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S T A T E O F R H O D E I S L A N D

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2026

A N A C T

RELATING TO HEALTH AND SAFETY -- FOOD-AS-MEDICINE PILOT PROGRAM

Introduced By: Representatives Caldwell, Slater, Kislak, and Spears

Date Introduced: February 27, 2026

Referred To: House Finance

It is enacted by the General Assembly as follows:

SECTION 1. The general assembly finds and declares that:

(1) Diet-related chronic diseases, including diabetes, cardiovascular disease, hypertension, and obesity, represent a significant and growing burden on Rhode Island's residents and healthcare system;

(2) Individuals experiencing food insecurity and chronic illness often face barriers to accessing nutritious food that supports disease prevention and management;

(3) Evidence-based food-as-medicine interventions, including medically tailored meals and nutrition supports, have demonstrated in a number of states nationwide the potential to improve health outcomes, reduce health disparities, and lower healthcare utilization and costs for high-risk populations;

(4) Healthcare delivery systems are increasingly transitioning to value-based purchasing and whole-person care models that emphasize prevention and the integration of health-related social needs; and

(5) A carefully scoped pilot program, developed in collaboration with health insurers and community-based service providers, is necessary to determine the feasibility, effectiveness, and sustainability of food-as-medicine interventions in Rhode Island.

SECTION 2. Title 23 of the General Laws entitled "HEALTH AND SAFETY" is hereby amended by adding thereto the following chapter:

CHAPTER 106

FOOD-AS-MEDICINE PILOT PROGRAM

23-106-1. Food-as-medicine task force -- Establishment.

(a) The food-as-medicine task force is hereby established within the executive office of health and human services (EOHHS) for the purpose of developing recommendations for the creation and implementation of a food-as-medicine pilot program in Rhode Island.

(b) The task force shall consist of the following members, or designees:

(1) The secretary of the EOHHS;

(2) The director of the department of health;

(3) The director of the office of healthy aging;

(4) The director of the department of human services;

(5) The health insurance commissioner;

(6) A representative from a community health center;

(7) A representative from a managed Medicaid insurer providing medically tailored meals;

(8) A representative from a commercial healthcare insurer providing medically tailored meals;

(9) A representative from a hospital system engaged in value-based care initiatives;

(10) A representative of an academic institution with research or evaluation expertise;

(11) A representative of a not-for-profit medically tailored meal provider;

(12) A general physician or advanced practice nurse with experience serving persons with chronic illness;

(13) A licensed registered dietitian nutritionist;

(14) One member of the Rhode Island house of representatives from the majority party, appointed by the speaker of the house;

(15) One member of the Rhode Island house of representatives from the minority party, appointed by the minority leader of the house;

(16) One member of the Rhode Island senate from the majority party, appointed by the senate president;

(17) One member of the Rhode Island senate from the minority party, appointed by the senate minority leader; and

(18) One public member representing the interests of individuals managing chronic illness.

(c) Members shall serve without compensation.

23-106-2. Duties of the task force.

(a) The task force shall examine and make recommendations regarding the design, scope, and implementation of a food-as-medicine pilot program in Rhode Island including, but not limited

to the following:

(1) Identifying specific populations that experience a disproportionate burden of diet-related chronic disease and are most likely to benefit from food-as-medicine interventions including, but not limited to, individuals enrolled in Medicaid, older adults, and individuals with complex medical needs;

(2) Defining appropriate eligibility criteria for participation in a food-as-medicine pilot program to ensure the efficient and effective targeting of limited resources;

(3) Identifying evidence-based food-as-medicine interventions to be included in the pilot program including, but not limited to, medically tailored meals and other nutrition-based supports;

(4) Assessing opportunities for collaboration with community-based service providers, health care providers, managed care organizations, and commercial insurers in the delivery of food-as-medicine interventions;

(5) Evaluating options for reimbursement, payment models, and financing mechanisms, including Medicaid authorities, value-based purchasing arrangements, and public-private partnerships;

(6) Examining data collection, evaluation, and reporting requirements necessary to assess health outcomes, utilization, cost impacts, and health equity implications of the pilot program;

(7) Identifying administrative, operational, or regulatory barriers to implementation of a food-as-medicine pilot program in Rhode Island;

(8) Developing recommendations for legislative, regulatory, or budgetary actions necessary to establish and sustain a food-as-medicine pilot program;

(9) Examining the feasibility of utilizing federal Medicaid authorities and federal grant programs including, but not limited to, a federal rural health grant program or a waiver or amendment under section 1115 of the Social Security Act, to support the design, implementation, and evaluation of a food-as-medicine pilot program;

(10) Identifying the populations, services, delivery models, and outcome measures that could be included in an application for a federal rural health grant program or a section 1115 waiver or waiver amendment to support food-as-medicine interventions for individuals with the highest burden of diet-related chronic disease; and

(11) Assessing the alignment of a food-as-medicine pilot program with existing Medicaid managed care, value-based purchasing, and health equity initiatives administered by the executive office of health and human services.

23-106-3. Meetings and staffing.

(a) The secretary of the executive office of health and human services (EOHHS), or

designee, shall convene the first meeting of the task force no later than ninety (90) days after the effective date of this chapter.

(b) The EOHHS, or such department, office, or program with relevant subject-matter expertise as designated by the secretary, shall provide staff support to the task force.

23-106-4. Reporting.

(a) The task force shall submit a report of its findings and recommendations to the governor, the speaker of the house of representatives, and the president of the senate.

(b) The report shall include recommendations regarding the scope, design, and implementation of a food-as-medicine pilot program including, but not limited to, any proposed legislation necessary to authorize or fund the pilot program.

(c) The report shall be submitted no later than December 31, 2026.

23-106-5. Medicaid waiver authority -- Food-as-medicine pilot.

(a) The executive office of health and human services (EOHHS) is authorized to seek federal approval to implement a food-as-medicine pilot program for eligible Medicaid beneficiaries.

(b) For the purposes of this section, the EOHHS may submit an application for, or amendment to, a demonstration project pursuant to section 1115 of the Social Security Act, or pursue other available federal Medicaid authorities, as necessary to implement and fund the food-as-medicine pilot program.

(c) The application for a section 1115 waiver or waiver amendment may include, but is not limited to:

(1) Coverage of evidence-based food-as-medicine interventions including, but not limited to, medically tailored meals and other nutrition-based supports, for Medicaid beneficiaries with chronic, diet-related diseases;

(2) Eligibility criteria designed to prioritize individuals with the highest health risks, health care utilization, and unmet nutrition-related needs;

(3) Delivery models that leverage partnerships with community-based service providers, health care providers, and managed care organizations;

(4) Payment and reimbursement methodologies consistent with value-based purchasing principles; and

(5) Data collection, evaluation, and reporting requirements to assess health outcomes, health equity, utilization, and cost impacts.

(d) The EOHHS may implement the food-as-medicine pilot program upon receipt of any necessary federal approvals and subject to the availability of federal financial participation.

23-106-6. Construction.

Nothing in this act shall be construed to require state expenditures beyond those authorized through federal approval, existing appropriations, or future legislative action.

SECTION 3. This act shall take effect upon passage.

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EXPLANATION

BY THE LEGISLATIVE COUNCIL

OF

A N A C T

RELATING TO HEALTH AND SAFETY -- FOOD-AS-MEDICINE PILOT PROGRAM

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This act would establish a food-as-medicine pilot program and task force to be administered by the executive office of health and human services.

This act would take effect upon passage.

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