August 8, 2025

The Honorable Mehmet Oz, M.D.
Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically via Medicaid.gov

Re: MaineCare 1115 Demonstration Waiver Extension Application: Substance Use Disorder Care Initiative

Dear Administrator Oz,

On behalf of Families USA, thank you for the opportunity to comment on Maine's proposed 1115 Medicaid Demonstration Extension Application. Families USA is a leading national, non-partisan voice for health care consumers, dedicated to achieving high-quality, affordable health care and improved health for all, including the more than 405,000 Mainers who access health care coverage through Maine's Medicaid program, MaineCare.[1]

Through this demonstration waiver renewal application, the Office of MaineCare Services (OMS) proposes to extend its current demonstration, the Maine Substance Use Disorder (SUD) Care Initiative (approved by CMS through December 31, 2025), to continue to advance strides the state has made toward addressing substance use disorder (SUD) treatment and overdose deaths among residents with MaineCare. By proposing to renew their demonstration and its original components — including pilots aimed at supporting MaineCare-enrolled parents with SUD and their families — OMS proposes to build on progress made in the first demonstration period to meaningfully improve the SUD continuum of care for vulnerable MaineCare enrollees. We applaud that effort.

In addition, the waiver application (renamed *Maine's Whole Person Care Waiver*) proposes to test a range of additional pilot programs aimed at adding proven and cost-effective components to the spectrum of services available under MaineCare. These pilots, if approved, would offer evidence-based interventions that target critical junctures in care for vulnerable subpopulations — from people experiencing homelessness to those with complex behavioral health needs — while shifting funding from inpatient to community-based settings in ways that improve the health of beneficiaries and reduce health care costs.

Families USA supports Maine's Whole Person Care Waiver and commends OMS for endeavoring to put in place cost-effective programs in the state that not only positively impact the lives of vulnerable MaineCare enrollees but invest in critical services that will expand care options for all Maine residents. We strongly urge CMS to approve the waiver in full. We ask that these comments, and all supportive

citations referenced herein, be incorporated into the administrative record in their entirety. Our detailed comments focus specifically on four pilot programs proposed under Maine's waiver application:

I. Contingency Management
II. Pre-release Medicaid Services for Justice Involved Individuals initiative
III. Food is Medicine
IV. Recuperative Care

I. Contingency Management

OMS seeks new waiver authority to implement a pilot program that uses a highly effective and evidence-based approach known as "Contingency Management" to treat stimulant use disorders (STUD) – the uncontrolled use of amphetamine-type substances, cocaine, and other stimulants – which are on the rise in Maine:

- The number of deaths related to methamphetamines doubled in Maine between 2019 and 2020,[2] and since 2019, methamphetamine-related seizures increased 215%.[3]
- Deaths involving cocaine make up 23% of all drug-related deaths in Maine, and cocaine is a co-intoxicant cause of death for 29% of fentanyl deaths in the state.[4]

OMS' proposed contingency management (CM) approach for addressing STUD among MaineCare members draws on five decades of research showing the ability of CM programs to increase substance non-use and adherence to treatment activities.[5] The CM model provides motivational incentives to reinforce positive behavioral change.[6] In a typical model, when a patient meets a treatment goal (e.g., submission of one or more drug-negative urine specimens) they receive a reward or incentive (e.g., cash or voucher). Positive reinforcements via CM make it easier for patients to meet treatment goals as they serve as a powerful counterbalance to the harmful reward system in place in the brain from prolonged stimulant use.[7] A body of research indicates the most effective CM programs offer rewards of at least $100 per month, which provides enough financial incentive to motivate behavior change.[8]

CM programs demonstrate short- and long-term effectiveness in treating STUD. Studies of a CM program in use by the Veteran's Affairs (VA) health system have found ***92.6% drug screening negativity among CM participants and increased likelihood of maintaining non-use of substances after one year*** (compared to treatment without motivational incentives).[9] CM's success in the VA system shows the promise of the model for delivery on large-scale basis, such as through MaineCare.

While CM programs are thought to be one of the most effective interventions to address substance use, they are one of the least available, provided in only 10% of addiction treatment settings.[10] OMS proposes to address this gap in behavioral health care by offering up to $750 per participant per year to MaineCare members who are diagnosed with STUD and who submit negative point-of-care drug tests to eligible providers.[11] The broad structure of OMS' proposal follows the evidence base and conforms to best practices, including ensuring CM program delivery at Certified Community Behavioral Health Clinics.

Families USA strongly urges CMS to approve OMS' proposed "Contingency Management" pilot program as an evidence-based and cost-effective approach to treating STUD for people enrolled in MaineCare. Not only does this pilot offer an important new tool to address STUD in the state, it is also a wise investment: because CM programs are so effective at reducing substance use and cost far less than other treatment options (for comparison, three months of outpatient drug rehabilitation can cost over $5,000[12]), numerous studies show these programs serve to reduce overall health care costs.[13]

II. Pre-Release Medicaid Services for Justice-Involved Individuals Initiative

OMS requests waiver authority to extend Medicaid coverage for a set of targeted "pre-release" services to individuals transitioning from jails, prisons, and youth correctional facilities. Under the proposed initiative, an estimated 54,528 eligible individuals will gain access to a range of services — including SUD and mental health treatment, case management, and a 30-day supply of prescription medication — up to 90 days prior to their release.[14] **Families USA strongly supports Maine's pre-release Medicaid initiative as it offers transitioning populations the tools they need to stay well as they readjust to living in the community.**

Currently, when MaineCare recipients become incarcerated, their access to Medicaid coverage is suspended following what is known as the "inmate exclusion," a general policy that limits Medicaid coverage for incarcerated individuals to coverage for inpatient stays at a hospital or other medical institution.[15] While this exclusion does not prevent inmates from receiving basic medical services within a correctional setting, these facilities are often under-resourced and ill-equipped to address the chronic health needs among their population,[16] which may be substantial: an estimated 80% of incarcerated people have serious mental illness, substance use disorders, and chronic health issues.[17] In Maine, 61% of the incarcerated population has a SUD diagnosis.[18]

While MaineCare will reinstate Medicaid coverage upon release (if a person remains eligible), the suspension itself serves to sever ties with health care providers in the community, meaning Medicaid-eligible people leave carceral settings without established connections to the health care system. Following release, former inmates report difficulty obtaining care which can contribute to post-release morbidity and mortality, and higher costs for the healthcare system when people report to the emergency department for conditions that can and should be addressed in primary care settings.[19]

Maine's initiative, if approved, would mitigate this problem by ensuring that people who arrived with Medicaid leave the correctional system with MaineCare coverage (assuming they remain eligible), avoiding any period of uninsurance. In addition, by targeting a set of Medicaid services for up to 90 days pre-release, the proposed initiative would enable eligible inmates to form important connections to health care providers outside of the carceral setting who not only can treat ongoing and unaddressed needs prior to release but can continue that treatment upon transition to the community. Finally, under this initiative, OMS proposes to streamline Medicaid determinations for other populations who may be Medicaid-eligible upon their release.

Families USA strongly urges CMS to approve Maine's proposed pre-release Medicaid initiative because prisons, jails and youth correctional facilities need additional tools to prepare inmates for reentry. Research consistently shows the significant and positive impact that pre-release Medicaid has on improving health outcomes, reducing recidivism rates, and contributing to greater economic stability:

- Individuals who are enrolled in Medicaid prior to release have reduced risk of adverse health outcomes, including overdose and suicide.[20]
- Pre-release Medicaid enrollment and care coordination have been shown to reduce recidivism by as much as 16% within the first six months.[21]
- Pre-release Medicaid programs increase the likelihood that formerly incarcerated people are employed by 25% and increase quarterly income by almost $200.[22]

Beyond improving individual outcomes, pre-release Medicaid programs benefit state/local governments by reducing budget demands and increasing efficiency. Arizona's 2015 pre-release Medicaid program led to $30 million in administrative savings, highlighting the potential economic impact for Maine.[23]

III. Food is Medicine

Extensive research demonstrates the link between nutrition and health and the impact improvements in diet can have on reducing chronic disease morbidity and associated health care costs.[24] Overall, diet quality is low for many Americans, which is a major driver of chronic disease.[25] The recent Department of Health and Human Services Report, "The MAHA Report Make Our Children Healthy Again Assessment," states:

> "Most American children's diets are dominated by ultra-processed foods (UPFs) high in added sugars, chemical additives and saturated fats, while lacking sufficient intake of fruits and vegetables. This modern diet has been linked to a range of chronic diseases, including obesity, type 2 diabetes, cardiovascular disease, and certain cancers."[26]

Low diet quality in the United States reflects a multitude of factors, but for many Americans, food insecurity and high food prices are a chief concern. For example, according to a 2025 Pew Research Center survey, 69% of Americans report the increased cost of healthy food makes it harder for them to eat healthy.[27] One approach to improving diet and health is to ensure low-income populations have access to healthy food through a "Food is Medicine" (FIM) program. FIM programs integrate nutritional resources into health care as a strategy to address the nutrition-related component of chronic disease.[28]

OMS seeks new waiver authority to implement a FIM pilot, which would allow MaineCare to provide an array of services, programs, and interventions that address nutrition – including medically tailored meals, food pharmacy/fruit and vegetable prescriptions, and nutrition counseling/education – to enrollees who have chronic disease, behavioral health conditions or are pregnant/postpartum.[29]

Families USA strongly urges CMS to approve Maine's Food is Medicine pilot, as the program is an important strategy to improving health outcomes and lowering health care expenditures for MaineCare members with high care needs. Similar FIM programs in other states show success in reducing health care costs related to chronic disease, an indicator that these programs are improving health overall:

- Under North Carolina's *Health Opportunities Pilot*, Medicaid beneficiaries who received food as part of their care had reduced emergency department visits and inpatient hospitalizations, leading to as much as $85 per beneficiary per month in reduced health care expenditures.[30] The longer participants received food supports, the greater the reductions in direct service spending.
- Beneficiaries enrolled in nutrition supports under Massachusetts' *Flexible Services Program* saw 23% reductions in hospitalizations and 13% reductions in emergency department visits, resulting in net savings of $210 per person for members enrolled in the program for longer than 90 days.[31] Between 2020 and 2023, the program yielded approximately $1.8 million dollars in total savings to the state's Medicaid program.[32]

IV. Recuperative Care

Like many states, Maine is experiencing a housing affordability crisis leaving an increasing number of Mainers homeless or housing insecure.[33] Across the state, the number of people experiencing homelessness has more than doubled since 2021.[34] Spikes in homelessness cause ripple effects through

the health care system as chronic homelessness is associated with higher morbidity and mortality,[35] and housing instability (i.e. couch surfing, frequent moves, foreclosures) increases the risk of diabetes, cardiovascular diseases and chronic obstructive pulmonary disease.[36] These adverse health outcomes translate to higher health care expenditures: on average, homeless individuals stay in hospitals for 22% longer than individuals with stable housing and costs incurred are typically absorbed by the health system or the state.[37] Longer hospital stays are a major contributor to hospital bed shortages in Maine.[38]

Often, the reason for prolonged hospital stay is that individuals experiencing homelessness are too ill or frail to recover from illness or injury on the streets, so it is not safe to discharge them.[39] Medical Respite (MR) programs offer an innovative solution to this problem. By discharging homeless patients to short-term residential care – moving them out of expensive and overburdened hospital settings – MR programs offer a safe environment for homeless patients to recuperate and receive medical care, adequate nutrition and other supportive services they need to recover (including referrals to ongoing medical treatment at community locations).[40]

Nationwide, there are 120 MR programs operating in 35 states.[41] Significant evidence demonstrates that MR programs improve outcomes and reduce overall health care costs:

- MR programs reduce average hospital length of stay, allow for timely and safe discharge for homeless patients, and save hospital beds for those who need them most.[42]
- One study following 407 homeless adults for 18 months found the MR program (compared to usual care) resulted in average annual net health care savings of $6,307 per person (USD 2012).[43]
- In Oregon, a program offering supportive housing with health-related services increased primary care visits by 20% while decreasing emergency department use by 18% and overall Medicaid expenditures by 12%.[44]

In Maine, MaineHealth (the state's largest health system) has operated its own MR program since 2022 to people with acute medical conditions who experience homelessness.[45] The shelter and onsite clinical services offered by MaineHealth enable participants to better adhere to treatment plans (for example, by enabling someone to take a full course of antibiotic treatment before they leave clinical care) thereby reducing further medical complications and future hospitalization. As a result, the MaineHealth system has seen a decrease in hospital says (freeing up 950 days' worth of hospital bed use), fewer ER visits, more use of appropriate outpatient services, and overall reduction in health care costs.[46]

OMS proposes to build on the success of MaineHealth's MR initiative by implementing a "Recuperative Care" pilot within its Section 1115 waiver, to allow the state to offer MR services for members experiencing homelessness with an acute medical or psychiatric condition. OMS' program proposes to offer onsite clinical pre- and post-hospitalization services at three different locations. **Families USA strongly urges CMS to approve Maine's Recuperative Care pilot program. The program will help scale the success of current medical respite programs in the state and will fill critical gaps in care for MaineCare members who experience homelessness.**

Conclusion

OMS' demonstration waiver extension application – including its original components and the proposed new pilots described here – focuses on holistic, evidence-based and cost-effective approaches to addressing root cause challenges for some of Maine's most vulnerable Medicaid-eligible residents. **Families USA applauds OMS for their commitment to improving access to care for MaineCare**

populations whose needs are often underserved within the confines of the health care system. We strongly urge CMS to approve the waiver in full.

For questions or comments regarding the recommendations in this letter, please contact Mary-Beth Malcarney, Senior Advisor on Medicaid Policy, Families USA at: mmalcarney@familiesusa.org.

Thank you for your time and consideration.

Sincerely,

Sophia Tripoli
Senior Director of Health Policy

[1] MaineCare 1115 Demonstration Waiver Application, Office of MaineCare Services, March 2025, https://www.maine.gov/dhhs/sites/maine.gov.dhhs/files/rule-2025-03/Maine%201115%20Waiver%20Draft.pdf.
[2] Sorg, Marcella. n.d. "MAINE DRUG DEATH REPORT for 2020." https://mainedrugdata.org/wp-content/uploads/2021/06/2020_Annual_ME_Drug_Death_Rpt_Final.pdf.
[3] Sauschuck, Michael, and Roy Mckinney. n.d. "ANNUAL REPORT 2021 a STATEWIDE DRUG TASK FORCE." https://www.maine.gov/dps/sites/maine.gov.dps/files/inline-files/2021AnnualReport.pdf
[4] Sorg, Marcella. n.d. "MAINE DRUG DEATH REPORT for 2020." https://mainedrugdata.org/wp-content/uploads/2021/06/2020_Annual_ME_Drug_Death_Rpt_Final.pdf.
[5] McPherson, Sterling M., Sara Parent, Andre Miguel, Michael McDonell, and John M. Roll. "Contingency Management Is a Powerful Clinical Tool for Treating Substance Use Research Evidence and New Practice Guidelines for Use." Psychiatric Times 39, no. 9 (2022). https://www.psychiatrictimes.com/view/contingency-management-is-a-powerful-clinical-tool-for-treating-substance-use-research-evidenceand-new-practice-guidelines-for-use; "Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way", Health Affairs Blog, March 11, 2020, DOI: 10.1377/hblog20200305.965186; U.S. Department of Health and Human Services. (2023). Contingency Management for the Treatment of Substance Use Disorders: Enhancing Access, Quality, and Program Integrity for an Evidence-Based Intervention. Retrieved January 2023 from https://aspe.hhs.gov/reports/contingency-management-treatment-suds; Rawson, R.A., Erath, T.G., Chalk, M., Clark, H.W., McDaid, C., Wattenberg, S.A., Roll, J.M., McDonell, M.G., Parent, S., & Freese, T.E. (2023). Contingency Management for Stimulant Use Disorder: Progress, Challenges, and Recommendations. Journal of Ambulatory Care Management. 46(2):152-159. https://doi.org/10.1097/ JAC.0000000000000450.
[6] "Contingency Management," Recovery Research Institute, https://www.recoveryanswers.org/resource/contingency-management/.
[7] "Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way", Health Affairs Blog, March 11, 2020, DOI: 10.1377/hblog20200305.965186.
[8] Becker SJ, DiClemente-Bosco K, Rash CJ, Garner BR. Effective, but underused: lessons learned implementing contingency management in real-world practice settings in the United States. Prev Med. 2023 Nov;176:107594. doi: 10.1016/j.ypmed.2023; "Contingency Management: A Highly Effective Treatment For Substance Use Disorders And The Legal Barriers That Stand In Its Way", Health Affairs Blog, March 11, 2020, DOI: 10.1377/hblog20200305.965186; "Letter to Secretary Becerra," Motivational Incentives Policy Group, 2022, https://www.naadac.org/assets/2416/mipg_letterto_hhs_sec_becerra_on_cm_12_may_2022.pdf.
[9] Dominick DePhilippis et al., "History and Current Status of Contingency Management Programs in the Department of Veterans Affairs," Preventive Medicine 176 (September 17, 2023): 107704, https://doi.org/10.1016/j.ypmed.2023.107704; Meredith K Ginley et al., "Long-term Efficacy of Contingency Management Treatment Based on Objective Indicators of Abstinence From Illicit Substance Use up to 1 Year Following Treatment: A Metaanalysis.," Journal of Consulting and Clinical Psychology 89, no. 1 (January 1, 2021): 58–71, https://doi.org/10.1037/ccp0000552.
[10] Becker SJ, DiClemente-Bosco K, Rash CJ, Garner BR. Effective, but underused: lessons learned implementing contingency management in real-world practice settings in the United States. Prev Med. 2023 Nov;176:107594. doi: 10.1016/j.ypmed.2023.107594.
[11] "MaineCare 1115 Demonstration Whole Person Care Waiver Application," Office of MaineCare Services, June 27, 2025, at page 19, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mn-sud-pa-07102025.pdf.
[12] "Average Cost of Drug Rehab," National Center for Drug Abuse Statistics, https://drugabusestatistics.org/cost-of-rehab/
[13] Murphy SM, McDonell MG, McPherson S, Srebnik D, Angelo F, Roll JM, Ries RK. An economic evaluation of a contingency-management intervention for stimulant use among community mental health patients with serious mental illness. Drug Alcohol Depend. 2015 Aug 1;153:293-9. doi: 10.1016/j.drugalcdep.2015.05.004; Olmstead TA, Petry NM. The cost-effectiveness of prize-based and voucher-based contingency management in a population of cocaine-or opioid-dependent outpatients. Drug Alcohol Depend. 2009;102:108–115. doi:

10.1016/j.drugalcdep.2009.02.005; Olmstead TA, Sindelar JL, Easton CJ, Carroll KM. The cost effectiveness of four treatments for marijuana dependence. Addiction. 2007a;102:1443–1453. doi: 10.1111/j.1360-0443.2007.01909.x; Olmstead TA, Sindelar JL, Petry NM. Clinic variation in the cost effectiveness of contingency management. Am. J. Addict. 2007b;16:457–460. doi: 10.1080/10550490701643062; Olmstead TA, Sindelar JL, Petry NM. Cost-effectiveness of prize-based incentives for stimulant abusers in outpatient psychosocial treatment programs. Drug Alcohol Depend. 2007c;87:175–182. doi: 10.1016/j.drugalcdep.2006.08.012; Sindelar J, Elbel B, Petry NM. What do we get for our money? Cost effectiveness of adding contingency management. Addiction. 2007a;102:309–316. doi: 10.1111/j.1360-0443.2006.01689.x; Sindelar JL, Olmstead TA, Peirce JM. Cost effectiveness of prize based contingency management in methadone maintenance treatment programs. Addiction. 2007b;102:1463–1471. doi: 10.1111/j.1360-0443.2007.01913.x.

[14] "MaineCare 1115 Demonstration Whole Person Care Waiver Application," at page 31.

[15] 22 Maine Revised Statutes § 3174-CC. Medicaid eligibility during incarceration (2025), https://legislature.maine.gov/statutes/22/title22sec3174-CC.html.

[16] Fiscella, K., Beletsky, L., & Wakeman, S. E. (2017a, March). *The inmate exception and Reform of Correctional Health Care*. American journal of public health. https://pmc.ncbi.nlm.nih.gov/articles/PMC5296706/#:~:text=This%20explicit%20exclusion%2C%20commonly%20referred,and%20external%20quality%20oversight%20mandates.

[17] Health Care Transitions for individuals returning to ... - ASPE. (2023). https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdfhttps://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf; Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, Koepsell TD. Release from prison--a high risk of death for former inmates. N Engl J Med. 2007 Jan 11;356(2):157-65. doi: 10.1056/NEJMsa064115. Erratum in: N Engl J Med. 2007 Feb 1;356(5):536. PMID: 17215533; PMCID: PMC2836121.

[18] "Medication for Substance Use Disorder (MSUD)Treatment Services," Maine Department of Corrections, December 2022, https://www.maine.gov/corrections/sites/maine.gov.corrections/files/inline-files/MDOC%20MSUD%20Year%20Three%20Report%20%282022%29.pdf.

[19] Mallik-Kane, K. (2008, February). *Health and prisoner reentry: How physical, mental and ...* Urban Institute. https://www.urban.org/sites/default/files/publication/31491/411617-Health-and-Prisoner-Reentry.PDF; McConville, S., Mooney, A. C., Williams, B. A., & Hsia, R. Y. (2018). How do ED patients with criminal justice contact compare with other ED users? A retrospective analysis of ED visits in California. BMJ open, 8(6), e020897. https://doi.org/10.1136/bmjopen-2017-020897/; Nally JM, Lockwood S, Ho T, Knutson K. Post-release recidivism and employment among different types of released offenders: A 5-year follow-up study in the United States. International Journal of Criminal Justice Sciences; 2014; 9(1): 16-34; "Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group," U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, January 2023, https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf.

[20] "Health Care Transitions for Individuals Returning to the Community from a Public Institution: Promising Practices Identified by the Medicaid Reentry Stakeholder Group," U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation, January 2023, https://aspe.hhs.gov/sites/default/files/documents/d48e8a9fdd499029542f0a30aa78bfd1/health-care-reentry-transitions.pdf.

[21] Aslim, E. G., Mungan, M. C., Navarro, C. I., & Yu, H. (2021). The effect of Public Health Insurance on criminal recidivism. *Journal of Policy Analysis and Management*, *41*(1), 45–91. https://doi.org/10.1002/pam.22345; Burns, M., & Dague, L. (2023, June). *In-kind welfare benefits and reincarceration risk*. National Bureau of Economic Review. https://www.nber.org/system/files/working_papers/w31394/w31394.pdf.

[22] Burns and Dague, 2023

[23] NCSL. (2023, January 16). *Connecting recently released prisoners to health care—how to leverage Medicaid*. NCSL Foundation. https://www.ncsl.org/civil-and-criminal-justice/connecting-recently-released-prisoners-to-health-carehow-to-leverage-medicaid

[24] "Healthy People 2030: Access to Foods That Support Healthy Dietary Patterns," U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-foods-support-healthy-dietary-patterns#:~:text=Consistent%20evidence%20demonstrates%20that%20a,children%20and%20adolescents%20as%20well; Erickson N, Sullivan ES, Kalliostra M, Laviano A, Wesseling J. "Nutrition care is an integral part of patient-centred medical care: a European consensus," *Med Oncol*. 40(4):112 (2023). doi: 10.1007/s12032-023-01955-5. Volpp, K.G. et al, "Food Is Medicine: A Presidential Advisory From the American Heart Association," *Circulation*, 148(18) (2023), https://www.ahajournals.org/doi/10.1161/CIR.0000000000001182.

[25] US Department of Agriculture, US Department of Health and Human Services. *Dietary Guidelines for Americans, 2020–2025*. 9th ed. 2020. Accessed May 1, 2023. https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf; Cheng J, Malone A, Thorndike AN. Importance of nutrition security to CVD prevention efforts in the USA. *Curr Atheroscler Rep*. 2023;25:219–230. doi: 10.1007/s11883-023-01097-z; Jayedi A, Soltani S, Abdolshahi A, Shab-Bidar S. Healthy and unhealthy dietary patterns and the risk of chronic disease: an umbrella review of meta-analyses of prospective cohort studies. *Br J Nutr*. 2020;124:1133–1144. doi: 10.1017/S0007114520002330.

[26] http://whitehouse.gov/wp-content/uploads/2025/05/MAHA-Report-The-White-House.pdf

[27] Emma Kikuchi, Isabelle Pula, Alec Tyson and Eileen Yam, "Americans on Healthy Food and Eating," Pew Research Center, May 7, 2025, https://www.pewresearch.org/science/2025/05/07/americans-on-healthy-food-and-eating/.

[28] "Food Is Medicine: A Project to Unify and Advance Collective Action," U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, 2025, https://odphp.health.gov/our-work/nutrition-physical-activity/food-medicine.

[29] "MaineCare 1115 Demonstration Whole Person Care Waiver Application," at page 33.

[30] "Significant Cost Savings Realized as Healthy Opportunities Pilots Reach Two-Year Anniversary," North Carolina Department of Health and Human Services, May 21, 2024, https://www.ncdhhs.gov/blog/2024/05/21/significant-cost-savings-realized-healthy-opportunities-pilots-reach-two-year-anniversary.

[31] Hager, K., et al., "Medicaid Nutrition Supports Associated With Reductions In Hospitalizations And ED Visits In Massachusetts, 2020–23," *Health Affairs*, 44(4):413–421 (2025), doi: 10.1377/hlthaff.2024.01409, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2024.01409

[32] Ibid.

[33] "Maine's Housing Outlook" Maine Housing Authority, n.d., https://www.mainehousing.org/docs/default-source/policy-research/research-reports/outlook-reports/2025-housing-outlook-report.pdf

[34] "2024 Point in Time Count: People Experiencing Homelessness in Maine," Maine State Housing Authority, 2024, https://mainehousing.org/docs/default-source/policy-research/research-reports/homeless-reports/2024-point-in-time-report.pdf?sfvrsn=85d69e15_3.

[35] Taylor, L.A., "Housing And Health: An Overview Of The Literature," *Health Affairs,* June 7, 2018, https://www.healthaffairs.org/content/briefs/housing-and-health-overview-literature.

[36] "Social Determinants of Health Series: Housing and the Role of Hospitals," n.d., https://www.aha.org/ahahret-guides/2017-08-22-social-determinants-health-series-housing-and-role-hospitals#:~:text=How%20is%20housing%20instability%20related,instability%20and%20influence%20health%20outcomes.

[37] Silver CM, Thomas AC, Reddy S, et al. Morbidity and Length of Stay After Injury Among People Experiencing Homelessness in North America. JAMA Netw Open. 2024;7(2):e240795. doi:10.1001/jamanetworkopen.2024.0795https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2815559#:~:text=The%20matched%20cohort%20comprised%208665,use%20among%20people%20experiencing%20homelessness.

[38] Wright, P. https://www.mainepublic.org/health/2025-02-26/maine-and-us-hospital-bed-capacity-climbing-towards-shortage-study-finds
[39] "Medical Respite Care," National Health Care for the Homeless Council, n.d., https://nhchc.org/clinical-practice/medical-respite-care/.
[40] "Medical Respite Care," National Health Care for the Homeless Council, n.d., https://nhchc.org/clinical-practice/medical-respite-care/.
[41] Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State | KFF
[42] Basu A, Kee R, Buchanan D, Sadowski LS. Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. Health Serv Res. 2012 Feb;47(1 Pt 2):523-43. doi: 10.1111/j.1475-6773.2011.01350.x; "Healing After the Hospital: Medical Respite Care," National Council of State Legislatures, July 18, 2022, https://www.ncsl.org/health/healing-after-the-hospital-medical-respite-care#:~:text=People%20who%20spend%20time%20in,local%20government%E2%80%94are%20outlined%20below.
[43] Basu A, Kee R, Buchanan D, Sadowski LS. Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. Health Serv Res. 2012 Feb;47(1 Pt 2):523-43. doi: 10.1111/j.1475-6773.2011.01350.x.
[44] "Using Health-Related Services to Address Housing Needs, A Guide for Oregon CCOs," Oregon Health Authority, n.d., https://www.oregon.gov/oha/HPA/HP-MAC/Documents/HRSguide_housing_final_draft.pdf.
[45] "Easing the Transition from Hospital Care: Community Partnership Helps Patients with Unstable Housing," MaineHealth, n.d., https://innovation.mainehealth.org/2023/08/18/patients-with-unstable-housing/.
[46] "Easing the Transition from Hospital Care: Community Partnership Helps Patients with Unstable Housing," MaineHealth, n.d., https://innovation.mainehealth.org/2023/08/18/patients-with-unstable-housing/.