Joint Rhode Island Health Care System Planning Cabinet & EOHHS Independent Advisory Council Meeting
July 28, 2026, from 1:00 to 2:30 pm
Department of Administration, Conference Room A2
1 Capitol Hill in Providence

Cabinet Member	Agency	Present
Secretary Richard Charest	Executive Office of Health and Human Services	Yes
Assistant Secretary Ana Novais	Executive Office of Health and Human Services	Yes
Director Kristin Sousa	Medicaid Program	Yes
Director Jerome Larkin, MD	Rhode Island Department of Health	Yes
Director Kimberly Merolla-Brito	Department of Human Services	Yes
Director Richard LeClerc	Department of Behavioral Health, Developmental Disabilities, and Hospitals	No
Director Ashley Deckert	Department of Children, Youth and Families	Yes
Director Matthew Weldon	Department of Labor and Training	Yes
Shannon Gilkey	Office of the Post-Secondary Commissioner	No
Meghan Connelly, for Maria Cimini	Office of Healthy Aging	Yes
Director Lindsay Lang	HealthSource RI	Yes
Commissioner Cory King	Office of Health Insurance Commissioner	Yes
Director Kasim Yarn	Office of Veterans Services	Yes

Advisory Council Members
Al Charbonneau, RI Business Group on Health; Edward D McGookin, MD, Cost Trends Steering Committee; Michael Florczyk, UnitedHealthcare; John Gage, RI Health Care Association; Lisa Tomasso, Hospital Association of RI; Michelle Muscatello, Delta Dental; Nicholas Oliver, RI Partnership for Home Care; Sam Salganik, Rhode Island Parent Information Network; Stacey Paterno, RI Medical Society; Tanja Kubas-Meyer, Rhode Island Coalition for Children and Families; John Minichiello and Nelly Burdette, Care Transformation Collaborative of RI; Paige Parks, RI KidsCount; Patricia Flanagan, PCMH Kids; Zachary Nieder, RI Foundation; John Tassoni, Substance Use and Mental Health Leadership Council; Larry Warner, Governors Council on Behavioral Health

Interested Parties
Mark S Adelman, Alisha Bourdeau, Bernard DiLullo, Carrie Bridges, David Nefussy, Emily Corbett, Ena Backus, Erin Boles Welsh, Fran Kilinski, Grace Kane, Jason Martiesian, Justin Day, Katherine Miller, Kevin Cabral, Rasheed Lawal, Mira Mehta, Lori Sims, Margaret Holland McDuff, Mark Weeden, Sarah Izzo, Susan Jacobsen, Tom Boucher, Sharon Torgerson, Lucy Rios, Cynthia Roberts, Jenna Wahl, Deb Faulkner,

Caitlin Towey, Elena Nicolella, Deanne Gentile, Megan Clingham, Chris Gadbois, Laura Dussault, Amy Copperman, Bob O'Neil, Dr. Jayme Banks, Emily Williams Foster, Gerard Goulet, Kate Murphy, Lauren Goldenberg, Luz Rodrigues-Amivie, Marie G, Nick Vinceletti, Beth Lamarre, Carrie O'Rourke, Deb Burton, Deidre M. Jones, Desiree Leclair, Daniella Dodd, Barry M Fabius, Gina Eubank, Bethany Gingerella, Jennifer Flaggs, Jordan Broadbent, Josh Kurman, Julia Brown, Kelly Nussbaum, Maureen Maigret, Nicole Pancino, Philip Chan, MD, Sandra Victorino, Shannon Martley Picozzi, Shawn Donahue, Stephen Lapatin

State Staff
Department of Behavioral Health, Developmental Disabilities, and Hospitals (BHDDH): Brenda Amodei, Louis Cerbo, Heather Mincey
Department of Children, Youth, and Families (DCYF): Joseph Carr
Department of Corrections (DOC): Joann Lynds
Department of Health (RIDOH): Rupsha Biswas, Tara Cooper, Deborah Garneau, Heidi Hartzell, Cheryl Leclair, Laurie Leonard, Megan Sheridan, Kelly Smith, Jim Suah, Nancy Sutton, Samara Viner Brown, Morgan Wieck, Michelle Wilson, Fernanda Lopes, James Day, Kristine Campagna, Loreen Angell, Megan Umbriano, Staci Fischer, Dana N Barclay, Irving Ogando
***Executive Office of Health and Human Services (EOHHS)*:** Marti Rosenberg, Sandra Powell, James Rajotte, Hailey Bathurst, Helen Yee, Rick Brooks, Margaret Carpinelli, Christopher Diaz, Mark Kraics, Storm Lawrence, Ann Martino, Stephanie Menders, Ashley G O'Shea, Catherine Parker, Jocelyn Roman, Anthony Salvo, Allegra Scharff, Blaise Rein, Cindy Thibodeau, Nicholas McCarthy-Belash,
Governor's Office (GO): Sarah Lessem
Office of Healthy Aging (OHA): Steven Boudreau
Office of the Health Insurance Commissioner (OHIC): Charlie Estabrook
Office of Veterans Services (VETS): Paul Murgo
Office of Primary Care (OPC): Greg Ebner

You may find the slide deck from the meeting here.

Meeting Minutes

I. Welcome & Introductions

a. Secretary Charest opened the meeting at 1:00 pm. In his remarks, he noted that as the Governor had asked him to stay on as EOHHS Secretary he was happy to do so. As of now, there is no set timeframe for him to leave.

b. The members approved the minutes from the May 26th meeting unanimously. Secretary Charest introduced the agenda of the meeting, which was to review recent accomplishments and upcoming plans for the Rural Health Transformation Program (RHTP), and to present on the current work in addressing the changes that have come with the federal budget bill H.R.1. Secretary Charest called on EOHHS Assistant Secretary Ana Novais to provide more detail on the RHTP updates.

II. Health Care System Transformation & RHTP – Introduction

Please note: The RHTP project is supported by the Center for Medicare & Medicaid Services (CMS) of the US Department of Health and Human Services (HHS) as part of a financial assistance award totaling $156 million with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS or the U.S. government.

Assistant Secretary Novais, described that agency directors would present on RHTP updates, focusing on what has happened in the last 6 months and the next steps for the program, especially in regard to the year 2 budget. Assistant Secretary Novais went on to introduce the presenters from RIDOH: Kristine Campagna, Fernanda Lopes, and Director Jerome Larkin, MD.

III. Health Care System Transformation & RHTP – RIDOH

a. Rhode Island Department of Health's (RIDOH) Director, Dr. Jerome Larkin, noted that RIDOH has been managing twenty-eight million dollars in funding and has been working on 3 dental programs, Emergency Medical Services (EMS) programs, and 2 perinatal programs, among others. He pointed out that RIDOH has been moving ahead on hiring a project manager and has hired a program manager. He also noted that RIDOH is moving ahead on several policy actions.

b. Kristine Campagna of RIDOH noted that the RIDOH RHTP programs started off with a monthly steering committee, and the project managers all meet every two weeks to stay on top of project timelines and pursue alignment. Ms. Campagna described that two contracts: The Women's Center and Dare to Dream, are in progress and awaiting pay orders. She also noted that the Addiction Medicine Initiative and the Family Medicine Project are in progress and that RIDOH is collecting quotes on EMS equipment. With a note on RIDOH's development of an Internal Policy Committee, Ms. Campagna called on Fernanda Lopes to speak on RIDOH's policy actions.

c. Fernanda Lopes, RIDOH, described the policy actions required by Centers for Medicare & Medicaid Services (CMS) that RIDOH has taken. Assistant Secretary Novais added that these actions will allow Rhode Island to be more competitive in future applications. Ms. Lopes continued that RIDOH is working to expand the scope of practice for pharmacists to independently issue tests and prescriptions, the scope of practice for dental assistants to provide drugs and supervise others, and to join Rhode Island into the physician assistant licensure compact. Assistant Secretary Novais pointed out that these are changes that must be implemented by 2027.

IV. **Health Care System Transformation & RHTP – Office of the Health Insurance Commissioner (OHIC)**

a. Commissioner Cory King, of the Office of the Health Insurance Commissioner (OHIC), described that OHIC has been involved in RHTP Initiative 11, and that the Hospital Association of Rhode Island (HSRI), the Care Transformation Collaborative of Rhode Island, and others have been brought in as subawardees. Mr. King went on to describe that OHIC has brought a contractor on board to develop a value-based payment (VBP) model to help hospitals and other health care entities receive funding through RHTP, that OHIC is hiring two policy analysts, and that the office is meeting with other subawardees to draft a "straw model proposal" of what types of value-based payment will be part of the model. He also said that subawardees will have access to incentive funds to distribute to qualifying providers, with those funds being put into use by January. He also noted that this money is separate from the grant funds that OHIC is managing.

b. Regarding VBP, Mr. King continued that OHIC is hiring a vendor to offer technical assistance directly to providers to support VBP implementation and that a request for proposal (RFP) for this work is forthcoming from the office.

c. Sam Salganik, of the RI Partnership for Home Care, raised the question as to how OHIC is thinking about balancing rural health transformation and general practice transformation when the larger practices that are best prepared to implement VBP serve a very different rural/nonrural patient mix than smaller providers.

d. Assistant Secretary Novais answered that the State is still receiving guidance on these details. She elaborated that for a provider to be eligible, they must serve rural populations or be developing programs that benefit rural residents. She added that this is a broad definition into which many providers fall and that defining a "rural serving provider" involves looking at patterns of where rural patients go to get care, and which services are unique in the state. Regarding these "unique" providers, the Assistant Secretary provided the example that Rhode Island Hospital is the only level 1 trauma center in the state, and that for this reason, even though it is located in Providence, it still serves rural patients.

V. **Health Care System Transformation & RHTP – Workforce/DLT**

Next, Director Matthew Weldon of the Department of Labor and Training (DLT) gave an update on their RHTP work:

a. Director Weldon described that DLT is working closely with EOHHS and the Assistant Secretary to figure out the right work cadence and approach to using the $8,000,000 that has been set aside for workforce, with several contracts in the works.

b. Assistant Secretary Novais added that RHTP includes a five-year service commitment for anyone who directly benefits from its workforce development programs and CMS requires states to have a system to track that commitment and recoup payments from providers who default. She pointed out that DLT's task will be to determine which roles are "clinical" to separate out healthcare sector jobs which can benefit from workforce development funds without the five-year obligation. She also noted that besides DLT, there are other important workforce partners such as the Office of Primary Care (OPC) and partners involved in developing EMS training to support EMS services in the state.

VI. **Health Care System Transformation & RHTP – EOHHS**

The Assistant Secretary then described the transition to Year 2 of RHTP at EOHHS.

a. She noted that the work currently being undertaken by partners of EOHHS reflects seventy percent of the money obligated for Year 1, which can be spent until October of 2027. She also pointed out that with Year 2 beginning in November, EOHHS is planning conversations on the lessons learned in the first 7 months of implementation for risks and challenges that partners have identified, and emerging questions for Year 2. These include EOHHS' plan to work more closely with Rhode Island Department of Children, Youth, and Families (DCYF) and the Rhode Island Office of Veterans Services (RIVETS).

b. Assistant Secretary Novais then reported on EOHHS's RHTP initiatives and programs, including work on data integration, building Community Clinical Care Hubs (CCCHs), Health Information Technology supports, and supporting local Networks in the eighteen rural towns within the RHTP program.

    i. EOHHS will integrate longitudinal data from the All-Payer Claims Data Base, the Office of Primary Care (OPC), and others with local-level collection of clinical and workforce data – and will also complete a data project making it easier to track spending on Health Related Social Needs
    ii. To implement the CCCHs, EOHHS has procured a consultant team which will help the State define the best Hub model that would work best for Rhode Island, to help link clinical services with community-based organizations providing Health Related Social Needs services.

iii. EOHHS is also procuring a consultant to support the Health Information Technology (HIT) fund to provide technical assistance to providers to assess their HIT needs and subsequent apply for grant funds to secure the tools they need to support back-office functions and improve patient experience within clinics.
iv. The Networks will allow EOHHS to funds groups of locally based organizations in the 18 eligible town, helping RHTP to maintain the necessary focus on local priorities and inform the development of grants within the projects.

c. Expanding on community and stakeholder involvement, Assistant Secretary Novais noted that July 31st would mark the inaugural meeting of the Rural Stakeholder Advisory Council (RSAC) to inform the structure of RHTP.

d. Finally, Assistant Secretary Novais also announced the hiring of Manuel Ortiz as the Director of RHTP, as well as a Chief Financial Officer, and additional staff for project management.

e. Mr. Salganik raised a question as to the consultant hired for the CCCH project. Assistant Secretary Novais announced that the consultant is Uncommon Solutions, a national organization with a background in similar projects. She noted that Uncommon Solutions would soon begin engagement with community partners.

VII. **H.R.-1 Implications on Health Care System Planning – Introduction**

Secretary Charest then opened a presentation on the Health Care System Planning implications of HR1, highlighting the work of the Federal Compliance Advisory Group. He recognized that work of Director Kimberly Brito, Department of Human Services (DHS), Medicaid Program Kristin Sousa, and the Director of HealthSource RI, Lindsey Lang in developing a significant report to the legislature in late 2025 on the meaning of HR1 for Rhode Island. He introduced Director Brito to provide updates on the changes that leadership has made based on that information.

VIII. **H.R.-1 Implications on Health Care System Planning – SNAP**

a. Director Brito began by discussing the effects of HR1 on SNAP in Rhode Island. She noted that SNAP is more than a nutrition program: it has an important influence on food security, financial stability, workforce participation, housing stability, and health issues like chronic disease, mental health care utilization, education outcomes, and the ability to work and subsequently meet newly imposed requirements. Director Brito described an observable decrease in caseloads, with 18,500 fewer individual recipients of SNAP and 9,371 households receiving benefits. She described that these reductions will continue to be observed over time as implementation continues to roll out. Some potential impacts that Director Brito

pointed out included increased reliance on food pantries, greater demand for community supports, and increased demand for benefit navigation—all of which are important for DHS to track.

b. Director Brito then described the three main changes to SNAP that have come with HR1:
    i. No option to self-attest to receive the standard utility allowance (which has resulted in a reduction in benefits for households),
    ii. Work requirements for able-bodied adults without dependents (ABAWD)
    iii. Narrowed SNAP eligibility for non-citizens has narrowed, along with additional verification requirements

c. Separately from eligibility changes, Director Brito also pointed out that the elimination of SNAP Ed and changes to the thrifty food plan mean that future SNAP benefits may not keep up with increased food costs, increasing food insecurity and related health harms for people using SNAP.

d. In describing DHS's response, Director Brito detailed five priority areas: protecting access to benefits, educating customers, supporting whole person health, monitoring outcomes, and strengthening partnerships. She described the importance of DHS being able to share this information, using their website as a central source of information and replacing projected changes with actual data as it becomes available.

IX. **H.R.-1 Implications on Health Care System Planning – Medicaid**

a. The focus of Director Sousa's update was on the rule taking effect in October that will impact non-citizens, describing that changes would roll out between 2026 and 2028, with some affecting certain populations and others changing the program more broadly. Some examples that she gave of these changes included a 2026 eligibility change for non-citizens, a 2027 community engagement requirement for adults in the expansion population, and a 6-month renewal cadence for adults in the expansion population.

b. Regarding the upcoming change in eligibility for non-citizens, Director Sousa described that the narrowed group of non-citizens to remain eligible would include lawful permanent residents after the 5-year waiting period, Cuban and Haitian immigrants, Compact of Free Association (COFA) migrants, children under 19, and pregnant and postpartum people. She described that others who had been previously eligible may not remain eligible, that loss of coverage for one person in the household does not determine the coverage status of the rest of the household, and that any changes in immigration status should be updated in Medicaid records as soon as possible.

c. Director Sousa described the timeline of notices that will be distributed to people who may be impacted by the changes. Between July 21st and 28th, initial notices to potentially impacted non-citizens will be sent out on yellow paper explaining what is changing, who is impacted, and urging people to check their account information to ensure it is up to date. Then, in August an additional request for documentation will be sent to the impacted population, in September, benefit decision notifications will be sent, and on October 1, benefits will end for those no longer eligible. She added that communications in October will include reference to other options available for those whose benefits are being taken away. Director Sousa also noted that non-citizens who lose Medicaid during this time may be eligible to apply for it in the future, and that members have a right to appeal if they believe that the decision was incorrect.

d. Director Sousa went on to describe that federal Medicaid changes are presently expected to affect the coverage of 3,653 people, with 1,186 of those people living in Providence, though this is only a snapshot of the information, and enrollments are always fluctuating. The Medicaid program is working closely with the Providence mayor's office to make sure that this information is getting out to the public.

e. Director Sousa then described the demographics of those affected by the change, with most being between 19 and 39 years old, 218 having a disability, and fewer than 11 living in long-term care. She also noted that the largest group affected by the change is Hispanic Rhode Islanders, and that the most common languages spoken among those affected being Spanish, English, and Haitian Creole.

f. Director Sousa noted that those whose coverage is being taken away may still be able to access care, providing examples of free and low-cost clinics like the Rhode Island free clinic, FQHCs with sliding scale payments, and Community Behavioral Health Centers (CCBHCs) which offer mental health and substance use services regardless of citizenship status. She also added that there may be options to purchase health insurance through employers and the exchange, though they may not be able to secure financial assistance. Director Brito noted that information is available on the DHS website in multiple languages and asked those present to share information in the community and provide assistance where it is needed.

g. Director Sousa informed the attendees that the Medicaid Program is presently working with nursing homes to help plan for changes. Mr. Salganik raised a question about the notice that has already gone out to people potentially affected by the change, asking how broad the definition of "potentially affected" was and how many notices were sent out. Anthony Salvo,

EOHHS, answered that the identification of people potentially impacted was based on CMS guidance, utilizing existing data and present requirements.

h. Mr. Salganik also asked whether, as people are removed from Medicaid coverage, Rhode Island is likely to see an increase in uninsurance that approaches 8% and how the state is planning for access to care for those people and dedication of financial support for safety net institutions. Director Sousa responded that both the Secretary and the Assistant Secretary have started planning for how to approach this issue. Secretary Charest noted that this will not just be a question of funding but also of how we get this information out to where it needs to go in Rhode Island.

i. Dr. Larkin brought up questions as to whether there is any calculation that can be made as to what any cost savings from HR1 changes in Rhode Island would actually be. Director Sousa answered that much of the population that is going to lose Medicaid are the people who we most want to be insured as they will incur the greatest cost when uninsured. (Please see the final Federal Compliance Advisory Group Report from October 30, 2025 for more information.)

X. **H.R.-1 Implications on Health Care System Planning – Health Source Rhode Island (HSRI)**

a. HealthSource RI Director Lindsay Lang made a presentation on changes in health insurance status for Rhode Islanders utilizing the exchange.

b. Director Lang first described that the end of enhanced advance premium tax credits (APTC) that help Rhode Islanders purchase insurance on HealthSource RI is going to have a significant effect on Rhode Islanders. The APTC will no longer be available to non-citizens and those with certain legal immigration statuses, that the APTC “five-year bar” for customers making less than 100% of the federal poverty line (FPL) is ending. She also described how pre-enrollment verification is going to significantly slow down the enrollment process. She noted that 7,300 Rhode Islanders are expected to lose coverage in the coming years due to HR1 and 13,000 are expected to drop due to eligibility concerns and APTC expiration. She noted that overall enrollment is down 9,000 customers when comparing the peak of enrollment in the fall of 2025 to the open enrollment in the spring of 2026, with 1,000 of those having dropped due to categorical immigration changes and the other 8,000 due to loss of APTC. Director Lang added that this was a slightly smaller loss than predicted, though HealthSource expects to see continued losses in the coming months.

c. Director Lang also noted that many people are now buying down into bronze-level plans with higher out-of-pocket costs due to premium increases, and that due to immigration-

related changes in January 2027, 3,000 to 4,000 people are expected not to stay on their plans through open enrollment.

d. Regarding pre-enrollment, she described that HealthSource is expecting draft regulations to be issued by CMS in August or September, with final regulations issued by the winter. She added that there will be a significant focus at HealthSource, DHS, and Medicaid to support related process changes, as annual CMS regulations govern marketplace operations and rules with a myriad of effects on operations, customers, and plans.

e. Director Lang went on to describe that when estimating the effect of expiring tax credits, premium costs have doubled for enrollees this year. She noted that those making less than 200% of the FPL will see the highest premium increase (between a 246% and 348% increase per month) and this is where Healthsource's efforts to reduce change will focus. The primary strategy to mitigate the damage of these changes will be the Rhode Island Marketplace Affordability Program (RIMAP), which will replace the enhanced APTCs for approximately 20,000 customers starting in 2027, with HealthSource looking to reverse the loss of coverage for an estimated 6,500 Rhode Islanders.

f. Director Lang also described that HSRI is working to maximize the tax credit coming to all HSRI customers, regardless of income, and to be as clear and transparent as possible with customers.

XI. Additional Health Care System Planning Updates

a. The Assistant Secretary then provided an update for that CMS will be visiting Rhode Island in late October or early November for a Rural Health Transformation Program site visit, and will expect to see the Cabinet engaged. She will share that date as soon as it is available.

b. She also shared a message to Save the Date for a convening summit that EOHHS will be holding on December 16th.

XII. Public Comment – Secretary Charest then opened up the meeting to Public Comment.

a. A question was raised in the chat for Director Lang, asking if there is data available on the children affected by the loss of APTC. Director Lang responded that the data was not on hand but could be made available.

b. Then, Lisa Tomasso, Health Association of Rhode Island, (HARI) asked whether we are doing anything to track changes in use of community-based services like food banks. Director Brito responded that there are dashboards in the process of being built, with an effort to make that data transparently available.

c. Meghan Connelly, Office of Healthy Aging (OHA) added that OHA is also specifically keeping track of utilization of meal sites and the senior center and sharing that data directly with DHS.

d. Stacy Paterno, Rhode Island Medical Society, (RIMS) then asked whether there is similar monitoring happening around medical determinations as HR1 changes put pressure on offices. Director Brito responded that those changes haven't been measured for Medicaid yet, but the process for how to handle that information is progressing.

e. Lucy Rios, Rhode Island Coalition Against Domestic Violence, (RICADV) raised that all of the stressors on HRSNs increase the risk for intimate partner violence and domestic violence. She also brought up the fact that with increased reliance on community resources, the cuts that the state is feeling are trickling down to providers and community-based organizations (CBOs). She then asked how CBOs, and specifically RICADV can be partners in the larger conversation. The Assistant Secretary responded that while many of the conversations from this Cabinet meeting have taken a systems and process perspective, the process has begun for how to engage more broadly outside of EOHHS and the state agencies. She added that the question of how to respond to what is happening at the community level from a prioritization perspective is one of the biggest challenges of the moment. She further described that one way that EOHHS is trying to accomplish this task is by creating a state-wide system to align and leverage resources to address HRSNs that already exist in silos at state-level agencies to bring them to the community level.

XIII. Conclusion

The Secretary thanked everyone for their participation and moved to adjourn the meeting at 2:30 pm.