesigned offices with QA and Program Integrity functions; target a 10–15% footprint reduction by FY2027.

Implementation Risks:

- Relocation or system delays could disrupt service; uneven telework adoption may affect consistency; staff engagement essential for buy-in.

Authority Changes Needed:

- Legislative and budget approval for facility changes and capital investments, DOA HR support for labor consultation and hybrid work adjustments.

Community Feedback:

- Strong support for appointment-based, hybrid access and reinvestment of facility savings into staff development, QA, and digital modernization

Option 2: Cross-Program "Braided Funding" Administration Model

Description:

- Implement a braided funding model that shares administrative resources—such as call centers, training, QA, and document processing—across SNAP, Medicaid, RI Works, and Child Care. Rather than siloing costs, DHS will allocate shared expenses proportionally under the federal Cost Allocation Plan (CAP) to improve efficiency, sustainability, and fiscal accountability.

Advantages:

- Reduces duplication and streamlines overhead; expands flexibility to fund core support functions through multiple federal matches; promotes consistent service standards and data-driven management; strengthens sustainability under tighter federal cost-share rules.

Disadvantages:

- Requires precise cost-allocation documentation; increases fiscal tracking complexity; may need system and organizational updates to separate program and administrative reporting.

Other Considerations:

- Expand CAP to include shared functions; establish SLAs and unified dashboards for performance tracking; reinvest administrative savings into staff development, QA, and technology; govern through the DHS CFO, COO, and Program Integrity Administrator under existing improvement structures.

Implementation Risks:

- Improper cost allocation or system limitations could create audit risk; staff training needed on time reporting and compliance.

Authority Changes Needed:

- Federal approval of updated CAP; revised MOUs for cost-sharing; procurement updates for multi-program contracts; budget authorization for a Cross-Program Administrative Account.

Community Feedback:

- Strong support from staff, fiscal, and advocacy partners for administrative alignment that preserves frontline capacity and reinvests efficiencies into training, QA, and wellness.

Option 3: Digital Modernization & Self-Service Expansion

Description:

- Expand DHS digital services to create a seamless, multi-channel customer experience across RIBridges, SNAP Connect, the Customer Portal, and the HealthyRhode app. The initiative increases online applications, document uploads, kiosk access, and virtual appointments to reduce manual processing, speed up service, and improve accuracy.

Advantages:

- Cuts processing time and errors through automation; expands 24/7 access via web and mobile; frees staff for complex cases; enables real-time data validation and consistent guidance through the Smart Policy Hub.

Disadvantages:

- Digital divide may limit access for some; ongoing investment needed in cybersecurity, accessibility, and vendor oversight.

Other Considerations:

- Complete statewide SNAP Connect rollout; enhance portal workflows and mobile alerts; install in-office kiosks for same-day scanning; partner with libraries and community groups for digital assistance; target 60% digital submissions by FY2027 and 30% faster processing.

Implementation Risks:

- Adoption may plateau without outreach; integration or support gaps could frustrate users; limited broadband may hinder access.

Authority Changes Needed:

- Budget and procurement approvals for technology investments, kiosks, and translation services; statewide digital-access communications plan.

Community Feedback:

- Strong support for self-service paired with assisted help; advocates stress modernization should enhance—not replace—human interaction and equitable access.

Section 10107: SNAP-Ed Grant

Program Description:

Section 10107 of H.R.-1 eliminates the Supplemental Nutrition Assistance Program – Nutrition Education and Obesity Prevention Grant Program (SNAP-Ed). SNAP-Ed is a federal grant program administered by state and local SNAP agencies. It funds evidence-based nutrition education, obesity prevention projects, and interventions designed to help SNAP-eligible individuals make healthier food choices and increase physical activity, consistent with the most recent Dietary Guidelines for Americans. In Rhode Island, SNAP-Ed has supported partnerships with community-based organizations, schools, health providers, and food retailers to deliver programs that improve diet quality, reduce food insecurity, and promote long-term health outcomes.

Program Change:

H.R.-1 eliminates all federal funding for SNAP-Ed, ending the program nationwide. This rescinds a longstanding federal investment in nutrition education and obesity prevention for low-income populations and shifts responsibility to states or private partners should they wish to continue such programs.

Populations, Providers, and Partners Affected:

- *Households:* Low-income Rhode Islanders who currently receive SNAP-Ed services, including nutrition classes, cooking demonstrations, and physical activity initiatives, will lose access to these supports.
- *Community Providers:* Local nonprofits, health agencies, schools, and cooperative extension services that rely on SNAP-Ed funding will lose a key funding stream, threatening program sustainability.
- *State Agencies:* DHS and its partners will no longer administer or monitor SNAP-Ed programming. The loss of funding may reduce the state's capacity to promote preventive health strategies among SNAP participants.

Effective Date and Key Milestones:

The elimination of SNAP-Ed funding takes effect October 1, 2026 (FY27). Final year of federal SNAP-Ed funding and wind-down of contracts with community providers in FY26. Federal funding ceases and states must either discontinue programming or identify alternative funding in FY27.

State Impacts:

- **Direct:** Rhode Island will lose all federal SNAP-Ed grant funds (estimated at several million dollars annually). Without alternative funding, all associated staff positions and provider contracts will end.
- **Indirect:** Loss of SNAP-Ed is likely to increase food insecurity and diet-related chronic diseases over time. Grocery retailers and community food providers may see reduced demand for healthier food options promoted under SNAP-Ed. Schools and nonprofits may face service gaps as preventive education and health promotion activities end.

Compliance Options for Consideration

[Applies to Sections 10107]

Option 1: Digital & Mobile Nutrition Outreach

Description:

- Sustain nutrition education after the loss of SNAP-Ed funding through a Digital & Mobile Nutrition Outreach Initiative. Using the HealthyRhode app, Customer Portal, and EBT systems, DHS will deliver short, evidence-based nutrition tips, recipes, and videos timed with benefit cycles to promote healthy food choices and reinforce Eat Well, Be Well (EWBW) incentives.

Advantages:

- Maintains statewide nutrition education at low cost; reaches more households via familiar digital tools; integrates with EWBW and other DHS programs; reduces need for printed materials.

Disadvantages:

- Requires frequent content updates and translation; may not reach households with limited internet or smartphones.

Other Considerations:

- Partner with DOH, URI, and Brown for verified content; deliver multilingual messages through push alerts and EBT receipts; track engagement via the Smart Policy Hub; fund through discretionary, public-health, or private sources.

Implementation Risks:

- Lapsed updates could reduce engagement; digital-only outreach may exclude some users.

Authority Changes Needed:

- Procurement for content vendors; updated agreements with DOH; policy transmittal establishing digital nutrition outreach as an ongoing DHS function.

Community Feedback:

- Strong support for accessible, culturally tailored messaging integrated with EWBW; customers value timely, mobile-friendly nutrition prompts tied to incentives.

Option 2: SNAP-Ed Substitution through Braided Funding

Description:

- Establish a Braided Funding Model combining resources from DHS, DOH, schools, and nonprofits to sustain nutrition education after the loss of federal SNAP-Ed funding. The approach leverages public-health grants, EWBW funds, and discretionary dollars to deliver coordinated, community-based nutrition programs under the Interagency Food Access Council framework.

Advantages:

- Maintains statewide nutrition education through shared investment; promotes unified messaging across agencies and schools; supports flexible, locally driven programming; links nutrition outreach with PER and food-access goals.

Disadvantages:

- Requires strong interagency coordination and careful fiscal alignment; varying funding rules may complicate reporting.

Other Considerations:

- Use EWBW funds as a core anchor with braided DOH and education grants; support school and community-based learning; coordinate outreach via the Smart Policy Hub; administer through the Office of Community Partnerships with mini-grants and shared evaluation tools.

Implementation Risks:

- Without clear governance, outreach could become inconsistent; fiscal tracking may be complex.

Authority Changes Needed:

- Interagency MOUs, budget authority for braided funding, and procurement flexibility for educational materials.

Community Feedback:

- Broad support for a sustainable, collaborative model linking schools, health agencies, and community partners, with added opportunities for volunteer engagement through SNAP-Ed Lite and Work-Requirement Hubs.

Option 3: Reduce SNAP Eligibility to 100% FPL and Establish a State-Funded Food Assistance Program

Description:

- If Rhode Island's SNAP Payment Error Rate (PER) remains above 6% and federal penalties become unmanageable, DHS could lower SNAP eligibility from 130% to 100% of the Federal Poverty Level (FPL) to reduce caseloads and exposure while creating a state-funded Food Assistance Program (FAP) for households phased out of SNAP. The FAP would mirror SNAP benefits but be funded and administered by the state.

Advantages:

- Reduces federal penalty risk and caseload size; simplifies eligibility and improves accuracy; allows innovation in benefit design and local partnerships.

Disadvantages:

- Eliminates SNAP for households between 100–130% FPL; shifts full cost and administration to the state; may cause public opposition and transition challenges.

Other Considerations:

- Conduct an equity impact review; design FAP to mirror SNAP via EBT; explore philanthropic and waiver-based funding; coordinate messaging through the Smart Policy Hub.

Implementation Risks:

- Political and public backlash; compliance challenges maintaining separate federal/state caseloads; system and call center strain during transition.

Authority Changes Needed:

- Legislative action to amend eligibility and establish a State Food Assistance Fund; budget and regulatory updates; federal consultation with FNS.

Community Feedback (Anticipated):

- Likely concern about lost federal benefits but conditional support for a state-funded bridge that preserves food access and program equity.

HEALTH INSURANCE MARKETPLACE

Overview of Approach

The impact analysis conducted by HealthSource RI is based on the State's interpretation of H.R.-1; rates available for 2026 health plans offered through HSRI as of October 1, 2025; the overlapping and interactive effects of parameters set by the CMS 2025 Marketplace Integrity and Affordability Final Rule; and available customer demographic information as it pertains to the impacts of the anticipated expiration of the enhanced Advance Premium Tax Credits. Fluctuations in HSRI enrollment from month to month may cause variations in future calculations of impacts to the average household and/or to the state as a whole, though the net effects are expected to remain directionally unchanged. Assumptions explored for purposes of this report did not include the examination of any portion of the CMS rule currently stayed or otherwise delayed in legal proceedings.

The policy changes that affect Rhode Island's Health Insurance Marketplace can be grouped into 4 main categories – each of which is described in more detail below:

- Category 1: Affordability Changes—Broad-Based (Expiration in Current Law)
- Category 2: Affordability Changes—Specific Populations (Sections 71301, 71302, 71119)
- Category 3: Enrollment Barriers (Sections 71303, 71304, 71305, Marketplace Integrity and Affordability Final Rule)
- Category 4: Operational Challenges (Various)

Organization into these four categories allows for a holistic picture of the Marketplace changes within H.R.-1 coupled with the impacts of the CMS Final Rule and inaction as of October 1 on the expiration of the enhanced Advance Premium Tax Credits.

Overarching Human Capital Resources Needs for Compliance

Two additional personnel resources will be required for implementation at HealthSource RI—an Interdepartmental Project Manager and an Implementation Director for Policy and Programs. These personnel resources will be needed to provide appropriate staffing coordination and expertise to HSRI. An Implementation Director for Policy and Programs will serve as HSRI's lead expert in navigating these new and developing complex policy, technical, and compliance requirements. The Interdepartmental Project Manager will be needed to coordinate work and help manage critical deadlines within HSRI and between agencies. Implementation of these changes will be complex and will require additional support due to the increased workload on staff. Several HR1 initiatives will span multiple systems and business processes which requires more complex project management. The technical and operations team will be tasked to design, development, test, implement, and integrate these initiatives within the timeline mandated by the legislation and forthcoming CMS guidance. Additionally, the team will be responsible for providing oversight reporting and outcome metrics for these initiatives. Several initiatives (including Pre-Enrollment Verification) will become programs that touch and rely upon multiple systems and will require ongoing support and management for auditors, finance, and data resolution.

Impact Analysis and Compliance Considerations

In this section, a summary of cost impacts by category and change is presented. This is followed by a description of the specific changes within the categorical type. Where applicable, options for compliance are presented related to the specific changes for Rhode Island to contemplate.

Figure 28: Summary of Projected Health Insurance Marketplace Costs

Cost Type	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 1: AFFORDABILITY CHANGES - BROAD BASED										
Benefits										
Personnel										
Operating (IT)										
Contracted Services	\$0.14	\$0.37	\$0.13	\$0.33						
Lost HSRI RR Revenue ²	\$1.3	\$1.3	\$3.7	\$3.7	\$4.8	\$4.8	\$4.8	\$4.8	\$4.8	\$4.8
CATEGORY 2: AFFORDABILITY CHANGES - SPECIFIC POPULATIONS										
Benefits										
Personnel										
Operating (IT)	\$0.06	\$0.06	\$0.20	\$0.20						
Contracted Services	\$0.02	\$0.06	\$0.06	\$0.16						
Lost HSRI RR Revenue ²	\$0.21	\$0.21	\$1.0	\$1.0	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5
CATEGORY 3: ENROLLMENT BARRIERS										
Benefits										
Personnel			\$0.17	\$0.17	\$0.18	\$0.18	\$0.18	\$0.18	\$0.19	\$0.19
Operating (IT) ¹	\$0.01	\$0.02	\$0.01	\$0.03	\$1.7	\$1.7				
Contracted Services			\$0.25	\$0.64	\$0.63	\$1.6	\$0.40	\$1.0	\$0.29	\$0.74
Lost HSRI RR Revenue ²	\$0.16	\$0.16	\$0.36	\$0.36	\$0.62	\$0.62	\$0.96	\$0.96	\$1.2	\$1.2
CATEGORY 4: OPERATIONAL CHALLENGES										
Benefits										
Personnel			\$0.18	\$0.18	\$0.18	\$0.18	\$0.19	\$0.19	\$0.20	\$0.20
Operating (IT)										
Contracted Services										
Lost HSRI RR Revenue ²										
TOTAL	\$1.9	\$2.2	\$6.0	\$6.7	\$9.6	\$10.6	\$8.0	\$8.7	\$8.2	\$8.6

Note:

1. Operating (IT) to implement PEV may range from \$670,000 to \$2.7M in SFY 2028. As such, totals reflect the midpoint of the range.
2. "Lost HSRI RR Revenue" refers to an anticipated change to restricted receipt account revenue, equal to 3.5% of HSRI premiums, anticipated as a result of HSRI enrollment losses, expressed relative to a baseline without the federal change.

CATEGORY 1 – AFFORDABILITY CHANGES—BROAD-BASED

Figure 29: Anticipated Fiscal Impacts of Expiring Enhanced APTCs (millions)

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 1: AFFORDABILITY CHANGES - BROAD BASED										
Expiring Enhanced APTCs	\$1.4	\$1.6	\$3.8	\$4.0	\$4.8	\$4.8	\$4.8	\$4.8	\$4.8	\$4.8

Note:

1. Estimates include lost HSRI restricted receipt account revenue, equal to 3.5% of HSRI premiums, anticipated as a result of HSRI enrollment losses, expressed relative to a baseline without the federal change.

Expiring Law: Lack of Extension for Enhanced Advanced Premium Tax Credits (APTCs)

Program Description:

Advanced Premium Tax Credits (APTCs) were enhanced temporarily in 2021 as part of the American Rescue Plan Act (ARPA), lowering the amount of household income Rhode Island residents must spend towards their health insurance costs when purchasing through the State Based Marketplace, HSRI, and newly offering APTC eligibility to households that were previously ineligible due to income above 400% of the Federal Poverty Line (FPL). Specifically, ARPA lowered the sliding scale for the percent of income that enrollees must spend on marketplace premiums, covering the difference with increased tax credits. The Inflation Reduction Act (IRA), passed in 2022, extended these enhanced tax credits for an additional three years through December 2025.

Program Change:

Enhanced tax credits are set to expire in December 2025 in the absence of Congressional action. Expiration of enhanced APTCs will alter APTC calculations and result in lower APTC amounts and higher net premiums for 2026 coverage.

Populations, Providers, and Partners Affected:

This change will affect the approximately 41,400 existing HSRI enrollees currently eligible for APTC. These enrollees will lose an estimated \$59.3 million in 2026 annual APTCs and see their premiums double on average. HSRI estimates that approximately 13,100 customers will drop coverage by 2027 as a result. Customers that drop coverage will leave an additional \$70M in federal assistance on the table. This money, instead of primarily flowing to local healthcare providers, will not arrive in Rhode Island at all.

Figure 30: Breakdown of Population Affected by FPL Group

Household FPL		# Eligible for APTC	Average Monthly Premium (2026)				Total Annual APTC Loss	
			With eAPTC	Without eAPTC	\$ Premium Increase	% Premium Increase	Eligible APTC	Subtotal (% of Total Eligible APTC)
<200%	<150%	8,645	\$13	\$59	\$46	348%	\$5,172,834	\$19,840,476 (33%)
	150-200%	11,642	\$40	\$137	\$98	246%	\$14,667,642	
200-250%	200-250%	7,459	\$86	\$205	\$119	138%	\$11,752,652	\$11,752,652 (20%)
250-400%	250-300%	5,243	\$138	\$260	\$122	88%	\$8,286,519	\$14,618,198 (25%)
	300-350%	3,206	\$206	\$318	\$112	54%	\$4,492,016	
	350-400%	1,921	\$291	\$369	\$79	27%	\$1,839,663	
>400%	>400%	3,288	\$446	\$779	\$333	75%	\$13,126,610	\$13,126,610 (22%)
Total Enrollees		41,404	\$109	\$220	\$111	101%	\$59,337,936	\$59,337,936 (100%)

Note:

- 2025 enrollment is adjusted for anticipated H.R.-1 immigration-related enrollment losses occurring in 2026 and 2027
- This analysis uses 2026 coverage parameters and 2025 enrollment; no changes in plan selection are assumed.

Effective Date and Key Milestones:

These changes are effective as of January 1, 2026. Key milestones include:

- November 2025–January 2026: Open Enrollment, beginning on November 1, 2025, will be affected by changes to APTCs and premiums. HSRI will provide outreach and decision-making support to customers experiencing larger than normal premium increases due to the expiration of enhanced tax credits.

State Impacts:

- Direct:** Anticipated impacts include a reduction in APTCs and significant increases in premium costs for individuals enrolled in coverage through HSRI, as well as a reduction in anticipated HSRI user fee revenue due to resulting HSRI enrollment losses.
- Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care. Even if customers remain covered, some will do so by enrolling in higher deductible plans, leaving them less able to seek the care they need, or unable to pay for care they received.

Compliance Options for Consideration

[Applies to Current Law Expiring on APTCs]

Option 1: The State will send a proactive notice to customers losing APTC to ensure customers are aware of larger than normal premium increases for plan year 2026.

Advantages:

- Ensures customers are educated regarding what to expect for their premiums in plan year 2026. Operationally, this will not require much additional work as HSRI is already planning broader messaging around premium rate increases. Customers may be able to consider changing plans or taking other actions to prepare for increase costs.

Disadvantages:

- Pursuing customer communications only does not mitigate the adverse effects of the expiration of enhanced tax credits. Customers are likely to still drop health coverage due to large premium increases.

Other Considerations:

- Communications will need to be accessible for all impacted customers. For instance, HSRI should, as it typically does, use a wide range of platforms to share messaging, as well as translate messaging to ensure all customers are able to digest the information.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Targeted outreach will be needed to those most impacted financially by the expiration of enhanced tax credits and those with high medical needs. The HSRI contact center will need to be prepared for higher call volumes and provide consistent, clear messaging that is aligned with resources from community partners and payers. Furthermore, partnerships with community-based organizations (CBOs) can be leveraged to help impacted customers understand their options for meeting their healthcare needs.

Option 2: Consider a state premium subsidy program to backfill losses in enhanced tax credits.

Advantages:

- Protects individuals from the financial and health-related costs of uninsurance and underinsurance, protects the stability of the individual market, and protects the healthcare system from costs associated with rising rates of uninsurance and underinsurance. Retains the \$70M in base tax credits that current customers will remain eligible for.

Disadvantages:

- Fully replacing the value of enhanced APTCs would be costly to implement, approximately \$59.3 million for those remaining enrolled.

Other Considerations:

- A state-based program would require additional operational changes for HSRI to implement. In a scenario with funding constraints, a program that replaces lost enhanced tax credits could be tailored to maximize impact by partially replacing lost APTCs and scaling the value of replacement across income groups.

Implementation Risks:

- None.

Authority Changes Needed:

- At minimum, this option would require state law changes to allow HSRI to operate an assistance program and to spend funds on implementation and benefits. Regulations may also be needed to provide further specificity or allow HSRI to modify the eligibility criteria or benefit level of the program as budget or policy requirements change.

Community Feedback:

- In the fall of 2024, HSRI, at the request of the Rhode Island General Assembly, convened a group of broad-based stakeholders to discuss the implications of the expiration of enhanced APTCs on marketplace coverage affordability. The Marketplace Coverage Affordability Work Group was charged with making recommendations for designing a state-based program to provide affordability assistance to Rhode Islanders enrolled in plans through HSRI. The Work Group included members of the HSRI Advisory Board and representatives from the Office of the Health Insurance Commissioner, the Executive Office of Health and Human Services, health insurance carriers, healthcare providers, healthcare consumers, advocacy organizations, and representation from the RI business community. At the conclusion of six sessions, the Work Group recommended the option presented here, establishing a state-based premium subsidy program that replaces all enhanced APTCs as a first priority or partially replaces enhanced APTCs as a second priority.

Option 3: Consider a state incentive program for small businesses to offer coverage through HealthSource RI for employers.

Advantages:

- As costs for employees buying individually go up, small business owners may want to offer coverage. However, many will have difficulty with the cost. An incentive program could help these employers afford coverage through HealthSource RI for Employers, the state's small employer coverage marketplace.

Disadvantages:

- Could be expensive, depending on program structure and duration.

Other Considerations:

- Large employers (over 50 full-time equivalents) are already required to offer coverage to full-time employees under federal law. Some small businesses offer health coverage, while others do not. Most workers who don't have access to employer coverage are either employees of small businesses, or part-time employees who don't qualify for their large employer's coverage.

Implementation Risks:

- None.

Authority Changes Needed:

- At minimum, this option would require state law changes to allow HSRI to operate an assistance program and to spend funds on implementation and benefits. Regulations may also be needed to provide further specificity or allow HSRI to modify the eligibility criteria or benefit level of the program as budget or policy requirements change.

Community Feedback:

- Community members suggested various ways of encouraging employers to offer coverage, or to otherwise help employees whose costs may rise if they purchase individual coverage.

CATEGORY 2 – AFFORDABILITY CHANGES—SPECIFIC POPULATIONS

Figure 31: Summary of Specific Populations Impacts

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 2: AFFORDABILITY CHANGES -SPECIFIC POPULATIONS										
No APTC 5-year Bar and No APTC Immigration	\$0.29	\$0.33	\$1.2	\$1.3	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5
No APTC Work requirements										
TOTAL	\$0.29	\$0.33	\$1.2	\$1.3	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5	\$1.5

Note:

- Estimates include lost HSRI restricted receipt account revenue, equal to 3.5% of HSRI premiums, anticipated as a result of HSRI enrollment losses, expressed relative to a baseline without the federal change.

Sections 71301, 71302: Reduced Immigration Statuses Eligible for APTCs and Deny APTC for Lawfully Present Individuals Under 100% FPL

Program Description:

Rhode Islanders are generally eligible for APTCs if they are over 100% FPL, have legal immigration status, are not incarcerated, and have no access to other affordable coverage (including Medicaid, Medicare, or employer-sponsored insurance). Currently, individuals with incomes <100% FPL who would be eligible for Medicaid except for their immigration status, are the only group of people under 100% FPL who are eligible to receive APTCs through the ACA Marketplace. These lawfully present immigrants will be eligible for Medicaid after the 5-year bar (i.e., 5 year waiting period after gaining qualified immigration status before receipt of Federal benefits). In addition to the 5-year bar individuals, other lawfully present immigrants, such as refugees, asylees, lawful permanent residents, and other categories are eligible to enroll in health coverage through HSRI and receive APTCs, if they meet the other criteria.

Program Change:

H.R.-1 eliminates the exception that allowed APTC eligibility for those with incomes <100% FPL and ineligible for Medicaid due to the 5-year bar waiting period. In addition, H.R.1 reduces the designation of "Eligible Alien" for tax credit eligibility. "Eligible Alien" is now

limited to lawful permanent residents, Haitian/Cuban entrants, and COFA immigrants. Refugees, asylees, victims of human trafficking, and others are no longer eligible for APTCs. These changes limit the number of lawfully present immigrants able to receive APTCs through the ACA Marketplace.

Populations, Providers, and Partners Affected:

This change is expected to affect up 4,125 existing HSRI enrollees: 1,125 5-year bar individuals with incomes <100% FP and 3,000 individuals who have immigration statuses that will no longer be included in the definition of "Eligible Alien".

Figure 32: Estimated Breakdown of Population Affected by FPL Group

Household FPL	Total Disenrollments Due to Immigration Status (2026-2027)	
	5-Year Bar (Begins PY26)	Other Immigration Statuses (Begins PY27)
<150% FPL	1,125	689
150-200% FPL	-	821
200-250% FPL	-	526
250-300% FPL	-	370
300-350% FPL	-	226
350-400% FPL	-	136
>400% FPL	-	232
Total	1,125	3,000

Notes:

1. Distribution of impacted individuals across FPL groups is assumed to be similar to overall enrolled population

Effective Date and Key Milestones:

These changes are effective as of January 1, 2026, for eliminating APTCs for 5-year bar enrollees with incomes <100% FPL and as of January 1, 2027, for reducing the number of immigration statuses that are eligible for APTCs.

State Impacts:

- **Direct:** Anticipated impacts include an elimination of APTC to lawfully present immigrants enrolled in coverage through HSRI who are either subject to the 5-year bar and have incomes <100% FPL or who are no longer included in the definition of "Eligible Alien". Due to the significant increases in premium that will result, it is anticipated that these individuals will drop coverage through HSRI. Coverage losses will also result in a reduction in anticipated HSRI user fee revenue.
- **Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care.

Compliance Options for Consideration

[Applies to Sections 71301, 71302]

Option 1: Develop communications and outreach strategy including sending notices to those impacted describing the new changes, their timing, and impacts to customers.

Advantages:

- In response to receiving communication regarding the changes, some customers may take action to update their immigration status and/or their income as applicable to remain enrolled in coverage.

Disadvantages:

- For customers with no information to update in their application, communications will still not prevent them from losing health coverage.

Other Considerations:

- As the change impacting customers subject to the 5-year bar will occur first in OE 2026, HSRI has the opportunity to learn from the communications and outreach strategy used to notify these individuals and may be able enhance its approach when engaging with customers impacted by the change to "Eligible Alien" definition, which begins with OE 2027.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Partnerships with CBOs, especially those that serve impacted individuals, will be crucial to ensuring disenrolled individuals are able to find alternative coverage, if any is available to them. CBOs and community stakeholders will need access to the messaging used in notices to these individuals to promote consistency and limit confusion. Additionally, consideration should be given to expanding current programs such as Cover All Kids and the charity care reimbursement statute in light of likely increases in uncompensated care. Specifically, uncompensated care reimbursements for primary care and behavioral health providers may help limit gaps in care for the disenrolled immigrant population.

Section 71119: No APTCs When Losing Medicaid due to Community Engagement Requirements

Program Description:

Currently, if an individual is deemed ineligible for Medicaid and has income >100% FPL, they can receive financial assistance through the ACA Marketplace.

Program Change:

H.R.-1 newly requires community engagement activities as a condition for Medicaid eligibility for those in the Medicaid expansion population. If deemed ineligible for Medicaid coverage due to failing to meet community engagement requirements and not otherwise exempt from these requirements, individuals will also be blocked from receiving APTCs through the ACA Marketplace.

Populations, Providers, and Partners Affected:

This change is not expected to impact any currently enrolled in HSRI coverage but will affect the number of current Medicaid enrollees who are able to remain covered by health insurance through HSRI. Currently, Medicaid and HSRI form a gapless continuum for nearly all Rhode Islanders, which will be disrupted by this change, leaving those losing Medicaid without access to HSRI coverage either.

Effective Date and Key Milestones

These changes are effective as of January 1, 2027, or earlier at the option of the state. States may be exempted from compliance with the approval of the Secretary until no later than December 31, 2028, if the state is demonstrating a good faith effort to comply and submits progress in compliance. Key milestones include:

- HHS is required to release an interim final rule by June 1, 2026.
- State Medicaid programs must start outreach to enrollees in September 2026, 3 months before the first lookback period for determining eligibility, December 2026.

State Impacts:

- **Direct:** Anticipated impacts include a reduction in coverage options for individuals determined ineligible for Medicaid due to a failure to meet Medicaid community engagement requirements as coverage through HSRI may be unaffordable absent APTCs.
- **Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care.

Compliance Options for Consideration

[Applies to Section 71119]

Option 1: The State may develop integrated trainings across DHS and the Contact Center to ensure an aligned approach to communicating the impact of work requirements on receipt of tax credits through the ACA Marketplace.

Advantages:

- Maintaining an aligned approach reduces the risk of customer confusion and frustration. Consistent messaging across agencies will ensure that those denied Medicaid eligibility due to failure to meet work requirements will be aware of their coverage options.

Disadvantages:

- None.

Other Considerations:

- Aligning data sharing and approaches to customer communications will keep all agencies informed as to the cause of Medicaid disenrollments. Understanding the connection between Medicaid and HSRI will help DHS and Contact Center representatives assist impacted customers more effectively.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Additional targeted outreach and communication will need to be formulated collaboratively between agencies to ensure impacted individuals know their full range of options when disenrolled due to not meeting Medicaid work requirements. Communications with customers will also benefit from a clear, centralized list of qualifying volunteer and employment options to assist customers in meeting requirements.

CATEGORY 3 – ENROLLMENT BARRIERS

Figure 33: Summary of Enrollment Barriers Impacts

Section	(\$ Millions)										
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030		
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF	
CATEGORY 3: ENROLLMENT BARRIERS											
No APTC for Income SEPs	\$0.17	\$0.19	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32	\$0.32
Short Open Enrollment			\$0.22	\$0.51	\$0.27	\$0.55	\$0.32	\$0.59	\$0.35	\$0.61	
Pre-Enrollment Verification			\$0.17	\$0.17	\$2.5	\$3.1	\$0.86	\$1.2	\$0.96	\$1.1	
No Limit APTC Recapture			\$0.08	\$0.19	\$0.04	\$0.09	\$0.04	\$0.07	\$0.05	\$0.07	
TOTAL	\$0.17	\$0.19	\$0.79	\$1.2	\$3.1	\$4.1	\$1.5	\$2.2	\$1.7	\$2.1	

Notes:

1. Operating (IT) to implement PEV may range from \$670,000 to \$2.7M in SFY 2028. As such, totals reflect the midpoint of the range.
2. Estimates include lost HSRI restricted receipt account revenue, equal to 3.5% of HSRI premiums, anticipated as a result of HSRI enrollment losses, expressed relative to a baseline without the federal change.

Section 71304 and The Marketplace Integrity and Affordability Final Rule: Eliminates the SEP for Households with Income Under 150% FPL

Program Description:

Special enrollment periods (SEPs) enable individuals to enroll in ACA Marketplace plans outside of Open Enrollment or to change their current plans. In addition to qualifying life events (QLEs), the federally-facilitated marketplace and most states offer SEPs that are tied to an individual's annual income. For example, individual's making < 150% FPL are eligible for a SEP to enroll in coverage and receive APTCs.

Program Change:

H.R.-1 newly disallows APTCs for those enrolling in coverage through an income-based SEP. In addition, CMS's Marketplace Integrity and Affordability Final Rule fully eliminates income-based SEPs through December 2026. This means that starting in 2027, individuals may be able to gain coverage through income-based SEPs but will not be eligible for APTCs when enrolling via these pathways, rendering them impractical.

Populations, Providers, and Partners Affected:

The program change will limit how many people will enroll throughout the year through an income-based SEP. As this change will affect enrollment on an ongoing basis, the expected impact is 74 applicants per month or 888 per year starting in 2026. These estimates are based on historical data of the number of new enrollments per year through an income-based SEP. In addition to those newly enrolling in coverage, this provision will affect customers who are already enrolled in coverage by limiting their ability to switch plans.

Effective Date and Key Milestones:

The change included in H.R.1 eliminating APTC eligibility is effective as of January 1, 2026. The change implemented by CMS's Final Rule eliminating the SEP for households with income under 150% FPL is effective October 24, 2025, through December 31, 2026.

State Impacts:

- **Direct:** Anticipated impacts include a reduction in incoming enrollment throughout the year due to the elimination of income-based SEPs. Coverage losses will also result in a reduction in anticipated HSRI user fee revenue.
- **Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care.

Compliance Options for Consideration

[Applies to 71304, Marketplace Integrity and Affordability Final Rule]

Option 1: The State has the option of implementing a toggle functionality when operationalizing this change within the RIBridges enrollment system.

Advantages:

- By adding flexibility to the systems design of this provision, the State will be able to respond to future changes regarding the availability of this SEP. Given that the CMS Final Rule provision eliminating the SEP for households with income <150% FPL sunsets at the end of December 2026, the state may consider future changes.

Disadvantages:

- If there are no future changes that affect this SEP, the toggle feature may not be needed.

Other Considerations:

- As changes to income-based SEPs differ between the Final Rule and H.R.1, the State will need to consider the interaction between the Final Rule and H.R.1. in determining how to move forward once the CMS Final Rule provision sunsets at the end of December 2026. Without this SEP, it is especially important to quickly reach those who might qualify based on another life event, such as losing other health coverage.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Additionally, navigators may play an important role in helping those impacted understand their options for gaining coverage. Tailored trainings will be provided to navigators to help affected customers. Partnerships with CBOs who serve high-needs populations will also be beneficial so that individuals with incomes <150% FPL who may already be involved with these organizations can limit any gaps in needed care and understand when they are able to enroll in coverage through HSRI.

The Marketplace Integrity and Affordability Final Rule: Shortening the Annual Open Enrollment Period for Individual Market Coverage

Program Description:

The open enrollment period (OEP) currently runs from November 1st to January 31st. State-Based Marketplaces have usually been granted flexibility to extend or shorten the OEP based on state-specific circumstances.

Program Change:

Under the Marketplace Integrity and Affordability Final Rule, the OEP will be shortened to start no later than November 1st and end no later than December 31st. Marketplaces will have flexibility to determine their specific OEP dates within these guidelines as long as the OEP length does not exceed 9 weeks and all OEP plan selections are effective on January 1st of the applicable plan year.

Populations, Providers, and Partners Affected:

This change is expected to impact coverage selection starting with OE 2027 and in future OEs, with an estimated loss of 200 enrollees annually.

Effective Date and Key Milestones:

These changes are effective as of Open Enrollment 2027.

State Impacts:

- **Direct:** Anticipated impacts include a reduction in individuals enrolled in coverage through HSRI. Shortening the period in which individuals may enroll in coverage will create challenges for some consumers who are not aware that they are only allowed 9-weeks to find coverage. Furthermore, enrollment later in the OE period (December 25th – January 15th), tends to skew younger with 58% of the adult enrollment growth during OE in 2025 coming from those under 45. A reduction in enrollment of younger, healthier individuals could affect the risk pool and result in higher average premiums. Shortening the open enrollment period is also expected to result in a need for short-term staffing solutions at the contact center in order to handle higher volumes and increased volume volatility during the shortened period. HSRI anticipates that hours will need to be extended during the day and on weekends to handle the surge in volume. Coverage losses will also result in a reduction in anticipated HSRI user fee revenue.
- **Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care.

Compliance Options for Consideration

[Applies to Marketplace Integrity and Affordability Final Rule]

Option 1: The State will develop broad-based customer outreach and communications to address the shortening of OE, including encouraging self-service or off-peak inquiries.

Advantages:

- Communications may be integrated into broader messaging regarding open enrollment processes. Ensuring customers are aware of changes to the open enrollment period will allow current enrollees to make needed plan changes and new applicants to enroll during the 9-week window. Reducing call volumes during busy times will improve the ability to service high call volumes.

Disadvantages:

- Some customers may not read notices or website banners and remain unaware of changes to the OE period. Furthermore, customers who do see communications regarding this change may not digest the full implications of how it will impact their actions during OE. This may be especially relevant to current customers who are not aware that any plan selection actions must occur during OE.

Other Considerations:

- In response to shortened OE, the Contact Center may have additional questions regarding when customers are allowed to apply for coverage and options if an individual misses the OE period.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Leverage CBOs and community partners in communications and outreach strategy. Support broad-based awareness of changes to OE to ensure customers are informed about when action is required.

Section 71305: No Limit APTC Recapture

Program Description:

Individuals receiving premium tax credits through the ACA Marketplace must file and reconcile with the IRS. If an individual received excess premium tax credits because their estimated income at the time of enrollment in coverage was lower than their actual income, they must repay the excess tax credits. The reverse is true if an individual reported higher annual income than they received in reality. To protect individuals, there is currently a repayment cap that varies with income so that those with lower annual incomes are subject to less severe penalties. For those with income >400% FPL, there is no recapture limit.

Program Change:

H.R.-1 eliminates the repayment cap so that an individual must reconcile the total amount of excess tax credits they received if they underestimated their income.

Populations, Providers, and Partners Affected:

This change is expected to have a marginal impact on enrollment in coverage through HSRI. Some customers may choose to forego APTC due to concerns regarding repayment of excess tax credits. This may also lead to coverage losses over time as customers who experience increases in repayment amounts may be disincentivized to enroll in coverage for the following year.

Effective Date and Key Milestones:

These changes are effective as of January 1, 2026.

State Impacts:

- **Direct:** This change will result in some customers having to repay tax credits when filing their taxes. This may be especially impactful to lower income households and people with seasonal jobs who may not be able to estimate their annual income precisely when enrolling in coverage. Coverage losses will also result in a reduction in anticipated HSRI user fee revenue, though these losses are expected to be marginal.

- **Indirect:** Large repayment amounts may force some individuals to make difficult choices within their household budget as this will be an unanticipated expense for most households and will compete with other expenses for basic necessities.

Compliance Options for Consideration

[Applies to 71305]

Option 1: The State will pursue broad-based communications and outreach to all customers and emphasize the importance of updating income throughout the year.

Advantages:

- Communications may be integrated into broader messaging regarding changes occurring and open enrollment. By ensuring customers are aware of the connection between receipt of tax credit, income, and recapture of excess credits, this allows current enrollees to make more informed decisions during the application process.

Disadvantages:

- Some customers may not read notices or website banners and remain unaware of the financial risks of misestimating their income for the year. Communications regarding financial risks may also impact customers decisions about whether to enroll in coverage.

Other Considerations:

- The Contact Center may have additional questions regarding receipt of tax credits and income reporting. HSRI has focused on income training, as well as Federal changes training for the Contact Center to ensure clear messaging. Additional scripting and/or training may be beneficial to help customers understand the implications of updating and accurately reporting their income.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- None.

Section 71303: Pre-Enrollment Verification

Program Description:

ACA Marketplaces perform routine eligibility verification for new and existing enrollees. Eligibility verification usually occurs during enrollment, renewal, and throughout the year. To confirm eligibility, marketplaces compare trusted electronic data sources to an enrollee's reported information. In cases where this is a discrepancy between the enrollee's information and the data source, the enrollee will be asked to confirm their eligibility. Failure to comply may result in loss of APTCs and coverage. Enrollees applying for the first time are currently allowed conditional eligibility when there is a discrepancy in information and can retain financial assistance and coverage for up to 90 days while submitting additional documentation.

Program Change:

H.R.-1 Eliminates “conditional eligibility”, requiring customers to verify eligibility criteria before they can enroll. Verification requirements including submitting information related to income, immigration status, health coverage status, place of residence, and family size. These requirements may be waived for 1 to 2 months due to a change in family size. Additionally, marketplaces are permitted to use any reliable data source to collect information needed for eligibility verification.

Populations, Providers, and Partners Affected:

This change is expected to prevent an estimated 1,000 enrollments and renewals per year due to burdensome verification requirements and inability to receive APTC until after verification. This change may also impact enrollment in future years as verification will be required on an ongoing basis.

Effective Date and Key Milestones:

These changes are effective as of January 1, 2028.

State Impacts:

- **Direct:** Inability to verify eligibility may lead to some individuals dropping coverage while awaiting verification due to loss of financial assistance. Coverage losses will also result in a reduction in anticipated HSRI user fee revenue.
- **Indirect:** Anticipated impacts are an increase in the uninsured rate in Rhode Island and more stress on the healthcare system through increased uncompensated care.

Compliance Options for Consideration

[Applies to 71305]

Option 1: The State will pursue broad-based communications and outreach to all customers and leverage existing third-party data sources for verification.

Advantages:

- Communications may be integrated into broader messaging regarding open enrollment. Ensuring customers are aware of changes to verification procedures will allow current enrollees to prepare to submit any required documentation.

Disadvantages:

- Some customers may not read notices or website banners and remain unaware of actions they must take to retain coverage. Customers who do see communications regarding this change may not digest the full implications of how it will impact their coverage.

Other Considerations:

- Marketplaces are allowed to use reliable third-party data sources to verify application information. Using these sources will remove the burden on customers to actively report their information and will result in more streamlined enrollment processes.

Implementation Risks:

- None.

Authority Changes Needed:

- None.

Community Feedback:

- Leverage CBOs and community partners in communications and outreach strategy. Partners may be able to assist those impacted with gathering needed documentation for verification. In addition, HSRI should consider proactive actions such as collecting verification documentation from current enrollees before OE begins so that efforts can be focused on new applicants during the OE period.

CATEGORY 4 – OPERATIONAL CHALLENGES

Figure 34: Summary of Impacts of Operational Challenges

Section	(\$ Millions)									
	SFY 2026		SFY 2027		SFY 2028		SFY 2029		SFY 2030	
	GR	AF	GR	AF	GR	AF	GR	AF	GR	AF
CATEGORY 4: OPERATIONAL CHALLENGES										
Various			\$0.18	\$0.18	\$0.18	\$0.18	\$0.19	\$0.19	\$0.20	\$0.20
TOTAL			\$0.18	\$0.18	\$0.18	\$0.18	\$0.19	\$0.19	\$0.20	\$0.20

The provisions detailed above are expected to warrant several operational challenges. For instance, the HSRI Contact Center is expected to handle increased contact volume in addition to the average 5,000 calls the center receives weekly. Furthermore, after a customer leaves coverage, it is difficult to track and communicate about re-enrollment and for some re-enrollment may not be feasible financially without APTCs. Next, interactions between systems and populations impacted will be challenging to operationalize. Medicaid Work requirements will demand broad coordination on customer service for the Expansion population. Since Medicaid, DHS, and HSRI share the same eligibility system, there will need to be coordination to ensure provisions impacting multiple populations are clear. Finally, limited Federal guidance on implementation of provisions will add to operational challenges across all changes. Given the short timeframes to implement many provisions, it will be difficult for the State to mitigate any negative effects.

The provisions detailed above are not exhaustive of all the upcoming changes impacting the Health Insurance Marketplace. Additional, lower impact provisions include expanded HSA eligibility for bronze and catastrophic plans, (section 71307 in H.R.1), and other provisions within the Marketplace Program Integrity and Affordability Final Rule. Lower impact provisions in the rule include: eliminating QHP eligibility for Deferred Action for Childhood Arrivals (DACA) individuals, verification of income for those attesting discrepant income over 100% FPL, eliminating the fixed-dollar and gross percentage thresholds, income verification when tax data is unavailable, removing the 60-day extension to resolve income inconsistencies, failure to file and reconcile code changes, updating premium adjustment percentage methodology, and expanding de minimis ranges for actuarial value to permit less generous plans.

MOVING FORWARD

In summary, the Federal policy changes enacted in H.R.-1 have significant impacts to Rhode Island's beneficiaries, providers, facilities, employers, community partners, and government. EOHHS, DHS, and HSRI are actively working to mitigate the impact of Federal budget changes, prioritizing continuity of essential services for Rhode Island's residents. However, changes to Medicaid, SNAP, and the Health Insurance Marketplace rules and operations require tough budgetary, programmatic, and policy decisions to be made at the State level.

Cross-System and Other Policy Implications

Medicaid, SNAP, and our Health Insurance Marketplace play a critical role in the lives of Rhode Islanders, and navigating this new Federal landscape will require looking at the entire system and collaborating across the whole-of-community to address many of these shifts. As decisions are made moving forward—based on both the State's fiscal climate and the nature of the information provided in this report—it is imperative to remember and center the following:

1. The people affected by the changes by ensuring adequate resources for communications and community engagement/outreach activities to influence consumer behavior to adapt to changes more readily, avoid leaving specific population groups out (e.g., homeless), and promote options like staying insured at a higher premium.
2. The technology changes necessary to adopt these requirements must be thoroughly tested as they are complex, interconnected, and affect operations of all agencies within this report due to the integrated nature of RIBridges.
3. The implementation of each change may have unintended consequences on other provisions and/or options (e.g., hospital license fees, provider taxes, and state directed payments or SNAP change effects on PER rates).
4. The effects of these changes affect safety net services (and the need for alternative care) beyond uncompensated, emergency care (e.g., uninsured need for continued Medication for Opioid Use Disorder, food insecurity ramifications on chronic disease).
5. The options chosen in this plan will dictate the level of additional program/policy staff needed by agencies—as well as contracted subject-matter expertise—to design and implement successfully.

Additional Considerations

Between July and October, EOHHS engaged stakeholders and residents through a series of community feedback sessions focused on the policy changes impacting the programs described in this report. Participants expressed broad support for these programs, highlighting that they provide a critical safety net for the most vulnerable Rhode Islanders and play a central role in maintaining stability and well-being across communities. Community members also contributed a range of programmatic ideas and potential revenue generating options, which have been summarized and can be found in [Appendix III: Summary Themes Across Community Feedback](#).

Noted Report Limitations

While this report is robust and comprehensive in nature, there are limitations and assumptions that should be noted. Resolution of the continued Federal shutdown may have unanticipated impacts on the existing Federal budget and/or potential compromises, changing the information presented in this report. Outyear impacts beyond Federal mid-term elections are estimates only, as Federal law and policy could once again change. Additional interagency impacts beyond the three agencies included in this report should be considered more fully through the Health Care

System Planning Cabinet and other key convenings. Timing of changes may be challenging for populations (e.g., SNAP changes in the holiday season) and providers (e.g., rate changes to align with Medicare caps). Lastly, there are key guidance for implementation that Rhode Island still has not received from CMS or FNS that impact the key milestones, implementation options, and overall impact analysis presented within this report.

Continued Community Participation and Transparency

EOHHS, DHS, and HSRI are deeply grateful for the public participation and comment in the FCAG process that assisted with understanding the full scope of Federal budget implications and developing creative yet responsive strategies and options. As noted in this report, Rhode Island has explored as many avenues as possible to protect vulnerable populations and ensure access to vital healthcare, food assistance, and affordable health insurance. Through continued transparent communication, the community can work proactively to be prepared for the adjustments that will be necessary as changes take effect in Rhode Island. Only by working together across branches of government—and in partnership with the community—will Rhode Island be able to support affected beneficiaries, partners, and systems. Rhode Island will continue to provide clear, timely information about changes to eligibility, benefits, or services for Medicaid, SNAP, and HSRI members, along with resources to navigate these transitions upon implementation.

APPENDICES

Appendix I: Federal Compliance Advisory Group Membership

GROUP	SECTOR	ORGANIZATION	NAME	TITLE
Advocates	Aging	Senior Agenda Coalition of Rhode Island	Maigret, Maureen	Policy Advisor
	Children	Rhode Island KIDS COUNT	Carroll, Michaela	Health Policy Associate
	Community / Housing	Local Initiatives Support Corporation – Rhode Island	Cola, Jeanne	Senior Executive Director
	Consumer	Protect Our Healthcare Coalition – Rhode Island	Durac, Shamus	Co-Chair
	Data / Policy	Economic Progress Institute	Nelson-Davies, Weayonnoh	Executive Director
	Developmental Disabilities	Rhode Island Developmental Disabilities Council	Kevin, Nerney	Executive Director
	Family Supports	Rhode Island Parent Information Network	Sam, Salganik	Executive Director
	Finance	Rhode Island Public Expenditure Council	DiBiase, Michael	President & Chief Executive Officer
Businesses	Business	RI Business Group on Health	Charbonneau, Al	Executive Director
	Commercial Insurance	Blue Cross & Blue Shield of Rhode Island	Wofford, Martha L.	President & Chief Executive Officer
	Insurance (Both Commercial & Managed Care)	UnitedHealthcare Community Plan of Rhode Island	Florczyk, Michael	Chief Executive Officer
	Managed Care	Point32Health	Gilligan, Patrick	Chief Executive Officer
Healthcare	Acute / Emergency Care	Hospital Association of Rhode Island	Dulude, Howard	Interim President
	Behavioral Health	The Providence Center	Roy, Jillian	President
	Children	Family Service of Rhode Island	Holland-McDuff, Margaret	Chief Executive Officer
	Health-Related Social Needs	East Bay Community Action Program	Shiple, Jesse	Chief Operating Officer & Acting Health Advisor
	LTSS/HCBS	Rhode Island Partnership for Home Care	Oliver, Nicholas	Executive Director
	Managed Care	Neighborhood Health Plan of Rhode Island	Marino, Peter M.	President & Chief Executive Officer
	Public / Physical Health	Rhode Island Health Care Association	Gage, John E.	President & Chief Executive Officer
		Rhode Island Health Center Association	Nicolella, Elena	President & Chief Executive Officer
Public Sector Unions	Workforce	Rhode Island AFL-CIO	Crowley, Patrick	President
State Agencies	HHS Agency Directors	The Rhode Island Department of Behavioral Healthcare, Developmental Disabilities & Hospitals	Leclerc, Richard	Director
		The Rhode Island Department of Children, Youth & Families	Deckert, Ashley	Director
		The Rhode Island Department of Health	Larkin, Jerome M.	Director

GROUP	SECTOR	ORGANIZATION	NAME	TITLE
		The Rhode Island Department of Human Services	Merolla-Brito, Kimberly	Director
		The Rhode Island Office of Healthy Aging	Cimini, Maria E.	Director
		The Rhode Island Executive Office of Health & Human Services	Sousa, Kristin	Medicaid Program Director & Deputy Secretary for Medicaid Benefits
		The Rhode Island Office of Veterans Services	Yarn, Kasim J.	Director, Office of Veterans Services
	HHS Leadership	The Rhode Island Executive Office of Health & Human Services	Charest, Richard	Secretary of Health & Human Services
		The Rhode Island Executive Office of Health and Human Services	Novais, Ana P.	Assistant Secretary
	Other Impacted State Agency Directors	HealthSource RI	Lang, Lindsay	Director
		The Rhode Island Department of Labor & Training	Weldon, Matthew D.	Director
		The Rhode Island Executive Office of Housing	Goddard, Deborah	Secretary of Housing
		The Rhode Island Office of Management & Budget	Daniels, Brian M.	Director
		The Rhode Island Office of the Health Insurance Commissioner	King, Cory	Health Insurance Commissioner
	State Policy Experts	The Office of the Governor	Lowe, Karyn	Director of Policy
		Rhode Island Senate	Tremblay, David	Deputy Senate Fiscal Policy Advisor
		Rhode Island House	Urbani, Lynne	Director of Policy for the Speaker

Appendix II: Summary Themes Across Community Feedback

The following tables summarize key themes and ideas gathered through the FCAG community engagement process. These summaries reflect input from:

- **Three gallery walk sessions** on SNAP, Medicaid, and the Health Insurance Marketplace, held during each FCAG meeting and offered both in person and online.
- **Three public surveys** on the same programs (SNAP, Medicaid, and the Health Insurance Marketplace), each offered in English, Spanish, and Portuguese.
- **Two surveys distributed to involved state agencies** (EOHHS and DHS).

The content below represents synthesized themes and considerations rather than verbatim feedback, highlighting the main ideas and priorities shared by participants across all sessions.

Medicaid Gallery Walk Feedback

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Eligibility Redeterminations (71107)	<ul style="list-style-type: none"> • Concern about people losing coverage due to administrative issues and churn. • Concerns about lack of communication and notifications as well as the complexity of forms. • Concern over general loss of access to care/providers. 	<ul style="list-style-type: none"> • Prioritize people with disabilities and older adults for outreach by expanding targeted navigator services. • Invest in customer-facing and eligibility staff training and work to simplify mailings and forms (or have explainers). • Leverage community partners for application assistance and transition supports for those losing care to Free Clinics.
Retroactive Eligibility (71112)	<ul style="list-style-type: none"> • Concerns about ability to pay medical bills and impact on providers who rely on retroactive payments. • Concern about the overall impact on vulnerable populations and families. • Concern about increased bad debt for providers. 	<ul style="list-style-type: none"> • Use state funds to cover the gap or create a state-funded insurance problem-solving program for clients in need. • Prioritize enrollees connecting to Federally Qualified Health Centers (FQHCs) and hospitals. • Advocate for Federal flexibility on the one-month limit for expansion populations and/or explore administrative simplification.
Disqualified Entity Payment Ban (71113)	<ul style="list-style-type: none"> • Concern about loss of Essential Community Providers (ECPs) and decreased access to preventive and family planning services. • Concern about reduced access for women and rural populations. • Concerns about the capacity of other providers to absorb patient volume. 	<ul style="list-style-type: none"> • Identify alternative funds to maintain services. • Conduct outreach to explain where services can be obtained and invest in mobile OBGYN services for rural areas. • Partner with clinics and FQHCs to increase family planning capacity and with hospitals for on-demand care options.
Provider Tax Uniformity and Caps (71115)	<ul style="list-style-type: none"> • Concern about loss of revenue and reduction of supplemental payments to providers. • Concern about the financial stability of the safety net and access to care. 	<ul style="list-style-type: none"> • Look for new revenue streams or explore ability to phase in tax reductions for certain providers to mitigate impact. • Develop a contingency plan for provider solvency in partnership with other State efforts.

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
State-Directed Payment Standards (71116)	<ul style="list-style-type: none"> Concern about significant cuts to provider payments and the loss of flexibility in Medicaid program design. Concern about provider participation and access to high-quality care, especially in managed care plans. Concern about the impact on specialty and rural providers. 	<ul style="list-style-type: none"> Consider a State-grandfathering of current payments and advocate for a longer phase-down. Review which providers are most at risk of closure due to payment cuts and examine other supplemental payment programs for cost efficiencies.
Community Engagement Requirements (71119)	<ul style="list-style-type: none"> Concern that requirements are burdensome and will cause loss of coverage for eligible, vulnerable people. Concern about the impact on non-English speakers and those with unstable housing. Concern about the cost and complexity of the required technology system for tracking. 	<ul style="list-style-type: none"> Maximize exemptions and coordinate across state programs for qualifying activities and administrative simplification. Prioritize education and outreach for enrollees to understand the rule and partner/provider training on exemptions. Streamline reporting and verification processes that has feedback loop back to clients and/or care managers.
Expansion Population Cost-Sharing (71120)	<ul style="list-style-type: none"> Concern about the impact of cost-sharing on low-income individuals accessing necessary care. Concern about the impact on people with chronic conditions. 	<ul style="list-style-type: none"> Maximize the annual out-of-pocket cap and exempt high-value services from copays. Focus education on the out-of-pocket cap and sliding scale options.

SNAP Gallery Walk Feedback

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Thrifty Food Plan (10101)	<ul style="list-style-type: none"> Concerns about food pantry capacity, funding gaps, and rising demand Suggestions to leverage business discounts, TANF, WIC, and community outreach 	<ul style="list-style-type: none"> Increase emergency food hub funding, partner with businesses for discounts, and raise revenue via new policy initiatives Expand outreach through pediatricians and childcare centers Expand community gardens and food access points
Work Requirement Modifications (10102)	<ul style="list-style-type: none"> Concerns about impacts on disabled individuals, caregivers, immigrants, and homeless Suggestions for volunteer programs, training expansion, and simplified reporting 	<ul style="list-style-type: none"> Coordinate across State agencies Expand employment training and invest in childcare subsidies Engage CBOs for outreach and support for non-English speakers
Standard Utility Allowances Rules (10103)	<ul style="list-style-type: none"> Concerns about winter impacts and verification processes Suggestions for energy efficiency support and data sharing with utility companies 	<ul style="list-style-type: none"> Prioritize implementation before winter, Provide home efficiency kits and resources Establish data matches with utility providers
Matching Funds Requirements (10105)	<ul style="list-style-type: none"> Suggestions to use community partners to reduce error rates, peer support, and workforce readiness training 	<ul style="list-style-type: none"> Engage community groups for education and application support to reduce customer-originated errors
Administrative Cost Sharing (10106)	<ul style="list-style-type: none"> Concerns about funding gaps and impact on community partners Suggestions for system efficiency, navigator expansion, and tax increases 	<ul style="list-style-type: none"> Raise taxes, streamline benefit systems, expand navigator programs, and analyze vendor performance
Nutrition Education (10107)	<ul style="list-style-type: none"> Emphasis on preserving legacy programs and embedding education in other services Suggestions for partnerships with United Way and local farms 	<ul style="list-style-type: none"> Incentivize retail-based education and support local farms Coordinate with RIDOH (WIC, FHV) and RIDE (schools) Train 211 staff and support expanded outreach programs
Eligibility Restrictions (10108)	<ul style="list-style-type: none"> Concerns about mixed-status households, DCYF families, and asylum seekers Suggestions for state funding and advocacy for safety nets 	<ul style="list-style-type: none"> Use state funds to support affected populations Advocate for tax reforms to support safety net costs Engage community groups for targeted safety net education

Health Insurance Marketplace Gallery Walk Feedback

POLICY CHANGE AREA	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Enhanced Advanced Premium Tax Credit (APTC) Expiration	<ul style="list-style-type: none"> Significant concern over loss of affordability and the need for state-level financial backfill and new revenue sources 	<ul style="list-style-type: none"> Raise state revenue (e.g., taxes on alcohol, cannabis, sugary drinks, tobacco, gambling, cars) to backfill the loss of enhanced APTC and provide state premium assistance The impact on older enrollees and couples is larger The value of state investment versus the cost of uncompensated care or medical debt should be calculated
End APTC for "5-year bar" customers under 100% FPL	<ul style="list-style-type: none"> Focus on immigrants and their families; difficulty in identifying impacted individuals due to immigration status privacy concerns 	<ul style="list-style-type: none"> Expand Cover All Kids to include adults with no available coverage options as a safety net for immigrant families losing coverage Rely heavily on trusted community partners as liaisons for outreach/supportive strategies to hard-to-reach populations
Eliminate APTCs for Legal Immigrant Statuses	<ul style="list-style-type: none"> Need to identify which state systems will feel the most impact (e.g., children/families) when DACA and immigrants lose coverage 	<ul style="list-style-type: none"> State-based tax credit to replace APTC Expand charity care statute to include primary care, dental, and behavioral health providers
Pre-Enrollment Verification	<ul style="list-style-type: none"> Focus on the operational challenge of getting individuals to gather necessary documentation <i>before</i> the enrollment period 	<ul style="list-style-type: none"> Consider options for pre-enrollment verification and gathering necessary information from enrollees <i>before</i> open enrollment begins Proactive marketing and outreach strategies listing out what docs may be needed for pre-enrollment Hire and work with CBOs and utilize Community Health Workers to assist with verification and documentation
Shortening Open Enrollment Period (OEP)	<ul style="list-style-type: none"> Concern over the shorter timeline and its potential impact on customers and contact center operations 	<ul style="list-style-type: none"> Consider options to ensure open/pre-enrollment can begin earlier to account for the earlier end date Consider a generous SEP for exigent circumstances for people with enrollment issues during OEP If possible, move towards year-round enrollment
Unlimited Recapture of APTCS	<ul style="list-style-type: none"> Concern about the impact on individuals with variable income 	<ul style="list-style-type: none"> Develop ways to ensure folks with variable income and hours are able to easily report
No APTC if Termed Due to Work Requirements Non-Compliance	<ul style="list-style-type: none"> Concern about "kicked off" individuals and the duration of their ineligibility (the "ban") 	<ul style="list-style-type: none"> Identify health workers (like home health CNAs) who may be impacted Consider any State options on how long a "ban" for those kicked off Medicaid for work requirements can be

Medicaid Community and Staff Survey Feedback

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Eligibility Redeterminations (71107)	<ul style="list-style-type: none"> Broad risk of coverage loss and churn Seniors may lose home care; families struggle to find care Missed notices could lead to administrative closures Possible "medical access deserts" in low-income areas 	<ul style="list-style-type: none"> Maximize ex parte (PEV) renewals; simplify forms/docs Revise notices (BDNs); track admin closures and returns to coverage Leverage HSRI call center; add volunteer hub for help Train providers/assisters; maintain QI on renewals
Retroactive Eligibility (71112)	<ul style="list-style-type: none"> Shorter retro periods increase risk of unpaid bills for facility care 	<ul style="list-style-type: none"> Coordinate with nursing/assisted-living on timely submissions Clarify that retro does not apply to MAGI; communicate clearly to applicants
Disqualified Entity Payment Ban (71113)	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> N/A
Provider Tax Uniformity and Caps (71115)	<ul style="list-style-type: none"> Higher demand on community food and health services 	<ul style="list-style-type: none"> N/A
State-Directed Payment Standards (71116)	<ul style="list-style-type: none"> Community agencies may lose staff due to low pay Concern about hospital stability; EMS/CNA shortages 	<ul style="list-style-type: none"> Ensure SDP standards do not block needed MCO rate increases Explore alternative approaches to sustain hospitals and safety-net capacity
Community Engagement Requirements (71119)	<ul style="list-style-type: none"> People unable to meet work rules may lose coverage Increased food insecurity; food pantries strained Added pressure on people with disabilities/behavioral health needs SSI coverage viewed as more stable than activity reporting 	<ul style="list-style-type: none"> Broad exemptions; define "medically frail" broadly Simple paths to claim exemptions; share data on who is affected Coordinate with OHA/RI Elder/senior centers; build on SNAP pathways Support people awaiting disability decisions; use RI Works where applicable Prepare for higher SSI applications; expand capacity and early transitions to SSI
Expansion Population Cost-Sharing (71120)	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> Track cost-sharing impacts with MCOs / providers Monitor effects on middle-income members and risk of coverage loss
N/A, Applies to All	<ul style="list-style-type: none"> Older adults overwhelmed by online forms/processes Address-verification rules may drop coverage for unstably housed, justice-involved, or youth aging out of care 	<ul style="list-style-type: none"> Improve SSI processing; expand disability-focused workforce programs If savings occur, reinvest in safety-net provider rates with access safeguards Pilot tools to keep addresses current ahead of federal deadline

SNAP Community and Staff Survey Feedback

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Thrifty Food Plan (10101)	<ul style="list-style-type: none"> • Cost-neutral TFP reduces purchasing power over time • Higher food costs in several RI regions worsen insecurity • Greatest impact on children, older adults, and people with chronic conditions • Ongoing racial/ethnic disparities in food insecurity 	<ul style="list-style-type: none"> • Seek regional cost adjustments; build an RI price-monitoring dashboard • Create a state supplement for very low benefits; consider TANF threshold changes • Expand nutrition incentives; partner with mobile markets/retailers and apps • Collect RI-specific cost data; coordinate New England advocacy • Explore insurer co-investment; increase support for the RI Community Food Bank • Strengthen links to WIC, school and summer meals; improve WIC/SNAP coordination
Work Requirement Modifications (10102)	<ul style="list-style-type: none"> • Increased churn, appeals, and paperwork burden • Transit reductions create mobility barriers to work or volunteering • Gaps for people with behavioral health needs or invisible disabilities • Added pressure on parents of teens (13–17) and adults 55–64 • CBOs expect higher demand for outreach and case management 	<ul style="list-style-type: none"> • Wait for FNS guidance before changing rules/systems • Broaden exemptions; define “medically frail” broadly; simple claiming process • Fund CHW navigators; restructure outreach staffing and coverage map • Provide SSI application support; assist while disability claims are pending • Form a cross-agency task force (EOHHS/DHS/DLT/RIDE/OHA + CBOs) • Add supports (childcare, transportation, digital access) • Build a statewide volunteer-opportunity network that meets WR rules • Review alignment with SNAP E&T; consider caregiver rule adjustments
Standard Utility Allowances Rules (10103)	<ul style="list-style-type: none"> • Many households face high utility costs, especially in older housing • Loss of LIHEAP-based SUA lowers benefits for non-elder/non-disabled households • Large statewide impact; families with young children at risk • Extra paperwork and confusion for applicants 	<ul style="list-style-type: none"> • Create a state-level utility offset/alternative deduction • Integrate SNAP with LIHEAP/weatherization; allow self-declaration where permitted • Screen for separate heating/cooling costs; train DHS staff and partners • Explore insurer co-investment to prevent unsafe coping strategies • Simplify forms; provide clear application support
Matching Funds Requirements (10105)	<ul style="list-style-type: none"> • State budget risk if error rates exceed federal thresholds • Resources may shift away from community programs • Delays/denials more likely for families, older adults, and people with disabilities • LEP/immigrant households more exposed to paperwork errors 	<ul style="list-style-type: none"> • CHW-led error-prevention coaching; plain-language notices; SMS reminders • Rapid error-review team (DHS + CHWs) to fix hotspots • Add staffing; standardized training and QA feedback loops • Rebuild centralized outreach model; explore AI tools to reduce errors • Identify sustainable revenue to avoid benefit cuts
Administrative Cost Sharing (10106)	<ul style="list-style-type: none"> • Longer processing times and more errors • Higher caseloads for applications, appeals, and recerts • Greater strain on CBO staffing, operations, and budgets • Disproportionate impact on LEP/immigrant households • Tradeoffs in the state budget; taxpayer concern 	<ul style="list-style-type: none"> • Formalize state–community compacts for intake and recerts • Modernize tech (mobile uploads, e-signature, multilingual chat) • Fund community eligibility assistance to reduce state workload • Review admin spend; add state budget support as needed • Consider new revenues (e.g., vaping/sugary-drink/alcohol taxes) • Increase state allocation to SNAP and the emergency food network

POLICY CHANGE (Section)	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Nutrition Education (10107)	<ul style="list-style-type: none"> Loss of SNAP-Ed reduces skills to stretch budgets and choose healthy foods High-need groups most affected (pregnant/postpartum, elders, chronic disease) Fewer community classes: partners lose capacity Progress on obesity prevention may slow 	<ul style="list-style-type: none"> Backfill with state/health-system funding; center CHW-led, culturally relevant programs Share existing materials; coordinate statewide efforts Create a state nutrition-education coordinator; use train-the-trainer model Convene partners; pursue federal/state/private grants Consider alternative revenues to sustain prevention
Eligibility Restrictions (10108)	<ul style="list-style-type: none"> Higher food insecurity in immigrant communities and specific cities Children at risk of hunger; potential increases in health costs Service organizations see rising emergency food demand 	<ul style="list-style-type: none"> Consider a state SNAP-like benefit for lawfully present groups losing eligibility Convene a task force on communication, due process inserts, and food access Increase state support for the RI Community Food Bank Apply changes at recertification; expand assister network and public-charge education Partner with philanthropy for bridge cash aid; connect families to WIC/RI Works Explore revenue options (e.g., Nourish RI-type initiatives)

Health Insurance Marketplace Community Survey Feedback

POLICY CHANGE AREA	IMPACT ANALYSIS: Stakeholder Themes	POTENTIAL SOLUTIONS: Stakeholder Feedback
Affordability Changes – Broad Based	<ul style="list-style-type: none"> • More people skip coverage; use ER for basic care • Worse health outcomes; delayed treatment • Higher uncompensated care; strain on hospitals/clinics • Older adults hit hardest • Nonprofits face higher demand with fewer funds • Strong public concern about harm 	<ul style="list-style-type: none"> • State audit to cut duplicative costs • Sliding-scale help; state affordability program • Update uncompensated care; consider state buy-in • Strengthen mandate hardship exemptions • Multilingual info; track long-term-care impacts • Consider state-based APTCs or other funding
Affordability Changes – Specific Populations	<ul style="list-style-type: none"> • Loss of benefits harms vulnerable groups • Less money for food/meds; chronic conditions worsen • More ER use; rising behavioral health needs • Shortage of bilingual/qualified staff • Confusion among older adults about Medicare/Medicaid/HSRI • System risk for older adults 	<ul style="list-style-type: none"> • Grants to CAPs/community clinics to grow capacity • Coverage option for immigrants via community providers • Affordability program; update uncompensated care; state buy-in • Up-front docs education; increase state staffing • Multilingual/tech assist (voice/AI) • Ensure funding for CHCs and specialty care
Enrollment Barriers	<ul style="list-style-type: none"> • Risk of self-medication if access is hard • Low-income families face paperwork and cost burdens • Support orgs may be overwhelmed • Online streamlining can reduce errors and calls • Program rules confuse many older adults 	<ul style="list-style-type: none"> • Community outreach with CHWs/navigators • State special enrollment period • Invest in systems; simple, frequent reminders • Improve online flow (jump-to, integrated screening, clear sites, fillable PDFs) • Expand navigator/CAC network, better income tools • Consider relief from penalties and premium shocks
Operational Challenges	<ul style="list-style-type: none"> • Complex rules/timelines may overwhelm residents • Staffing strain; higher call volume; system costs • Underserved and small communities most affected • Clear info and online tools ease burden 	<ul style="list-style-type: none"> • Cross-agency system of care • Fund/train Community Health Workers • DHS–HealthSource RI team for guided help • Invest in systems, train community partners • Statewide network of community assisters with coordination • Enhance online app (jump-to, POA upload, multilingual/voice guidance)
Applies to All	<ul style="list-style-type: none"> • Need clear PSA campaigns and early messaging • Extend deadlines; simplify documentation • Explore protections for low-income customers • Big impact on adults just above Medicaid • Training videos and shared messages with CBOs 	<ul style="list-style-type: none"> • N/A

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