Joint Health Care System Planning Cabinet Meeting and the EOHHS Independent Advisory Council

September 11, 2025, 11:30 am to 1:15 pm
Department of Administration, Conference Room 2B/C
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	Yes
Director Jerome Larkin, MD	Rhode Island Department of Health's (RIDOH)	No
Director Kimberly Merolla-Brito	Department of Human Services (DHS)	Yes
Director Richard LeClerc	Department of Behavioral Health, Developmental Disabilities, and Hospitals	Yes
Director Ashley Deckert	Department of Children, Youth and Families (DCYF)	Yes
Director Matthew Weldon	Department of Labor and Training (DLT)	No
Bonnie Rayta, for Commissioner of Postsecondary Education, Shannon Gilkey	Office of the Post-Secondary Commissioner	Yes
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	No
Director Karyn Lowe	Office of Governor McKee	No

Online Attendees: Singleton, Cindy (OHHS), Amodei, Brenda (BHDDH), Suah, Jim (RIDOH), (OHHS), Larry Warner (UW), WaltersClinton, Kilah (OHHS), Scharff, Allegra (RIDOH), Dexter, Michael (RIDOH), Wilson, Michelle (RIDOH), Campagna, Kristine (RIDOH), Mayernik, Jessica (DLT), John Tassoni- SUMHLC, Richard Glucksman (BCBS), Isaac Rubinstein (One Neighborhood Builders), Mag Morelli (Leading Age), Christine Gadbois (Care Link), Dulski, Robert (Care NE), Al Charbonneau (Business Group on Health), Erin Williams (Providence College), Antonio, Jocelyn (Brown University), Kristen Frady (Wood River Health), McCloskey, Molly (OHIC), Lawrence, Storm (OHHS), Gerard Goulet (Health Policy Analytics), Nicholas Oliver (Age Friendly RI), Joao Carvalho (CCHW), Vasquez, Rebeca (RIDOH), Lopes, Fernanda (RIDOH), OShea, Ashley G. (OHHS), Florczyk, Michael (UHC), Lamarche Baez (Care NE), Brooks, Rick (OHHS), Vargas, Maryoli (DLT), Alison Croke (Wood River Health), Gray, Mark (LTGOV), Matos, Sabina (LTGOV), Sutton, Nancy (RIDOH), Seymour, Emma (OHHS), Gina Eubank (CCAP), Melissa Goldstein (HEZ), Peter Pogacar MD (Brown Health), Pelletier, Diane (RIDOH), Clemons, Rachael (OHHS), Slocum, Susannah

(OHHS), Tsangarouli, Erin (RIDOH), Max Mason De Faria, Ena Backus, Melissa Husband, Leonardo Arriola Carnicelli, Tanja Kubas-Meyer, John Minichiello, Marran, Mary, Patrick Crowley, Kara (Unverified), Leclair, Cheryl (RIDOH), Desiree Leclair, HWEC (Unverified), Kristin Read, Wagner, Michael, Medeiros, Katelyn (OCA), Perla Fernandez, Robyn Hall, Nancy Wolanski, Lynn Blais (Unverified), Kelley, Jacqueline (RIDOH), Garneau, Deborah (RIDOH), Tina (Guest) (Unverified), Martins, Kevin, Frank McMahon, Alvarado, Alyssa (DLT), David Gellis, Ortiz, Manuel (RIDOH), Michelle Muscatello (DELTA), Kara (Unverified), Shannon Martley Picozzi, Zwetchkenbaum, Samuel (RIDOH), Schultz, Cathy (OHHS)

In-person Attendees: Joan Kwiatkowski (PACE), Elena Nicolella (RIHCA), Mark Jacobs, Sam Zwetchkenbaum, DMD (RIDOH), Ed McGookin, MD (Brown Health), Beth Bixby (TIDES), Lisa Tomasso (HARI), Sandy Valentine (RICARES), Nelly Burdette (CTC-RI), Zack Neider (RIF), Peter Hollman (RI Medical Society), Shamus Darac (RIPIN), Elizabeth Silvestre (BHDDH), Staci Fisher (RIDOH), Ateev Mehrotra (Brown University), Sam Salganik (RIPIN), Ara Millette (Brown Health), Chris Ausura (RIDOH), Elizabeth Burke (Brown University), Beth Lange, MD (RIAAP/PCMH kids), Mark Jacobs, MD, Tanja Kubas-Meyer (RICCF), Margaret McDuff (FSRI), Sandra Victorino (CHAE), Stacey Paterno (RIMS)

I. Welcome & Introductions and Meeting Agenda Overview

A. 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 July minutes, the minutes were unanimously approved. All were in favor.
B. Secretary Charest reviewed the agenda:
    a. The Joint Health Care System Planning Cabinet and the EOHHS Independent Advisory Council Meeting held by the Executive Office of Health and Human Services (EOHHS) was to focus on community engagement and health equity in Rhode Island.
    b. The agenda included community engagement findings, discussion of a new CMS grant opportunity to transform rural health, a report on the Federal Compliance Advisory Group progress, and updates on long-term planning.

II. Marti Rosenberg, Health Policy and Planning Director at EOHHS, Community Engagement

a. Ms. Rosenberg began with a Preliminary Report on Health Care System Planning Community Engagement

Prioritizing Community Engagement

The Office of Health Care System Planning (OHCSP), created by Governor Mckee's Executive Order, is developing a Rhode Island State Health Plan. The process began with the creation of the 2024 Foundational Report, written with the engagement of key health care experts and professionals. The Report includes recommendations to improve the healthcare system within 5 sectors: Primary Care, Behavioral Health, Hospitals, Long-Term Care and Healthy Aging, and Health Related Social Needs. The report includes several cross-cutting priorities, including Data, Workforce Transformation, and Value-Based Payments.

OHCSP is committed to ensuring the ongoing participation of health care patients/consumers in this process. During the spring and summer of 2025, the Office contracted with the Health Equity Zones to ask consumers the following questions:

- What are the most pressing healthcare issues impacting Rhode Islanders?
- What is working in our health care system?
- What changes do they want to see in the system?

1. EOHHS engaged the 14 different Health Equity Zones with diverse geographic communities across the state. The stakeholders consisted of local residents, community organizations, businesses, and government agencies within those areas.

Partnership with Health Equity Zones

- Rhode Island's Health Equity Zones (HEZs) represent 14 diverse geographies across the State, including rural, urban, and suburban communities.
- Each HEZ consists of local groups of residents, community organizations, government agencies, and businesses working to build trusting relationships and address the larger issues that affect health and economic opportunities for Rhode Islanders.
- Since 2015, Rhode Island's HEZs have built the local infrastructure, trust, and experience needed to lead equitable, community-centered engagements and assessments.
- The Office of Health Care System Planning contracted with the HEZ to conduct community listening sessions based on these unique attributes.

Rhode Island Health Equity Zone Initiative

5

The Health Equity Zones had 32 listening sessions, consistently asking the same questions between April and June. The sessions were held in multiple languages.

Community Engagement Process

- The 32 Community Listen Sessions involved an average of **8 participants per session**, for a total of **253 individuals**. Sessions were held in English, Spanish, and Khmer.
- A standardized guide ensured **uniformity in questions across all sessions**, enabling comparable insights while allowing for locally driven discussions rooted in the unique context of each community
- Health Care System Planning state staff attended the sessions to listen and document the conversations, leading to **200 pages of notes**
- State staff used software to conduct a **preliminary review** of the listening session transcripts

Community Engagement Process

- Fourteen Health Equity Zones each carried out two listening sessions, throughout the state, for a total of **32 sessions** between April and June 2025
- Sessions used consistent questions to identify barriers, successes and priorities for Rhode Islanders across eight critical Planning sectors:
  - Primary Care
  - Behavioral Health
  - Oral Health
  - Hospital Care
  - Long-term Care and Healthy Aging
  - Health Related Social Needs
  - Data
  - The Health Workforce

3. Ms. Rosenberg noted that the process dug deep into how participants define health, asking questions such as: When we talk about health, what resonates with the community? EOHHS received a variety of responses, including: Health is fundamentally equated with life. Health is feeling strong, having energy, and resilience. Health is having the capacity to enjoy life, while being able to confront challenges without constantly struggling. Health is deeply limited by social determinants and environmental factors.

How did participants define "Health"?

Participants described health as encompassing far more than just the absence of illness, highlighting its broad impact on their lives and the pervasive challenges within the healthcare system.

- **Health is fundamentally equated with "life"**
  - It's about "feeling strong, with energy and resilience" and having the "capacity to enjoy life and confront challenges" without "constantly struggling."
- **Health is deeply intertwined with, and often limited by, social determinants and environmental factor**
  - Participants recognized that "all of the things outside of the doctor's office that may or may not affect my health" are crucial, including "where we live, work and play."

4. Ms. Rosenberg continued: When we talk about social determinants and environmental factors, we are reflecting on what the community is saying to us - what we heard very clearly in the sessions. These are initial examples of what's working, and this report highlights some system bright spots.

Initial Examples of What's Working – Highlighting Some System Bright Spots

- **Integrated Behavioral Health Programs**
  - Integrated behavioral health models, which place a therapist directly within a primary care facility to provide services for individuals in crisis, was lauded as "wonderful" and helpful for brief, focused interventions.
- **Primary Care Provider Relationships**
  - Consumers with an existing Primary Care Providers (PCPs) expressed satisfaction with their primary care experience citing "good relationships" with their consistent PCP.
- **Support for Long-Term Care at Home**
  - A "very good" program in Rhode Island that pays family members to provide care for elderly relatives at home was highly valued, as it helps keep individuals out of institutional settings. Additionally, some "extraordinary" long-term care programs were noted for providing comprehensive support, including medical care and even entertainment.
- **National Advantage in Access to Care**
  - One participant noted a national advantage in the U.S. where patients can often access a clinic or hospital for initial assessment even without immediate payment or prior approval, contrasting with systems in some other countries that require upfront payment.

6. Ms. Rosenberg called upon several Health Care System Planning staff participants to share additional insights from the community engagement sessions, as the process included had many Interagency Strategy Team members present to take notes.

a. Sandra Powell, the Associate Director of the Office of Health Care System Planning focused on primary care. She noted that she had attended two sessions in South Providence. “People were very pleased when they referred to their primary care physicians. They raised the same issue we have all been talking about: access. Stakeholders reported difficulty finding a primary care physician and described long wait times for appointments. People were having the very issue we are all trying to solve finding a practitioner. Some described following their practitioners from location to location as the practitioners' locations changed over time. Some also spoke about the role of MAs and nurse practitioners. They really valued them because there they felt a connection and seemed to have more time to talk to answer their questions and concerns. Although what did come up was that sometimes people didn't understand the credentialing of their medical paraprofessionals. Not sure if they were as knowledgeable or could be as helpful to them. These opinions give us something to think about, making the public aware of their qualifications and credentials.” Additional system bright spots included the quality of care from nurses and frontline staff, another nurse practitioner or physician assistant taking on tasks, oral health receiving some good compliments, and the strength of community organizations.

Opportunities for Improvement

- **Impact of Social Determinants of Health**
  - Participants strongly linked health outcomes to the importance of social needs like housing, food security, transportation, and economic opportunity, advocating for a more integrated approach.
- **Need for Patient Advocacy**
  - Patients often feel they need to "advocate for [themselves]" and be "well versed in the rules and regulations" of the system to navigate care effectively.
- **Lack of Trust in the System**
  - Repeated negative experiences, financial opaqueness, and perceived lack of accountability contribute to a "lack of trust" in healthcare institutions and government oversight.
- **Disparities and Discrimination**
  - Experiences of discrimination based on insurance type (Medicaid vs. Private), race, ethnicity, and even physical appearance (e.g., tattoos) were reported by participants, leading to what they saw as unequal treatment.

b. Rick Brooks, EOHHS Director of Health Workforce Transformation added “I had the opportunity to sit in on several community sessions. One was organized by Providence Unidos in June, and the other was a larger learning community event in May. We inquired about what needs to be done to help grow the healthcare workforce and increase the diversity of the workforce. How can we recruit more young people for healthcare jobs and careers? What are some of the challenges? What would make it more possible for folks already in the healthcare workforce in unlicensed roles to pursue higher education and help with professional licenses, and some of the things we heard were for starters. Folks expressed significant respect for healthcare workers and for the challenges that healthcare workers face on the job. Many noted the responsibilities that healthcare workers have, including the expectations and pressures on them. They also noted that health care workers and some of these folks were health care workers themselves, frequently understaffed, often underpaid, and sometimes undervalued, and that for entry-level workers, it’s difficult to make ends meet. They noted the importance of diversity and lived

experience in the healthcare workforce to maximize connections and support for patients. They also noted the lack of diversity among senior management and leadership. They emphasized the importance of career exploration programs for youth and support for foreign-trained health professionals regarding higher education in general. Some important takeaways: being a healthcare student is very difficult, especially while holding a job. The academic requirements are significant. The time and expense are significant barriers. They strongly emphasized the importance of expanding financial and other supports for working students. They noted the challenge of taking on significant loans or debt, which is often not offset right away by earnings or salaries. So, they suggested more loan forgiveness programs to offset educational debt, and that stipends for students while studying to pursue health professions would help to motivate young people. In conclusion, I think the main takeaway folks emphasized is that there's a direct public benefit to educating the healthcare workforce. Still, there's not always strong enough public support for that education. A session participant commented, what will we do when no one can afford to go to a health professional school?" The impact of social determinants of health, the need for more integration, more access, and advocacy for patients were common themes. There was an acknowledgement of a lack of trust in the system. Some described negative experiences, some financial opaqueness, and a lack of accountability, both in healthcare and government. Some perceived disparities and discrimination on a range of reasons.

Future Vision - What Should the System Look Like?

Participants envisioned a healthcare system that is fundamentally patient-centered, accessible, equitable, and integrated with broader community needs.

- **A System that is Accessible, Affordable, and Simplified**
  - Participants envisioned a healthcare system that is accessible, affordable, and designed with the consumer first.
- **Humanized and Respectful Patient-Provider Relationships**
  - Participants expressed a want for a more "humanized" healthcare system that treats people like people, not patients of a system.
  - Care that is compassionate.

c. Michelle Brophy, Associate Director, BHDDH shared, "Access to connections in the community, access to employment, volunteer opportunities, and connecting that to a home were all suggestions. Participants pointed out that if we worked in a community, we couldn't afford a home in that community. When they talked about home, they were referring to affordable houses or apartments, and sometimes to nursing facilities. They asked how we can ensure that everyone has access to a safe place to be cared for their health needs. They also wanted to talk about what the State can and will do to assist in these areas. We said we'd bring all this back, and they'd hear from us again about how the state can really facilitate important conversations about the connection to housing, employment, and community connections was a big one. People felt they didn't have a lot of support in their communities, and they didn't

know what was available or what we could do there to help facilitate connection."

d. Allegra Scharff, RIDOH's Chief of Healthcare Equity and EOHHS Olmstead Coordinator noted, "I had the opportunity of going to Bristol's community listening session and have reviewed various listening session notes. Someone said they had to make the terrible decision between food and medication because they couldn't afford both. There is a need for empathy and personal connection. We also heard some folks say, 'I wish my provider would look up from their computer. I wish that they would look me in the eye when they're talking to me. I've had experiences of the staff mocking me. I wish they were trained not to do that.' Folks also shared that we get asked this stuff all the time, but what's happening with it?

I'm glad we're here to discuss what will happen with this information. Similarly, issues were mentioned around the hospital systems. People wonder if the community is represented on advisory boards for real. The bulk of the Bristol session was centered on dental care. One said, at first, 'I had private insurance, and I got the quality stuff. But then, when I was on state insurance, I got the dollar brand.' There were a lot of similar comments like I feel the quality of care that I get is less than what my insurance provides when I make less money."

7. Ms. Rosenberg returned to the slides, noting that the final slide focuses on our opportunities for improvement. The high cost, the financial burden, and the need for empathy and personal connection were frequently expressed. Rhode Islanders are looking for a different system that is accessible, affordable, and that simplifies humanized, respectful patient-provider relationships. They are telling the State they need integrated care that addresses social determinants and is used effectively.

She concluded by sharing that EOHHS is proposing additional discussions and analysis on the 200-plus pages of feedback so that the Cabinet and the Advisory Council can really dig into these perspectives. The staff will proceed to an in-depth review by sharing additional information with Workgroups whenever possible.

Achieving the Future Vision – Proposal for Next Steps

- OHCSP proposes additional discussions and analysis on the information shared by Rhode Island patients at the Listening Sessions
  - The participants' comments on specific health care sectors at subsequent meetings would benefit from an in-depth review both at Workgroup and Cabinet meetings.
- OHCSP is planning additional Community Engagement, tied to the creation of the Rhode Island State Health Plan and the Rural Health Transformation Program grant

8. Conclusion: Community Engagement Process Insights:
   a. Key sectors identified include primary care, behavioral health, and social needs.
   b. Participants provided feedback on health issues, successes, and desired changes.

c. Participants in the community engagement process highlighted several areas needing attention. Opportunities for improvement were identified.
d. Major issues include SDOH, lack of trust in the system, and financial burdens faced by patients and their families.
e. There is a strong call for systemic change towards equitable care and improved patient advocacy.

III. Manny Ortiz, RIDOH's Chief of the Office of Primary Care and Rural Health Information Presentation

The Opportunity: Rural Health Transformation Program

Five-Year CMS Initiative to Strengthen Rural Healthcare Access

- New 5-year, $50 Billion CMS program (H.R. 1, July 2025)
- One-time state application for FY2026–FY2030 funding
- First round $25B—equal distribution: $500M per state over 5 years
  - Base funding: $100M/year if all states apply and are approved
- Second round $25B—proportional distribution: $500M per state for 5 years
  - Rhode Island is unlikely to receive this potential bonus because it is based on the proportion of the states' rural areas
- Application materials are expected before mid-Sept 2025; CMS must decide by Dec 31, 2025

A. Rhode Island intends to apply to the CMS Rural Health Transformation Program grant opportunity, a new five-year initiative to strengthen rural healthcare access. The application is due to CMS in the first week of November.
B. This is a one-time investment in healthcare access for the rural areas. The grant is not to fund ongoing structures and operations or fill the gap of any cut funding.
C. The State will build an interagency team to draft the application.

Rural Health Transformation Plan Elements

HR.1 outlines that the state's plan must describe how Rhode Island will:

1. Improve access to hospitals and other providers for rural residents
2. Improve health care outcomes of rural residents
3. Prioritize use of new and emerging technologies that emphasize prevention and chronic disease management
4. Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other providers to promote quality improvement, increase financial stability, maximize economies of scale, and share best practices
5. Recruit and retain clinicians
6. Prioritize data and technology-driven solutions that help rural providers furnish health care services as close to the patient's home as possible
7. Outline strategies to manage long-term financial solvency and operating models of rural hospitals
8. Identify specific causes that are driving standalone rural hospitals to close, convert, or reduce service lines

Allowable Activities: State must pick at least 3

Use of funds categories listed in H.R. 1:

1. Evidence-based prevention & chronic disease management programs
2. Payments to health care professionals for care/services (as defined by CMS)
3. Consumer-facing tech to manage chronic disease
4. Training/TA for advanced hospital technologies (AI, robotics, remote monitoring) to improve care delivery in rural
5. Recruit & retain clinicians in rural areas (minimum of 5-year commitment)
6. IT/cybersecurity upgrades (hardware or software) to improve efficiency, cyber security, or patient outcomes
7. Right-size rural care systems (align inpatient/outpatient/pre-hospital/post-acute services)
8. Expand behavioral health/SUD treatment access
9. Innovative models of care/value-based care
10. Other CMS-approved uses for sustainable rural health services

D. Key elements include improving access to providers, health outcomes, and fostering partnerships in rural areas.

a. Rhode Island's plan will focus on improving access, outcomes, technology use, and clinician recruitment.

b. Outlines strategies to improve rural healthcare access and outcomes through various initiatives.

c. The state must describe how it will improve access to medical facilities and providers for rural residents.

d. Strategies include recruiting and retaining medical professionals using technology for chronic disease management and enhancing local partnerships.

e. Allowable activities for funding include evidence-based prevention programs, clinician training, and IT upgrades

The focus will be on creating new access points without establishing new facilities, with an emphasis on telehealth and innovative care models.

Rhode Island's Rural Context

Understanding Eligibility, Scope, and Alignment

- **Current Federal Definition**: Block Island only
  - *Block Island Health Services is a CMS-Certified Rural Health Clinic*
- **RIDOH's Rural Definition**
  - Allowed by FORHP for use in administering the State Office of Rural Health (SORH) program
  - Expands to 18 cities and towns
- **Additional Eligible Facilities**
  - Federally Qualified Health Centers and Certified Community Behavioral Health Clinics may qualify
- **Strategic Alignment**
  - Supports Healthcare System Planning Cabinet's Foundational Report and the Governor's RI 2030 Plan

E. Mr. Ortiz concluded by noting that the State wants to hear ideas from its community partners. He invited all present to join a Community Listening Session or submit ideas with related data and sustainability plans to RIDOH.OPCRH@health.ri.gov or by filling out the following survey https://redcap.link/RI_RHTP.

Next Steps – Community Engagement Sessions

- Please joins us at a **Virtual Community Input Session** to share ideas and suggestions for the Rural Health Transformation Program Application:
  - Tuesday, September 16, from 5:30 to 7:00 PM
    Join the meeting now
    Meeting ID: 216 377 647 231 7
    Passcode: dB7fR2dn
  - Friday, September 19, from 11:00 am to 12:30 PM
    Join the meeting now
    Meeting ID: 218 326 327 544 1
    Passcode: Zy7Ga3c4

We will announce additional Community Input Sessions over the next couple weeks.

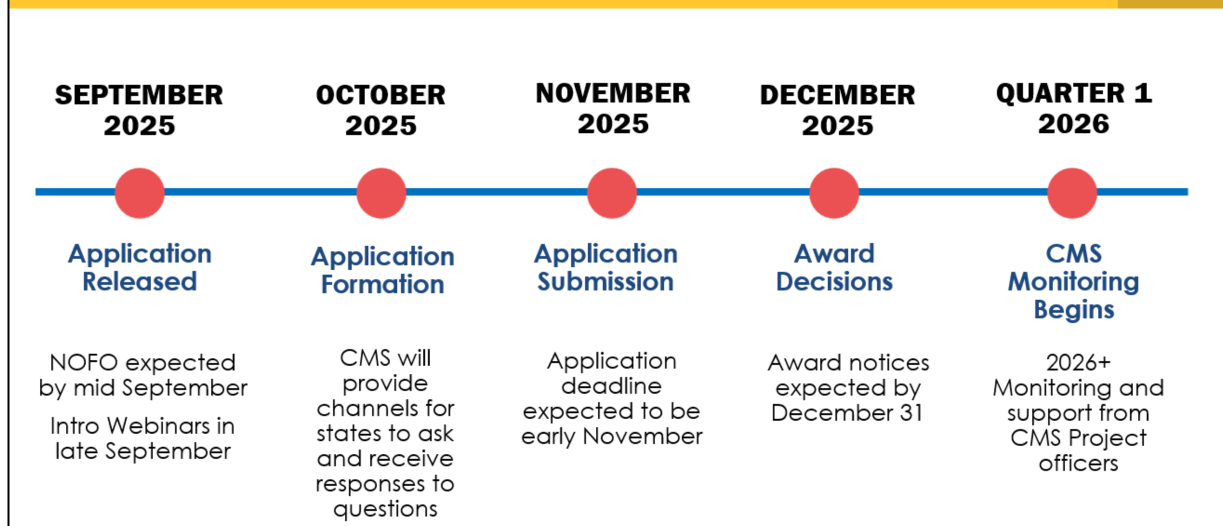
More info here: health.ri.gov/healthcare/rural-health-transformation-program

Next Steps – Community Engagement Survey

- **Rhode Island is seeking input** from residents, healthcare professionals, hospitals, EMS, community-based organizations, state and local agencies, and regional partners to help shape Rhode Island's Rural Health Transformation Plan.
- Your feedback will help **identify priority needs, gaps, and opportunities to transform rural health care.**
- **This survey is for planning and information-gathering purposes only**. Please note that responses will not result in funding or contracts, but they are critical to informing Rhode Island's application to CMS.
- All responses are due by **11:59 PM EST on Monday, September 29, 2025**. For questions about this form, please contact the Rural Health Transformation Program Team at RIDOH.OPCRH@health.ri.gov.

Please click on this link: https://redcap.link/RI_RHTP

Federal Expected Timeline



F. EOHHS expects the NOFO to be released in September, and the State will submit it in November.
G. Decisions by December 31st. Money would be flowing by January.

IV. Long-Term Planning Process Update

A. Ms. Rosenberg shared a Proposal for the Rhode Island State Health Plan, including alignment with the Rural Health Plan, ongoing Community Engagement, and affirmation of next steps in Long-Term Planning

B. EOHHS is taking the next step to implement the Planning Cabinet's goals, with a focus on integrating patient-centered approaches, addressing health equity, and ensuring affordability and quality in the healthcare system.

Long Term Planning Process Update

- **National Environmental Scan - Completed**
  - Understanding long term planning processes and approaches taken by comparable states
- **Foundational Report Analysis - Completed**
  - Collation of problem statements
  - Aligning proposed strategies and recommendations to current State Goals
- **Draft Initial *Rhode Island State Health Plan* Structure and Timeline – Ready for Review**

C. Next steps are to develop a comprehensive long-term health care plan for Rhode Island, building on prior foundational work and addressing various health system goals.
   a. The foundational document includes a national environmental scan and problem statements.
   b. Proposed strategies and recommendations are based on established goals.
   c. The plan aims to transition from crisis planning to a long-term vision.
   d. Emphasis on integrating patient-centered approaches and addressing health equity.

D. Goals and Challenges in the Health System
   a. Last year's focus was primarily on solvency, which did not adequately address quality or health equity.
   b. Goals include improving access, quality, and integration of care, and addressing the need to dismantle silos in the health system.
   c. The Plan must include metrics for tracking success and improvement.

E. Affordability and Access to Health Care
   a. Participants raised concerns about the rising costs of health care and the need for addressing affordability – with a focus on the anticipated financial hardships for consumers in 2026 due to increasing health care costs
   b. Affordability is linked to access, and both need to be addressed in the planning process.

V. James Rajotte, EOHHS Director of Strategy and Innovation, Federal Compliance Advisory Group Updates

C. Mr. Rajotte provided key updates on the Federal Compliance Advisory Group's (FCAG) work regarding changes in Medicaid and SNAP programs.
   a. The FCAG has been reviewing changes due to HR1 and their implications for Medicaid and SNAP.
   b. An overall ending report with detailed options and community feedback will be passed on to the Governor's office and the Legislature at the end of October.
   c. Changes to SNAP will affect approximately 35,000 individuals, with a specific focus on utility allowance restrictions.

D. Community Engagement and Feedback Mechanisms

EXECUTIVE OFFICE OF HEALTH & HUMAN SERVICES STATE OF RHODE ISLAND

a. Mr. Rajotte emphasized the importance of community engagement in the planning process.
b. Surveys are being conducted to gather feedback on changes to Medicaid and SNAP.
c. Community input is crucial for understanding impacts and generating ideas for improvement.
d. Future meetings are scheduled to continue discussions and gather further input from stakeholders.

II. **EOHHS Secretary, Richard Charest, Public Comment & Closing Remarks**

A. The health care system, planning cabinet, and members of the Independent Advisory Council in the room affirm that the process described today makes sense, and we should continue to go in the direction that we're having. The Secretary then called for public comment.

B. Dr. Beth Lange, a pediatrician at Waterman Pediatrics said that she had read the minutes from July's meeting that she had missed and had a question and a concern about the clarification of the definition of primary care. She noted that it is a challenge because many medical professionals perform primary care duties but are not strictly primary care providers. She noted that there are a lot of data points to collect, including not just primary care, but specific specialty care, including specialists engaged in primary care. She said that she would submit that the definition of primary care is not ambiguous and suggested that EOHHS not use the definition in July's minutes. She said, "Primary care is comprehensive and accessible. We are the first point of contact for people in primary care. We provide a wide range of healthcare services, including preventive care... We manage those things as primary care providers, and we collaborate with our specialties because there are not enough primary care providers in this state." She continued, noting that if the state uses a definition of primary care that is too broad, there is risk of diluting it with specialists who primarily see patients but who do not actually practice primary care. This could lead to a missed opportunity to build on our primary care infrastructure. She added that OBGYN is a challenge in that they have one foot in each canoe, and that has always been the case. She concluded that we should be very clear in our definitions, recognizing that if we are not properly resourced and we aren't looking at the crisis we have, we'll create tension that puts us in a bad place.

C. Sandy Valentine of RICARES, noted that it was National Recovery Month and she extended an invitation to the Rally for Recovery to all meeting attendees.

D. BHDDH Associate Director of Interdepartmental Services and Vulnerable Population, Michelle Brophy shared that BHDDH and Family Services were partnering to shine a light on the crisis of suicide with a movie screening on September 25th.