



Rhode Island Executive Office of Health and Human Services
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Health Care System Planning Cabinet Meeting
July 10, 2025
11:30 am to 1 pm
Department of Administration, Conference Room 2A
Providence, RI

Cabinet Members:	Agency:	Present:
Secretary Richard Charest	Executive Office of Health and Human Services (EOHHS)	Yes
Assistant Secretary Ana Novais	EOHHS	Yes
Director Kristin Sousa	Medicaid Program	No
Director Jerome Larkin, MD	Rhode Island Department of Health's (RIDOH)	Yes
Director Kimberly Merolla-Brito	Department of Human Services (DHS)	Yes
Director Richard LeClerc	Department of Behavioral Health, Developmental Disabilities, and Hospitals	Yes
Deputy Director Brandi DiDino, designee for Director Ashley Deckert	Department of Children, Youth and Families (DCYF)	No
Director Matthew Weldon	Department of Labor and Training (DLT)	Yes
Commissioner of Postsecondary Education Shannon Gilkey	Office of the Post-Secondary Commissioner	No
Director Maria Cimini	Office of Health Aging (OHA)	Yes
Director Lindsay Lang	HealthSource RI (HSRI)	Yes
OHIC Commissioner Cory King	Office of the Health Insurance Commissioner	Yes
Director Kasim Yarn	Office of Veterans Services	Yes
Director Karyn Lowe	Office of Governor McKee	Yes

EOHHS Independent Advisory Council Members Present:

Lt. Governor Sabina Matos
 Professor Ateev Mehrotra, Brown University School of Public Health
 Al Charbonneau, RI Business Group on Health
 Elena Nicoletta, RI Health Center Association
 Joan Kwiatkowski, CEO of PACE Organization of Rhode Island
 John Fernandez, President & CEO, Brown University Health

John Minichiello, Care Transformation Collaborative Rhode Island
John Tassoni – Substance Use and Mental Health Leadership Council
Larry Warner, Chair of the Governor's Council on Behavioral Health
Laurie Pisciotta, Mental Health Association of Rhode Island
Lisa Tomasso, Vice President, Hospital Association of Rhode Island
Melissa Husband for Peter Marino, Neighborhood Health Plan of RI
Michael Florczyk, UnitedHealth Group
Michael Wagner, MD Care New England.
Nelly Burdette, Care Transformation Collaborative RI
Patrick Vivier, Dean of URI College of Health Sciences
Peter Pogacar, MD, American Academy of Pediatrics, RI Chapter
Representative Tina Spears, Community Provider Network of RI
Richard Glucksman, Blue Cross & Blue Shield of Rhode Island
Sandy Valentine, Executive Director, Rhode Island Communities for Addiction Recovery Efforts
Sandra Victorino, LMHC, Commission for Health Advisory and Equity
Shamus Durac, Protect Our Health Coalition
Stacy Paterno, Executive Vice President, Rhode Island Medical Society
Tanja Kubas-Meyer, Executive Director, RI Coalition for Children and Families

Public and Community Partners Present:

Alex Moore, Political Director of SEIU District 1199
Angela Lello, UnitedHealthcare
Barry Fabius, MD - UnitedHealthcare
David Gellis, MD Arches Medical
John Gage, RI Health Care Association
Ena Backus, Freedman Health Care
Gerard Goulet, Health Policy Analytics, LLC
Grady Dorey, CPNRI
Jocelyn Antonio, Brown University
Professor Marianne Raimondo, RIC
Nancy Wolanski, United Way
Nathan Hostert, Brown University School of Public Health

State Staff Present:

Allegra Scharff, RIDOH
Aryana Huskey, EOHHS
Blythe Berger, RIDOH
Brenda Amodei, BHDDH
Charles Estabrook, OHIC
Cheryl LeClair, RIDOH
Chris Ausura, RIDOH

Cindy Singleton, EOHHS
Emma Seymour, EOHHS
Fernanda Lopes, RIDOH
Jacqueline Kelley, RIDOH
James Rajotte, EOHHS
Jim Suah, RIDOH
Katelyn Medeiros, Office of the Child Advocate
Kilah Walters-Clinton, EOHHS
Manny Ortiz, RIDOH
Marti Rosenberg, EOHHS
Michael Cronan, EOHHS
Mike Dexter, RIDOH
Nicolas John, DHS
Paul Murgo, VETS
Rick Brooks, EOHHS
Rosemary Reilly-Chammat, RIDE
Dr. Samuel Zwetchkenbaum, RIDOH
Sandra Powell, EOHHS
Tara Cooper, RIDOH
Jocelyn Roman, EOHHS
Keith Murray, DLT
Nancy Sutton, RIDOH
Michelle Brophy, BHDDH
Storm Lawrence, EOHHS
Raimond Mackenzie, RIDOH
Olutosin Ojugbele, MD, RIDOH
David Levy, RIDOH
Kimberly Rauch, DHS
Michelle Wilson, RIDOH

I. Welcome & Introductions and Meeting Agenda Overview

- At 11:30am, Secretary Richard Charest welcomed in-person and online attendees to the Rhode Island Health Care System Planning Cabinet and EOHHS Independent Advisory Council Joint Meeting. After a review of the May minutes, RIDOH's Director, Dr. Jerome Larkin, called for a motion to approve the minutes, and OHIC Commissioner Cory King seconded the motion. All were in favor.

Health Care System Planning Cabinet & EOHHS Independent Advisory Council Joint Meeting Agenda

1) **Welcome & Introductions** and Review of the May Minutes – Secretary Richard Charest

2) **Updates/Strategic Discussion** - Assistant Secretary Ana Novais

A. Implementation Priorities from the Foundational Report

- Data Development and Analysis
- Legislative and Budgetary Update - State Legislature & Federal Updates
- Health Related Social Needs - Presentation from Chris Ausura, from the Health Related Social Needs Work Group

B. Long-Term Planning

- Proposal for Year 2 Retreat and RI Health Care System Plan Development
- Ongoing Reporting

3) **Other Updates from Cabinet Members and Community Partners/Discussion**

4) **Public Comment & Closing Remarks** – Secretary Charest

II. Updates/Strategic Discussion

A. Implementation Priorities from the Foundational Report

Data Development and Analysis

Introduction of our FY26 Data Dashboard and Analysis Project

- Initial focus on Primary Care and Hospital Fiscal Transparency
- Subsequent focus on Behavioral Health, Health Related Social Needs, and Nursing Homes
- Introduction of Ena Backus, from Freedman Healthcare (ebackus@freedmanhealthcare.com)

Questions to Cabinet and Advisory Council Members:

- Over the summer, we will be determining the critical dashboard components you think would assist state agencies and Health Care System Planning Community Partner (HCSP) participants in decision-making. What ideas do you have now, to begin this discussion?
- We will be seeking participants for this data planning. Please indicate your interest.

- Assistant Secretary Novais introduced Ena Backus, from Freedman Healthcare, who is the lead Initially, the focus is on primary care and hospital fiscal transparency (although

the Fiscal Transparency bill did not pass). Behavioral health (BH) and Health Related Social Needs (HRSN) will follow.

- The dashboards are for monitoring, evaluating, and projecting future needs for the healthcare system.
- The primary care assessment will first focus on the Foundational Report recommendations - drawing on existing inventories, analyses, and lists that provide information about the State's currently available primary care capacity.
- Primary care will be considered by geography and resource distribution to build a consistent foundation for statewide primary care analysis.
 - Additionally, Freedman HealthCare (FHC) will support BH dashboards, HRSN, and similar fiscal transparency for nursing home facilities.
 - FHC will engage with RI's subject matter experts and various stakeholders.

B. Dashboard components that would assist in future decision making:

- The primary care dashboard will give a better understanding of where there are access issues, with a part to be public-facing. Based on certain parameters of information, a user would have insight into where they may be able to go for a doctor's appointment that accepts their insurance.
- Including the waitlist time for the first appointment, and if the provider accepts new patients, was suggested.
- The HCSP Team will work with URI to collect primary care information: Who's practicing in the State? Who's licensed? What are the gaps? Do we have an equal distribution of primary care?
- An unclear definition of primary care is a challenge. Many medical professionals perform primary care duties but are not necessarily strictly primary care providers. There are a lot of data points to collect, including not just primary care but specialty care, to include specialists engaged in primary care.
- The initial data elements we contemplate using will be shared, which may help elicit additional requests for information to collect.
- One of the most challenging areas within the insurance regulatory world is provider directories and their accuracy. The practice is dropped from the listing if primary care information is not updated quarterly. If providers aren't feeding this information into the directory, the information will not be fully useful for the consumer. Potential consideration of updating puts administrative burdens on recording this information for providers.
- RIDOH has 400+ licenses and license types for thousands of providers. The primary care dashboard design should conform to the licensing inventory.
- Traditionally, measures of unmet demand, like patients without a usual source of care, come from surveys. Many data elements can be pulled into a public-facing primary care dashboard that deals with resource allocation and access measures. Dashboards on revenues, expenditures, and profitability would be useful. Considering hospitals, there's

a disagreement with the NASHP Hospital Cost Tool, but that information is in the public domain on 4600 hospitals in the country. Working with the local hospitals to refine some data elements might be helpful.

C. Academic Partnerships Update

Data Development and Analysis

Introduction of our Health Economics Academic Partner Project

- Initial focus on economic analyses of Foundational Report components
- Plan for prioritization of additional areas of study
- Introduction of some of our key partners from the University of Rhode Island and Brown University

Questions to Cabinet and Advisory Council Members:

- Over the summer, the Office of Health Care System Planning and our academic partners will be firming up research questions – and in the future, there will be opportunities for HCSP participants to help define research questions. What ideas do you have now, to begin this discussion?
- We will be seeking participants for this research planning. Please indicate your interest.

1. Leveraging academic partners:

Assistant Secretary Novais noted that our partnerships with URI and Brown University are testaments to our commitment to evidence-based research in Health Care System Planning – and their support and expertise will be invaluable in our efforts. She introduced Dean Patrick Vivier and Professor Ateev Mehrotra.

- Dr. Patrick Vivier, MD, URI Dean of the College of Health Sciences at the University of Rhode Island, shared that URI is launching a Department of Public Health for the first time at the URI College of Health Sciences, with a Masters of Public Health program this fall.
 - Offering research, geographic information systems, and analytical expertise to make information available to help people make primary care choices.
 - Pledged the College of Health Sciences' support to be part of RI's HCSP effort and to work closely with EOHHS and RIDOH.
- Dr. Ateev Mehrotra, Chair of Health Services, Policy and Practice at Brown University's School of Public Health described the scope of the Brown faculty and their ability to support the Office of Health Care System Planning in improving Rhode Island's health care system. There are a team of professors at the School of Public Health working to develop research ideas about what could support the Office's work.
 - Shared examples of Brown's work:

- **Research on Rhode Island's affordability standards and the long-term impact.** While it has decreased the revenue to our state's hospitals, Brown estimates it has also reduced premiums in Rhode Island by \$1000 compared to states that don't have these affordability standards. A \$1000 premium reduction means more money for Rhode Islanders in their pockets.
- **Children's Behavioral Health,** looking at the impact of appropriately referring children to treatment if they screen positive in a school setting for mental illness.
- **Primary Care Access.** Calling a number of PRIMARY CARE practices in the state to assess how many are accepting new patients and defining the wait time as a secret shopper type study.

2. Areas recommended for further study: Cabinet and Advisory Council members proposed ideas for additional future study:

- Monitoring the number of uninsured patients.
- Researching the impact of Medicaid cuts on hospitals. There is a lot of concern about what we will see in the next two to five years in hospitals.
- Some primary care legislation aims to change the requirements for an in-person visit while virtually seeing more behavioral health incidents and people concerned with immigration issues. The proposal will limit what people are asking for. Digital approaches to solve access issues need further study.
- Researching the quality of telehealth care compared to an in-person visit.

D. State Legislative session and budgetary updates

Legislative and Budgetary Update - State

Discussion of some of the key General Assembly legislative and budgetary actions that will affect our health care system and health care system planning in State Fiscal Year 2026.

- What are the outcomes that are most important to your organization?
- What did not pass that you plan to address in the 2026 Legislative Session?
- What do you suggest the Office of Health Care System Planning work on for review in the Governor's budgetary or legislative process for 2026?

1. **2025 Legislative Outcomes:** Assistant Secretary Novais introduced the discussion about legislative outcomes and invited Cabinet and Advisory Council members to share information about legislation that was critical to their organizations.
 - Secretary Charest noted that significant work was dedicated to passing fiscal transparency legislation, that would have required multiple entities to share unaudited financial statements with EOHHS, including hospitals, federal qualified health centers, certain physician practices, nursing homes, and Certified Community Behavioral Health Clinics – but the bill did not pass. There is an intention to re-engage in pursuing transparency again after monitoring what's happening at the federal level. Transparency can be a tool for monitoring what's going on and enabling a proactive approach to assist.
 - In addition, the General Assembly did pass legislation allocating funds for hospitals, nursing homes, and primary care. Primary care staffing is expected to continue to be a challenge. Practices taking a team-based approach may make practitioners more efficient by having ancillary staff support compensated.
 - Jacqueline Kelly, from RIDOH, noted the following legislative outcomes:
 - RIDOH is drafting regulations to implement the legislation allowing foreign-trained physicians to practice in Rhode Island, which passed in June. The hope is to improve access to primary and behavioral health care.
 - Legislation passed allowing pharmacists to provide up to 100-day refills on non-controlled substance medications to patients without a prescription. Providing 90-day refills for ADHD medications without a prescription will not require regulations.
 - Golf courses will need an AED on the premises.
 - Athletic trainers must now be trained in administering EPI-Pens and have them available on the sidelines.
 - The Commissioner of OHIC, Cory King, shared:
 - A bill enacted a three-year pilot program eliminating the need for prior authorizations for primary care providers. OHIC will have a role in promulgating rules and regulations to be implemented by January 1, 2026.
 - OHIC was authorized to do a rate review for primary care with a report by September 20, 2026 – which is earlier than was originally expected. The agency will be making recommendations around Medicaid payments and incorporating broader commercial and Medicare reimbursement considerations, with the help of subject matter experts from state agencies and primary care practices. OHIC is looking to determine how much it costs to deliver primary care in its best form, with a few different iterations depending on whether it's a hospital-owned or private practice.
2. **Discussion:** Cabinet and Advisory Committee members discussed the impact of the legislative changes:

- Expanding financial transparency would help regulate private equity healthcare. Not necessarily because it's bad, but it might be differently motivated.
- OHIC will collaborate with EOHHS to coordinate on reducing providers' administrative burden by ending prior authorization for primary care providers. However, nothing in the legislation compels Medicare Advantage or self-insured businesses to comply with this pilot. (Self-insured groups in the state account for six in ten people with employer-sponsored insurance).
- Rhode Island needs to develop tools to monitor what is going on at the federal level. The H.R. 1 legislation might influence people going off Medicaid, making them uninsured.
- Secretary Charest noted that it would be important to continue to advocate for primary care staffing – and consider increasing the team-based approach to healthcare. We need to identify how practices are compensated for their team-based approach.
- Other priorities shared by participants included:
 - Transparency around health systems.
 - Regulate private equity in healthcare, including nursing homes. Private equity companies might be motivated differently.
 - Coordinate to reduce the administrative burden on practices.
 - Track Emergency Department utilization.
 - Pursuing increasing tax credits.
 - Monitor changes at the federal level on the Drug 43 B discount program. Worried our advances will go away as the uninsured rates skyrocket.
 - Planning how to fund Medicaid when \$250 million will no longer be in the General Revenue. How do we fill that gap?

Legislative and Budgetary Update - Federal

Updates that participants have to share about the federal budget or legislative process:

- What are you hearing from any national organizations with which you are affiliated?
- Other insights from your federal policy tracking?

1. Feedback:

- EOHHS is organizing a federal compliance work group with input from experts and the public to evaluate, from a Medicaid perspective, the impacts of federal changes on our state organizations, hospitals, and the population in general. A comprehensive assessment will be developed to make recommendations to the legislature, the Speaker, the Senate President, and the Governor by October 31st.
- Need to monitor H.R. 1's impact on Medicaid. As clinical care coverage goes away, expect a bigger emphasis to be needed on our peer recovery report specialists with minimum salaries.
- Plan how RI can afford to comply with the H.R. 1. There are nuances regarding immigration categories. Quirky little things that will have an impact on the state from an implementation perspective.

2. Chris Ausura presented on the Health Related Social Needs (HRSN) Project Launch:

- RI has a lot of different uncoordinated pieces that support HRSN
- The State is developing a strategy to approach a cohesive foundational system with a set of activities that to begin in the early Fall:
 - Initial phase - recruiting a Design Team to develop the strategic plans.
 - Identify adequate baselines.
 - Recommend what must be in place to meet aspirational goals.
 - Work towards the creation of a care model in RI.
 - We are aiming to select 3-4 communities with a high level of HRSN need and use those communities to test the model of implementing the HRSN system design.
- To carry this out, we are creating a HRSN Design Team. Mr. Ausura requested that Cabinet members recommend 1-2 representatives to participate in the HRSN Design Team and that Advisory Council members nominate Design Team participants as well.

Next Steps

- We are seeking 1-2 representatives from each member of the Cabinet
- Members of the Cabinet and the Advisory Committee are also asked to recommend any external partners who meet the team selection criteria
- A half day HRSN Care Model Design Team kickoff event will be held in late September/early October
- Additional time commitments and activities will be planned during the kickoff

E. General Comments/Questions on HRSN Plans: Chris Ausura answered questions from participants on the HRSN planning process:

1. What is the impact of the federal budget reconciliation on HRSN? Will strategies need to be changed to accommodate?
 - Mr. Ausura answered that the State wants this to be rapidly saleable, as significant changes may occur to support the revenue of the HRSN safety net.
2. Have we defined the communities we want?
 - Mr. Ausura replied that the Design Team should define the criteria for the communities. The criteria are to be adapted across multiple types of communities.
 - He also noted that this initiative differs from the HEZ model in that it will intensively look at and aligns state and community-level resources, considering what we are seeing from a performance and quality service delivery system. EOHHS will scale, align, and ensure the HRSN plan is doable.

F. Long-Term Planning Proposal: Marti Rosenberg, Director of the Office of Health Care System Planning, introduced the work that the Office is doing on the Long-Term Health Plan.

Long-Term Planning Proposal

The Office of Health Care System Planning is taking the next steps on the Rhode Island Health Care System Plan this summer, preparing for a Fall/early Winter Summit, similar to our November 2024 Retreat.

To create the plan, we will build on the Foundational Plan – for each goal, aligning its problem statements, strategies, recommendations – along with targets and indicators to be measured.

Within each sector, we will ask the public/private Workgroups to reconvene in the Summer and Fall, and affirm these aligned components of the long-term plan.

1. Ms. Rosenberg noted that after the Workgroups are engaged in the development of the specific Long-Term Health Plan, the Office is considering holding another retreat or summit towards the end of the year to bring all participants together, toward the completion of the plan.
2. She also shared that the Office will continue to share a Bi-monthly Program Report listing a progress summary, especially for topics not covered in meetings.

Public Comment: Secretary Charest invited public comment from participants.

1. Planning for the federal reconciliation bill should be our top priority. We have time to address and assess some of the system's shortcomings. There is much opportunity to shore up our system to maintain eligibility. Assessing community assets for maintaining eligibility.
2. EOHHS to report out the status of the systems so we can be more responsive in the community to assist.
3. Concern was expressed regarding hospital capacity being jeopardized and interest in reconvening the Hospital Workgroup.

The Secretary adjourned the meeting at 1:00 pm.