# CoCs & Medicaid Survey REPORT

*Findings, analysis, and implications for Medicaid programs centered on people experiencing homelessness.*

*JULY 2024*

Built for Zero Public Health Team
Upstream Strategies

COMMUNITY SOLUTIONS

# EXECUTIVE SUMMARY

## Overview

The 2023 Annual Homelessness Assessment Report (AHAR) found that on a single night in January 2023, approximately **653,100 Americans were experiencing homelessness** across the United States.[1] Homelessness affects both physical and mental health and makes accessing health care difficult. As the National Health Care for the Homeless Council asserts, being unhoused "creates new health problems and exacerbates existing ones."[2]

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. In the last decade, Medicaid has been championed as a strong resource and lever for individuals at risk of or experiencing homelessness and as coverage options expanded under the Affordable Care Act of 2010. In the fourteen years since, an increasing number of states have explored health-related social needs and social determinants of health mechanisms that linked their most vulnerable citizens to critical services.

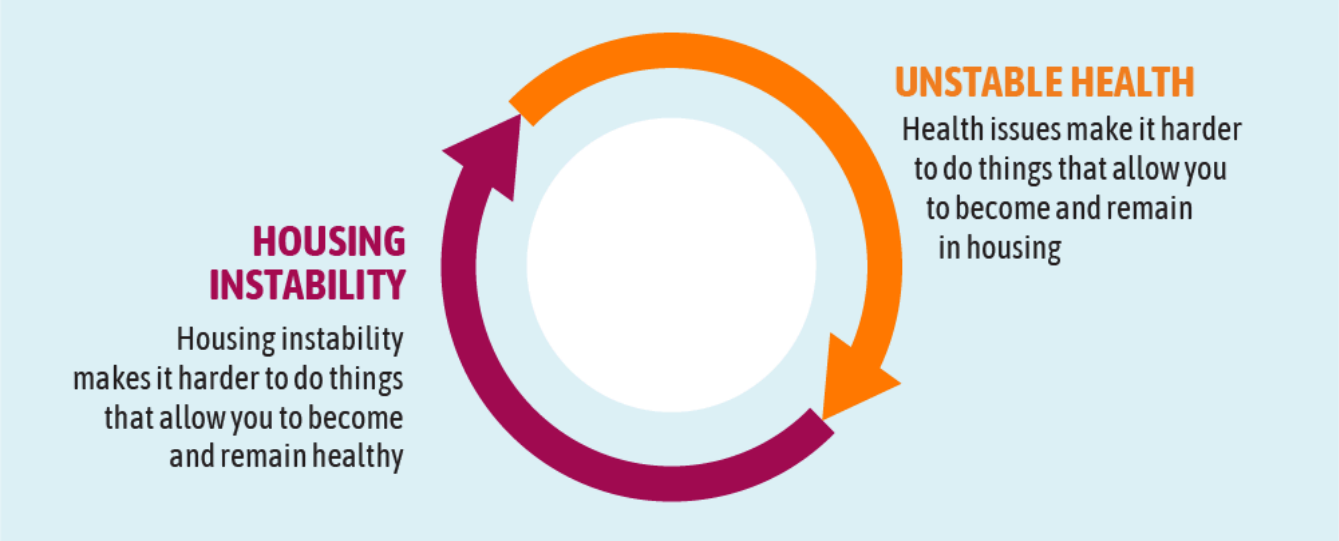



*Figure 1:* ***Relationship between housing and health***

[1] "The 2023 Annual Homelessness Assessment Report (AHAR) to Congress." December 2023. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.

[2] National Health Care for the Homeless Council. 2019. "Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council. https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf.

As each state varies in their population, demographics, and governance structure, these differences can be leveraged to meet the needs of people experiencing homelessness and expand the health care services available through the homeless response system. States have the flexibility to customize their programming and design service provision that meets their citizens' specific needs.

As Built for Zero listened to community members and their needs, there seemed to be a critical voice missing in the design and research around these innovative Medicaid and Housing programs: the Continuum of Care (CoC) staff. This survey was designed to explore a sample of CoC staff understanding, expertise, and challenges with Medicaid and its related programs. Most often, CoC staff and frontline workers have a deep understanding of the needs of their local population and the types of services most in-demand and impactful to these individuals.

## Survey Overview

- **66** complete responses and **16** partial responses
- **81%** completion rate overall
- Respondents represent **48 different CoCs** from **27 different states**, 22 of which have expanded Medicaid, and 5 which have not.
- **33% of respondents were at the Director level** in their CoC, while 39% were at the programmatic or project level. The remaining 28% were either Coordinated Entry, Data/HMIS, or Outreach Staff.

## Key Findings

- Most CoC respondents see Medicaid as a powerful program that can benefit their work in some form or another.
- Partnerships exist between Medicaid teams or Managed Care Organizations and CoCs. Some even include joint case conferencing or data integration.
- There's still a significant gap in perceived value and understanding when it comes to these Medicaid programs.
- Data integration is a common starting point, but it's complex, technical, and burdensome, so there needs to be a clear goal.
- Waivers that are connected to housing supports or unhoused populations aren't well understood or leveraged by CoCs.

## Key Recommendations

- Expanded education and training for CoCs on Medicaid and Managed Care Organizations (MCOs)
- Exploration of models for MCOs and Medicaid to join case conferencing led by CoCs, either with or without data integration supports.
- Inclusion of CoC Leadership at Medicaid roundtables, waiver design working groups, and other cross-sector discussions.
- Increased dissemination of evidence and evaluations from existing waivers, pilot programs, and tests for shared learnings.

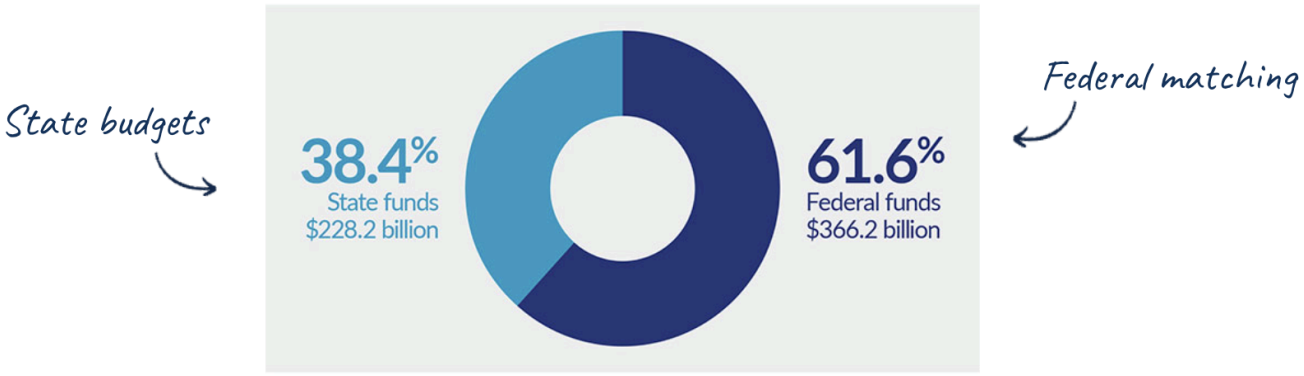
# A.

# Background & Methodology

# BACKGROUND

## Medicaid can support the homeless response system to help drive reductions in homelessness and meet health-related social needs .

Medicaid provides health coverage to millions of Americans, including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Funding is braided, with a mix of state and federal funds that varies from state to state. In the last decade, Medicaid has been championed as a strong resource and lever for individuals at risk of or experiencing homelessness and as coverage options expanded under the Affordable Care Act of 2010. In the fourteen years since, an increasing number of states have explored health-related social needs and social determinants of health mechanisms that linked their most vulnerable citizens to critical services.




Source: Pew analysis of data from the Centers for Medicare & Medicaid Services and the National Association of State Budget Officers



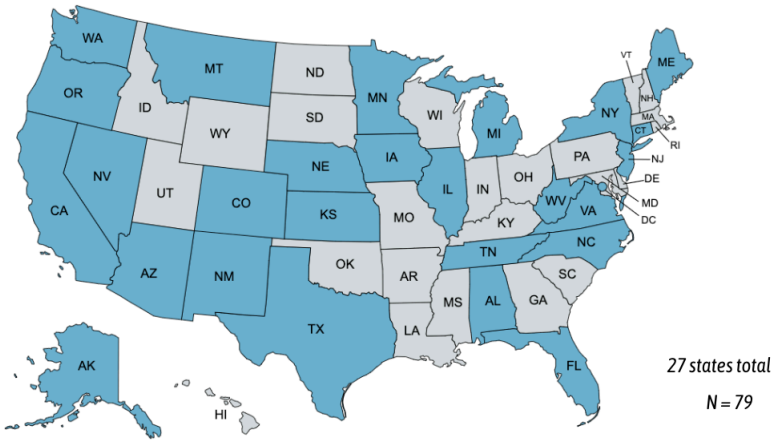
Most recently, states have taken drastic measures to link Medicaid and housing through pilot demonstration projects aimed at improving outcomes for all related systems and patients. California launched CalAim with a trove of resources and funding mechanisms to support and encourage Managed Care Plans and Medicaid providers to focus on unhoused individuals in their communities. States such as Oregon and Arizona have passed waivers (which extend eligibility and test supportive or wraparound services) that will explore how short-term rental assistance funds could prevent and end homelessness in their communities.

As Built for Zero listened to community members and their needs, there seemed to be a critical voice missing in the design and research around these innovative Medicaid and Housing programs: the Continuum of Care (CoC) staff. This survey was designed to explore a sample of CoC staff's understanding, expertise, and challenges with Medicaid and the related programs. Most often, CoC staff and frontline workers have a deep understanding of the needs of their local population and the types of services most in-demand and impactful to these individuals.

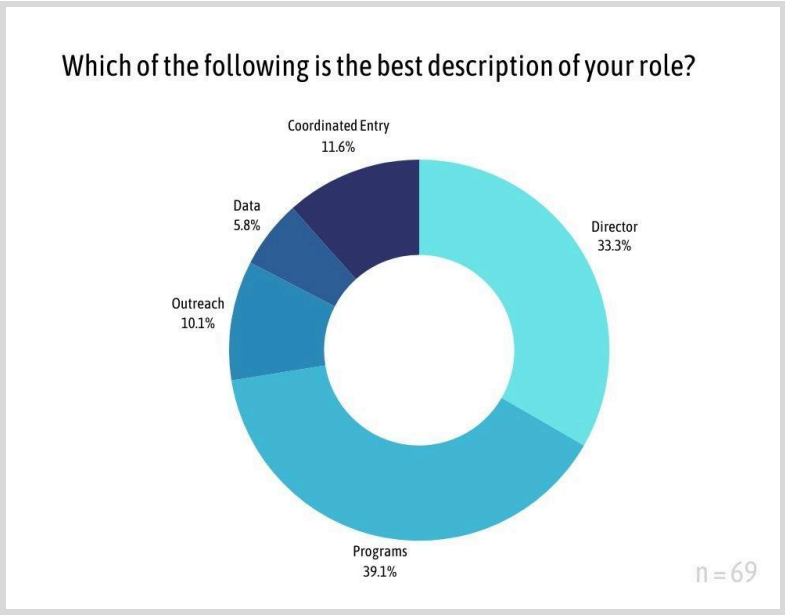
# METHODOLOGY

## Response Characteristics

- The survey was first distributed to the Built for Zero communities on **December 1 and remained open until December 21.**
- Overall, there were **66** complete responses and **16** partial responses to the survey, which is an 81% completion rate. As some questions included skip logic or were for specific states only, the sample size for key data is included below.
- These 82 total responses represent 48 different CoCs from 27 different states, 22 of which have expanded Medicaid and 5 which have not.




- 33% of respondents were at the Director level in their CoC, while 39% were at the programmatic or project level. The remaining 28% were either Coordinated Entry, Data, or Outreach Staff



# B.

# TRENDS & OBSERVATIONS

# FINDINGS

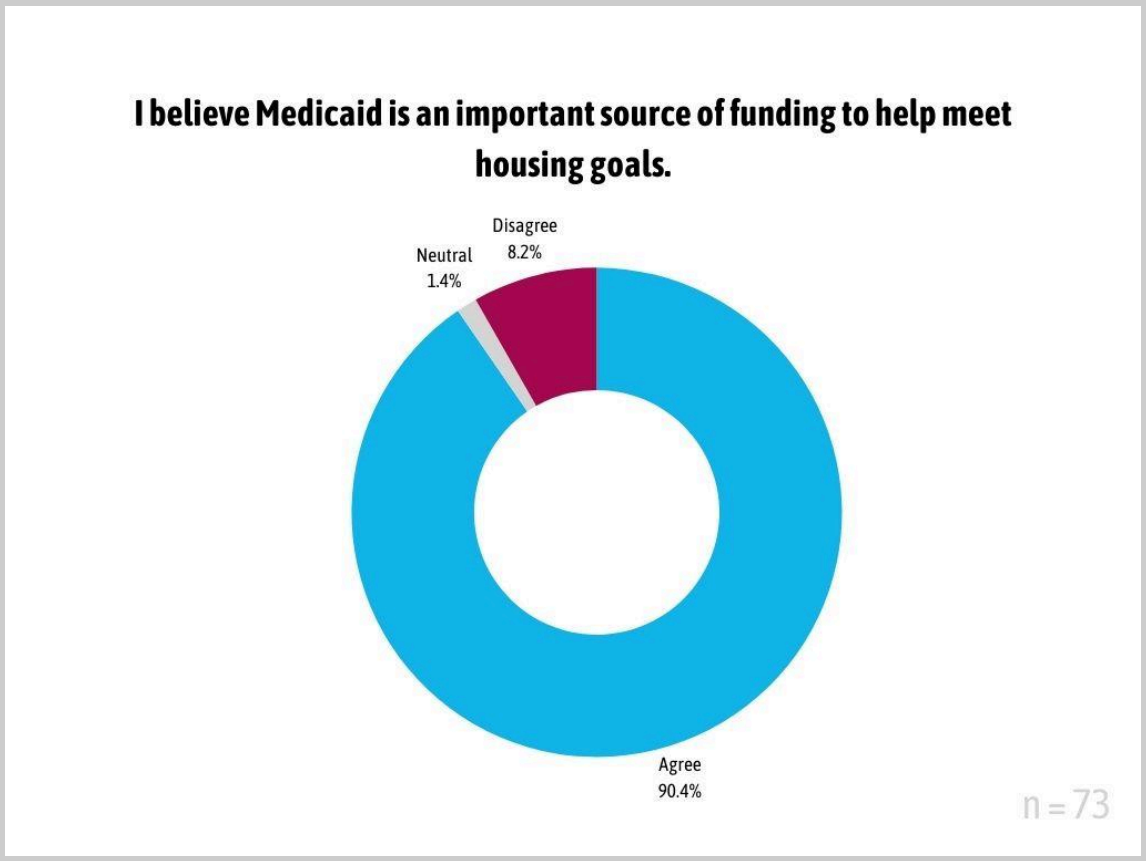
## *THE POWER OF MEDICAID & HOUSING SUPPORTS*

The transformative power of Medicaid has slowly grown from a whisper to a roar in homeless response system discussions and strategic planning sessions, and many CoCs are connected to pilot programs in their backyards. This supposed power comes from a simple arithmetic: the federal government annually spends roughly $7 billion on homelessness supports compared to more than $700 billion annually through Medicaid. Many advocates within the homeless response system have championed the belief that access to Medicaid dollars can transform organizational capacity and unlock myriad housing options that are currently out of reach.

Critics of Medicaid's expanded role into housing and health-related social needs cite a misalignment of programming meant to serve as emergency health insurance or a safety net program. Regardless, each state has their own unique policies, waivers, and programs pertaining to Medicaid access and funding, and thus, it's not as simple as applying for a NOFO or submitting a grant application. This complexity, coupled with the variability between states, increases the burden each community faces to learn and understand local policies.

### Finding 1: **Most CoC respondents see Medicaid as a powerful program that can benefit their work in some form or another.**

In general, respondents seemed aligned on the understanding that Medicaid is a powerful mechanism that, when wielded strategically, can have massive benefits on vulnerable populations. In fact, when asked if they believe Medicaid programs and CoCs have shared housing objectives that can be achieved through Medicaid, **73% of respondents agreed.** Further, an overwhelming majority (90.4%) agreed that they saw Medicaid as an important source of funding to help meet housing goals.



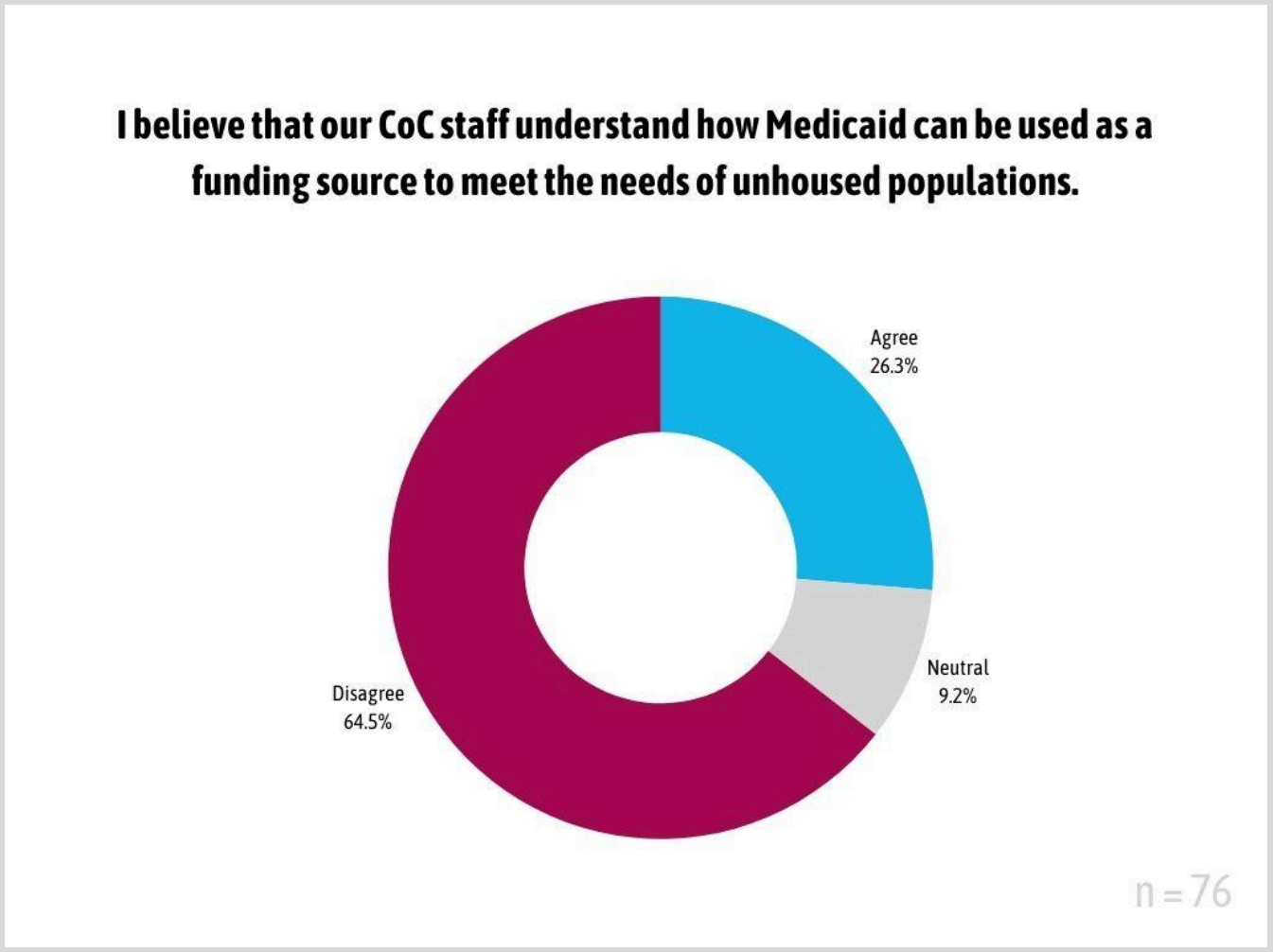

Within free text responses, respondents drove this point home even further:

> *"These partnerships provide a huge impact on ensuring individuals are housed or have access to services if they are experiencing homelessness."*
>
> *"There is so much opportunity for partnership. Our MCO is amazing and is willing to collaborate with us as they roll out the new 1115 Medicaid Waiver, which includes new benefits for those experiencing or at risk of homelessness."*

Lastly, respondents seem to have a belief in the eventuality and sustainability of this power, as 72% agreed with the statement *"I believe Medicaid will continue to support housing services for many years to come."*

## Finding 2: **There's still a significant gap in perceived value and understanding when it comes to these Medicaid programs.**

*Although there is a belief in Medicaid's power and impact throughout a state's most vulnerable populations, respondents consistently cited a lack of understanding, training, and knowledge directly related to their local work. When asked if they believed that their CoC staff understood how Medicaid can be used as a funding source to meet the needs of unhoused populations, 64.5% disagreed.*



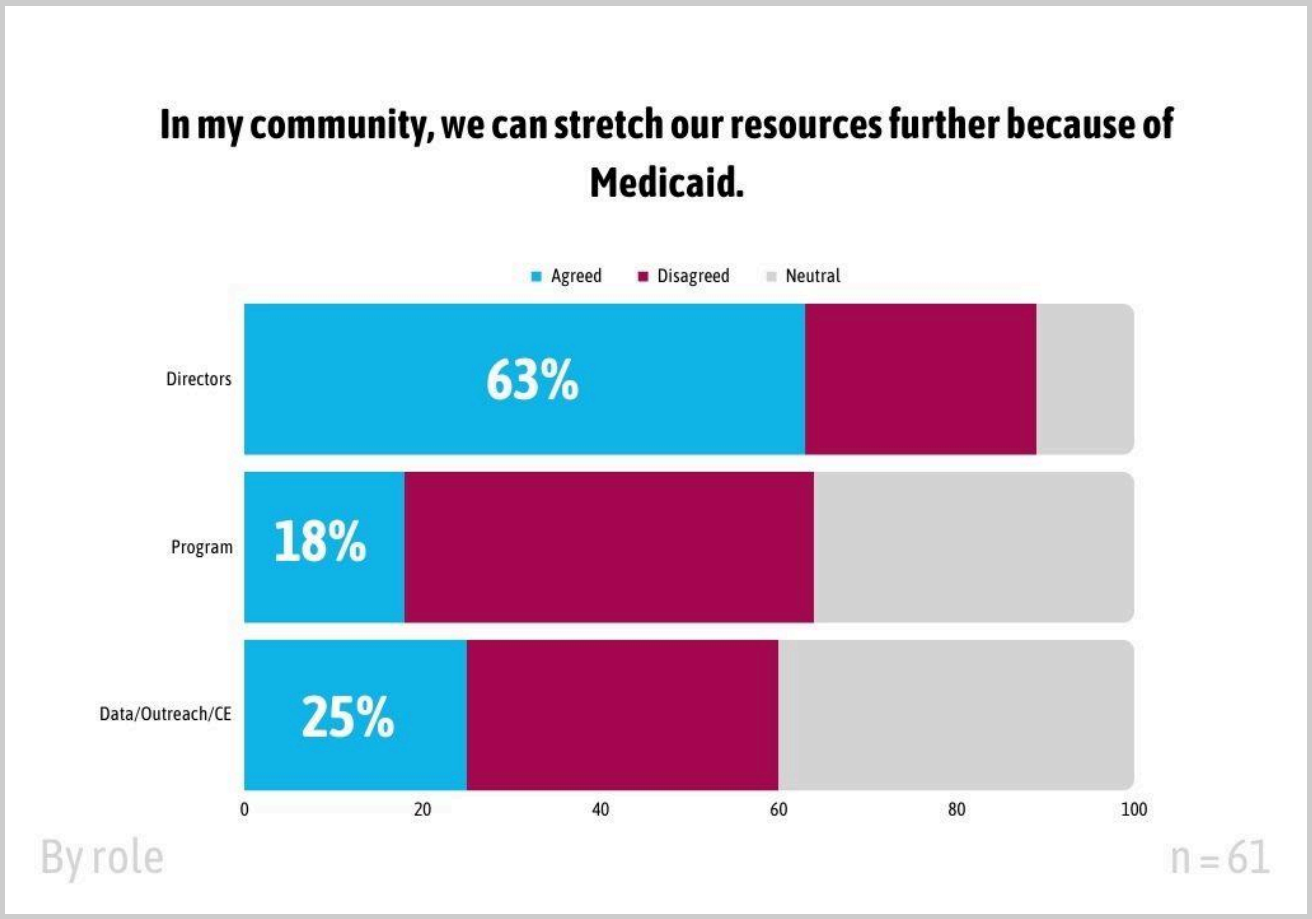

When asked if more people have access to housing and housing-related services in their community because of Medicaid, only 26% agreed.

Respondents cited specific challenges and gaps in their responses as well:

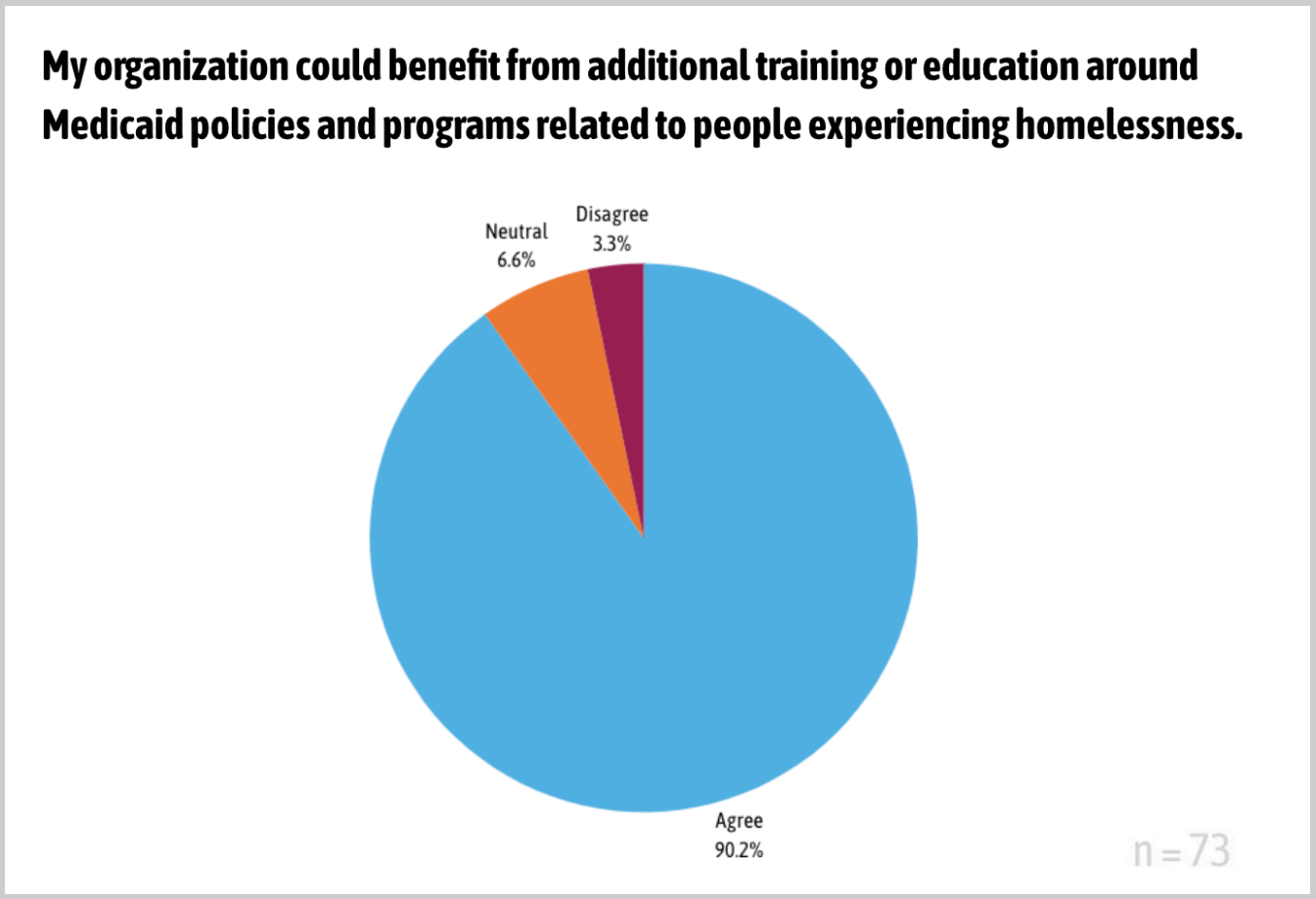
*"Our state Medicaid has a lot of challenges in regards to low reimbursement rates, lack of staff capacity/turnover, and lack of provider network, which limits the ability to benefit everyone in our community relying on Medicaid as a payer source."*

*"We very much could leverage Medicaid to increase housing in ways that are not currently happening with staffing, collaboration, funding, information sharing, and initiatives."*

Part of the challenge in keeping up with the complex and ever-changing nature of Medicaid services in a state is getting that message across to all levels of an organization. Throughout the survey, we looked at how responses varied between Director-level and frontline staff and found that the belief that Medicaid allows the CoC to stretch resources further was a major point of division. 63% of Directors agreed, compared to only 18% of program staff and 25% of data or outreach staff.



Generally, these cited challenges or gaps with Medicaid weren't seen as a fault of Medicaid's structure or impact, but more so as a gap in knowledge and training. 90% of respondents agreed that their organization could benefit from additional training or education around these policies as they related to people experiencing homelessness. Further, when asked where they would turn to learn more about Medicaid policies for their community, 40% suggested they'd turn to Google, while 48% said they'd turn to their local Medicaid office and 32% their state health department.



# CROSS-SECTOR COLLABORATION AND PARTNERSHIPS

The homeless response system has seen a gradual broadening of its definition, scope, and makeup over the last decade. Work that once sat squarely in the CoC's domain has expanded in complexity and urgency, which required cross-sector partners to participate and play a role in the homeless response system. Built for Zero has seen pockets of bright spots in these collaborations throughout the country, and as more and more surface, there is more evidence to support a framework or template for collaboration where it has yet to grow.

## Finding 3: **Partnerships exist between Medicaid teams or Managed Care Organizations and CoCs. Some even include joint case conferencing or data integration.**

**50% of respondents currently partner with Medicaid or Managed Care Organizations (MCOs) in their state.** Digging deeper into those with existing partnerships, the majority (61%) saw involvement from their MCOs or ASOs, while the state Medicaid office (32%) and local Medicaid office (23%) were also mentioned as partners in this work.

In exploring the nature of these partnerships…

- 39% said their CoC is providing data or information directly to CMS or MCOs.
- 39% said that MCO case managers are actively collaborating in direct care.
- 25% said that Medicaid or an MCO is providing funding to the CoC.
- 14% said they are actively co-designing programming or funding opportunities in these partnerships.
- 4% said they are co-designing policies.

The lack of co-design opportunities within these partnerships reflected a common structure that often restricted input from CoCs. In fact, 31% of respondents said that the CoC's suggestions and recommendations are taken seriously by these partners, while 24% said they felt this occurred sometimes.

**The 50% of respondents who do not currently partner with Medicaid or MCOs in their states cited that this work as inactive (such as work that started during COVID, work that is just beginning, or work done informally on a case-by-case basis).**

> *"We have a big infrastructure gap that can't be funded by Medicaid dollars or built and staffed overnight. MCOs and hospitals are focused on reduced costs and spending but are just barely informed about the homeless response system and its constraints. They don't understand why case managers can't get people into more permanent housing."*

Of the respondents that did not have a strong current partnership with Medicaid or MCOs *(n = 32)*, 57% stated that one barrier that's prevented this partnership from taking place is the lack of a relationship with anybody in the Medicaid space.

The CoC's primary job is still connecting people to housing, though, and it's unsurprising that 48% of respondents responded that their efforts were instead more focused on other priorities that provided services and housing.

Incentives and funding sources play a critical role in all work of the CoC. We found that 29% of respondents stated that the lack of an incentive or funding to encourage such partnerships is one reason such collaborations haven't materialized in their community.

> *"The partnership between our MCO and CoC is important based on population demographics and the number of individuals that utilize Medicaid and its services. This provides a huge impact on ensuring individuals are housed or have access to services if they are experiencing homelessness."*

Lastly, 71% of respondents indicated that they would see value in having their local MCO or Medicaid provider(s) join the CoC's case conferencing meeting on occasion. 12% of respondents already have their MCO or Medicaid providers at these meetings, which is a promising start for cross-sector collaboration.

# DATA INTEGRATION & SHARING

Data plays a key role in public health, health care, and homeless response strategy and efforts. Each sector has their own unique data structures, fields, and procedures that ensure data quality and security for their clients. As these sectors begin to explore collaborations, data often becomes an important diagnostic tool to identify key shared sub-populations and challenges that stretch across multiple systems. HMIS, the Homeless Management Information System, much like Electronic Health Records, is reliant upon a technology vendor for a technology solution that is HUD-compliant and suitable for use locally. This creates an increased level of complexity for data sharing or integration across sectors, as there is not a "one-size-fits-all" approach.

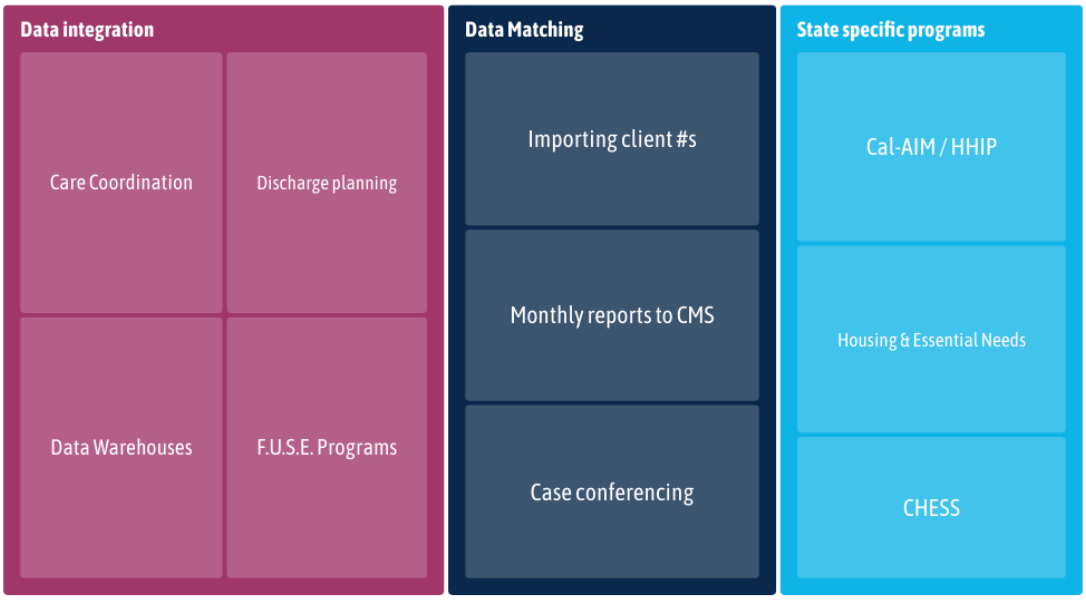
As medical complexity continues to rise for unhoused populations, calls for data sharing (data moving bi-directionally between systems) or data integration (data matches or one-way data movement) will continue to surface, especially if Medicaid waivers continue to cover health-related social needs or housing supports.

## Finding 4: **Data integration is a common starting point, but it's complex, technical, and burdensome, so there needs to be a clear goal.**

Data-driven projects do exist in many communities and they often range from one-time data matches to ongoing monitoring and reporting for state-specific programs. The inclusion of examples such as care coordination and discharge planning reinforces the role of the homeless response system within the spectrum of care and highlights the usefulness of comprehensive case management across complex systems.

**In fact, 36% of respondents had explored data sharing projects that connected their HMIS data with Medicaid or MCO data.** When asked for examples, results varied but included multiple projects like care coordination, monthly reporting, and state-specific Medicaid program requirements.

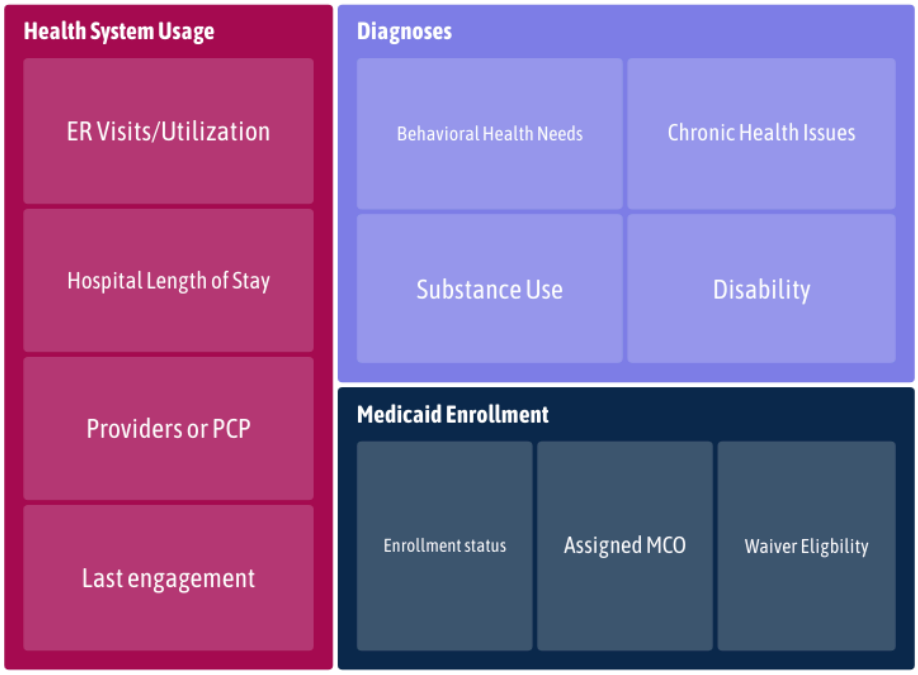
# Examples of existing data sharing projects included:



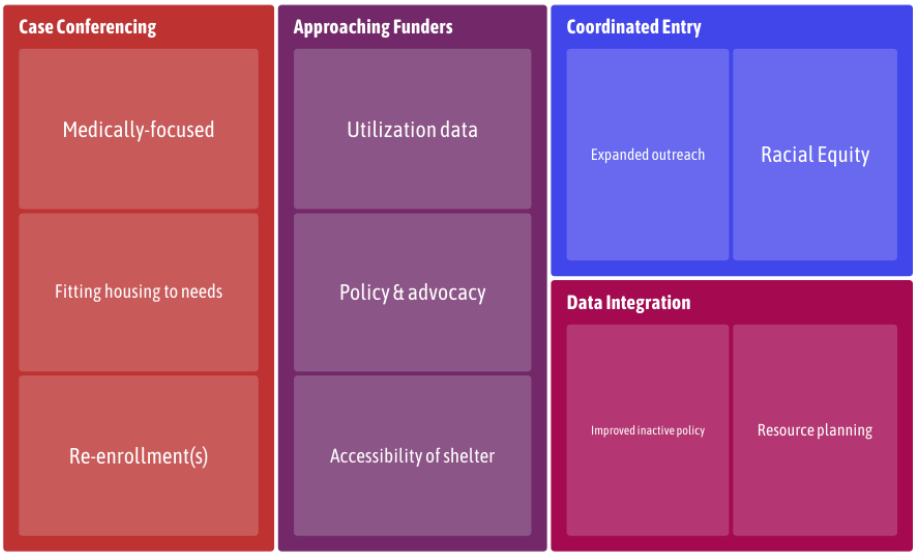

A common entry point for Medicaid and HMIS data integration or sharing starts with enrollment data. Sometimes that includes what MCO a client is enrolled with, sometimes if they are enrolled in Medicaid at all. We found that **57% of respondents already had this field in their system.** Of the 43% that do not currently have this field, 76% thought adding it would be insightful or useful.

Although this data field was in demand when we dug deeper with those respondents that **already have** this field in their HMIS, 60% marked that they **did not find this field useful.**

In general, respondents identified many types of data they'd like to receive from MCOs or Medicaid providers to better inform the CoC's work. These included:




Respondents also provided a glimpse into how this data would be useful to their work, with numerous communities highlighting case conferencing possibilities, funding efforts, and improved data integration.



# MEDICAID WAIVERS

## Finding 5: **Waivers that are connected to housing supports or unhoused populations aren't well understood or leveraged by CoCs.**

**Context**

Under the Social Security Act, states hold the ability to apply for special circumstances, where a state can waive certain Medicaid program requirements in order to cover certain populations or services that Medicaid would not otherwise cover. There are different types of waivers that grant different flexibilities; the different waivers are often referred to by numbers or number-letter combinations and although a great variety of waivers exist across the United States, the primary type linked to housing and homelessness are 1115 or 1915(a) waivers.

These waivers are reviewed by CMS, and if granted, typically run for a five-year demonstration period. WIthin that period and the waiver, there are limitations on how funds are allocated, particularly on what can be spent on policy infrastructure as compared to direct care funds for members.

**Findings**

Although waivers are touted as a powerful mechanism that unlocks resources for individuals experiencing and at risk of homelessness, there was confusion among many respondents as to where their state stood. 34% of respondents were unsure if their state had a waiver that supported people experiencing homelessness or provided supportive housing. The other 66% marked that their state either did or did not have a waiver, but in diving deeper, **42% of the respondents** *(n = 19)* **that marked that their state did NOT have a waiver actually came from states that DO have a waiver.**

Generally, there was a lack of confidence and exposure to these mechanisms. Only 51% of those respondents that came from states with related waivers confidently and correctly marked that they were aware of such waivers.

However, when waivers were active and known with CoCs, there was promising indications that these programs can support CoC strategy and goals. Of those with waivers, 46% currently leveraged this waiver to connect individuals to housing or related services. However, 46% did not. Importantly, 44% of respondents felt that their state's waiver has resulted in growth of new services in communities (such as recuperative care, housing navigation, affordable housing, case management, etc).

Much of this was also state-specific, particularly where innovations with Medicaid and relevant waivers have been touted as big bets. These include CalAim Programming in California, CHESS services and housing supports in Connecticut, and rental assistance pilots in Arizona and Washington. Coupled with the below question around where individuals learn about Medicaid policies and programs, these findings likely indicate that the issue at hand is not the power or

structure of waivers within states, but the inclusion and education of frontline staff, CoC leadership, and key community organizations on how to utilize these offerings.

# C.

# RECOMMENDATIONS

# RECOMMENDATIONS

## Expanded education and training for CoCs on Medicaid & MCOs.

Throughout the survey responses, it was clear that there is great demand for education and training specific to how CoCs can partner, participate, and support programmatic efforts of Medicaid partners and MCOs. The complexity of this work (and related waivers and policy changes) creates a steep learning curve. With a large chunk of respondents turning initially to Google for more information, it's critical to create frameworks and webinars that unlock these tools for CoCs and create space where all levels of their organizations can learn and thrive.

## Exploration of models for MCOs and Medicaid to join case conferencing led by CoCs, either with or without data integration supports.

As stated above, 71% of respondents saw value in having these organizations join case conferencing, with or without data integration efforts. It's imperative that we look at the 12% of respondents that already have this structure in place and find replicable models for these partners to come to the table. A great example of this is in Washington County, Oregon, where HealthShare is an active participant at the CoC's medical case conferencing discussions. These partners must come together to build relationships, see each other's work in action, and have an open dialogue about their systems and their limitations. MCOs will walk away with a deeper understanding of the implications of limited affordable housing stock and CoCs will gain a rich understanding of where MCO resources can stretch and where they falter.

## Inclusion of CoC Leadership at Medicaid roundtables, waiver-design working groups, and other cross-sector discussions.

CoC leadership plays a critical role in shaping their organization's policy and programming for a calendar year and often has the final say in how resources are allocated and dispersed. If these leaders aren't invited and encouraged to participate in discussions and working groups related to these programs, the CoC will be unlikely to have the capacity to actively participate and be prepared for adjustments to their work. Lastly, CoCs are operating with significant capacity and resource challenges, including frontline worker burnout and fatigue, but they also represent a clear avenue for decision makers to explore conversations with individuals with lived experience of homelessness and ways to raise up the voices of those currently unhoused. These end-user inputs are invaluable to any design process, and the CoC is the driving force to make them happen.

## Increased dissemination of evidence and evaluations from existing waivers, pilot programs, and tests for shared learnings.

With so many tests and pilots happening in different communities, it's crucial that each instance is rigorously evaluated and documented to allow for scalability across their state and eventually across the country. Organizations that support these efforts should come together frequently to discuss their early learnings, structure of work, and key barriers. There's no active space for national or even state dialogue around these learnings, but it would be powerful for states to document, create, and explore such conversations.

# ACKNOWLEDGEMENTS

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Centers for Disease Control & Prevention (CDC)
HC2 Strategies

# APPENDIX

## *Shared Definitions*

### *Please refer to these definitions throughout the survey.*

**Continuum of Care (CoC)** - A regional or local planning body that coordinates housing and services funding for homeless families and individuals.

**Medicaid** - Medicaid (administered through CMS) is a medical assistance program that serves children, adults, and families. Medicaid will pay medical bills for people who meet certain eligibility requirements such as income, age, or disability. Covered services include hospitalizations, physician services, medications, and different levels of care in nursing and residential facilities.

**Managed Care Organizations (MCO) -** An MCO is a health insurance company or organization. MCOs:

- offer health insurance to enrolled members,
- maintain a network of doctors, hospitals, and other providers where the insured member can access services, and
- pay providers on behalf of the insured member for covered services.

MCOs can be for-profit, nonprofit, or public/governmental agencies, and are typically regulated by state agencies that oversee insurance companies. *Other names for MCOs include Managed Care Plans (MCPs), health plans.*

**Waiver (typically referred to as a 1115 or 1915 waiver):** Under a Medicaid waiver, a state can waive certain Medicaid program requirements, therefore covering populations or services that Medicaid would not otherwise cover. There are different types of waivers that grant different flexibilities; the different waivers are often referred to by numbers or number-letter combinations, such as 1115, or 1915(b), which refer to the section of the Social Security Act authorizing the flexibility.

**Centers for Medicare & Medicaid Services (CMS):** The federal agency that sets the rules and regulations that state Medicaid programs must abide by, and that approves funding according to those rules. CMS is also the agency with authority to approve waivers. At the state level, programs are usually interacting with the state Medicaid agency, and that state agency is usually the entity that interacts with CMS.

# Survey Questionnaire

1. **Please select the community organization you primarily represent.**
2. **What is your title within your organization? _____**
3. **What is the name of the organization that you represent? _____**
4. **What is your name? _____**
5. **What is your email address? _____**

## *Attitudes & Knowledge*

6. **I fully understand how Managed Care Organizations are connected to Medicaid in my state.**
   - ☐ (Agree)
   - ☐ (Disagree)
   - ☐ (Other) _____

7. **Medicaid is an important source of funds to help meet housing goals.**
   - ☐ (Agree)
   - ☐ (Disagree)
   - ☐ (Other) _____

8. **I believe Medicaid will continue to support housing services for many years.**
   - ☐ (Agree)
   - ☐ (Disagree)
   - ☐ (Other) _____

9. **Medicaid programs and CoCs have shared housing objectives to achieve through Medicaid.**
   - ☐ (Agree)
   - ☐ (Disagree)
   - ☐ (Other) _____

## *Data*

10. **Does your HMIS system currently have a field that tracks a client's Medicaid enrollment status?**
    - ☐ (Yes)
    - ☐ (No)
    - ☐ (Maybe) _____

11. **(If no) Would a field in your HMIS system that tracks a client's Medicaid enrollment status be useful or informative to your work?**
    - ☐ (Yes)
    - ☐ (No)
    - ☐ (Maybe) _____

12. **(If yes) Has the field in your HMIS system that tracks a client's Medicaid enrollment status been useful or informative to your work?**
    - ☐ (Yes)
    - ☐ (No)
    - ☐ (Maybe) _____

13. **Have you explored data sharing projects that would connect HMIS data with Medicaid or MCO data?**
    - ☐ (Yes)
    - ☐ (No)
    - ☐ (Other) _____

14. **What data would you like to receive from MCOs or Medicaid providers about your shared clients?**
    - ☐ _____

15. **Would you see value in having your local MCO or Medicaid provider join your Built for Zero case conferencing (from time to time)?**
    - ☐ (Yes)
    - ☐ (No)
    - ☐ (We don't currently have BFZ Case Conferencing set up.)
    - ☐ (They are already present at these meetings.)
    - ☐ (Other) _____

## *Partnerships*

**16. Does your organization currently partner with Medicaid, Managed Care organizations, or other similar entities?**

- ☐ (Yes)
- ☐ (No)
- ☐ (Other) _____

**17. (If NO) What has prevented this partnership from taking shape?**

*Select All that Apply*

- ☐ We don't have a relationship with anybody in the Medicaid space.
- ☐ We are more focused on other priorities that provide services and housing.
- ☐ There's no incentive or funding to encourage this partnership.
- ☐ No particular reason.
- ☐ Other

**18. (If YES) Which of the following are involved in this partnership or program?**

*Select All that Apply*

- ☐ State Medicaid/CMS Office
- ☐ Local Medicaid/CMS Office
- ☐ Managed Care Organizations
- ☐ State Medicaid Contractors
- ☐ Other_____

**19. (If YES) Which of the following are true about your partnership?**

- ☐ Medicaid or a Managed Care Organization is providing funding/money to the CoC.
- ☐ Our CoC is providing information or data to CMS/MCOs.
- ☐ We are actively co-designing programming.
- ☐ We are actively co-designing policy.
- ☐ We are actively co-designing investments/funding opportunities.

**20. (If YES) Is this partnership built for the short-term, long-term, or both?**

- ☐ Short-term
- ☐ Long-term
- ☐ Both

21. **(If YES) Does it feel like the CoC's suggestions and recommendations are taken seriously by these partners?**
    - ☐ Yes
    - ☐ No
    - ☐ Somewhat

## *Waivers & Demonstrations*

**General Waivers**

22. **Does your community have an 1115 or 1915 waiver that enables and supports people experiencing or supportive housing?**
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

23. **(If Yes to above) Does your organization currently leverage this 1115 or 1915 waiver to connect individuals to housing or related services?**
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

24. **(If Yes to above) Please explain how your organization currently leverages this 1115 or 1915 waiver to connect individuals to housing or related services.**
    - ☐ Free text

## *CalAIM (CALIFORNIA ONLY)*

25. **Does your organization currently leverage the 1115 waiver to provide community supports?**
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

26. **Does your organization currently leverage the 1115 waiver to provide Enhanced Care Management?**
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

27. **Has the waiver resulted in new services in your community? If so, which ones?**
    - ☐ Yes
    - ☐ No
    - ☐ I don't know

28. **Which, if any of the following, have been results of new partnerships with your local MCOs? If so — in what ways?**
    - ☐ Data sharing
    - ☐ Collaborative planning
    - ☐ Funding for services
    - ☐ Engagement in CoC meetings
    - ☐ Other

## *Outcomes & Value*

29. **In my community, more people have access to housing and housing-related services because of Medicaid.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

30. **In my community, we can stretch our resources further because of Medicaid.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

31. **Medicaid's participation in the housing and homelessness space is adding value to individuals experiencing homelessness.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

32. **Medicaid and MCOs have adjusted their processes to fit our (CoC's) system and needs.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

33. **Medicaid and MCOs have encouraged us to adjust our processes to fit their system and needs.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

34. **My organization could benefit from additional training or education around Medicaid policies and programs related to people experiencing homelessness.**
    - ☐ Strongly Agree
    - ☐ Agree
    - ☐ Neutral
    - ☐ Disagree
    - ☐ Strongly Disagree

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35. **Thank you for taking the time to complete our survey! Would you be willing to be contacted by Built for Zero for a follow up conversation about your responses?**

- ☐ Yes, you may contact me.
- ☐ No, please do not contact me.