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Emerging Constraints on CalAIM-Funded Services in Permanent Supportive Housing

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Executive Summary

California's efforts to reduce chronic homelessness depend on permanent supportive housing (PSH) and the services that help residents find and keep housing. CalAIM made Medi-Cal a source of funding for those services, and early evidence shows that housing-related services improve housing stability and reduce avoidable health care use. But federal actions and state budgetary constraints are changing how that funding works in practice. Some managed care plans are cutting rates that have already fallen below the cost of delivery, requiring more documented contacts with residents before they will pay the full monthly rate, and denying authorizations on grounds that housing stability is evidence that support is no longer needed.

The State has also proposed capping authorization periods for these services at six months, though the California Department of Health Care Services (DHCS) acknowledges that stabilization typically takes longer. These changes are not occurring everywhere, and plans face real fiscal constraints, but they put the housing-health partnerships built under CalAIM at risk. This brief describes what is changing, highlights the implications of these shifts for PSH providers, and discusses what these developments mean for state policy.

Common Acronyms

BHSA: Behavioral Health Services Act

CalAIM: California Advancing and Innovating Medi-Cal

DHCS: California Department of Health Care Services

ECM: Enhanced Care Management

HTNS: Housing Transition Navigation Services

HTSS: Housing Tenancy and Sustaining Services

MCP: Managed Care Plan

PSH: Permanent Supportive Housing

Introduction

In 2022, California launched **CalAIM** (California Advancing and Innovating Medi-Cal) with an ambitious goal to make Medi-Cal more coordinated, equitable, and person-centered. A central part of that effort was better integrating health care and housing for people experiencing homelessness. Recognizing that homelessness incurs **significant costs** to the health care system, and that housing is an important social determinant of health, California allows Medi-Cal managed care plans (MCPs) to pay for housing-related interventions through a new category of services called Community Supports. These include helping people find a place to live, covering some of the costs of moving in, and providing the ongoing supportive services that help them stay housed, known collectively as the Housing Trio (see Box: *CalAIM in Brief*).[1]

CalAIM's initial five-year demonstration ends in December 2026, and the results so far are promising. A DHCS **evaluation** found that Medi-Cal members who

received at least one of these housing-related services had fewer emergency room visits and hospital admissions. Some supportive housing providers have also been able to **integrate Medi-Cal payments for services** into their properties, with positive outcomes for care coordination, services staff, and housing retention. The Housing Trio is also the only set of Community Supports offered by every plan in every county, **though uptake remains low relative to need**.[2]

While implementation barriers remain, CalAIM provides expanded funding for the services on which **permanent supportive housing (PSH)**—deeply affordable housing paired with voluntary on-site services for people exiting chronic homelessness—depends. California has invested heavily in building supportive housing through programs like Homekey and the Low-Income Housing Tax Credit (LIHTC), but service providers continue to face **chronic shortfalls** in the funding needed to deliver services and support residents over the long-term.

CalAIM's policy innovations are increasingly at risk, in large part due to federal actions and state budgetary

CalAIM in Brief

CalAIM is a five-year initiative that aims to provide cost-effective services to Medi-Cal members with the most complex needs, with the goal of improving health outcomes and reducing reliance on expensive medical care.

To achieve these goals, CalAIM authorizes Medi-Cal MCPs, the health plans the State pays to deliver Medi-Cal benefits and manage members' care, to offer their members a menu of Medi-Cal-funded services known as **Community Supports**. These include the "Housing Trio" of housing-related services: Housing Transition Navigation Services (HTNS), which help people find and secure housing; Housing Deposits, which cover one-time move-in costs such as first month's rent and a security deposit; and Housing Tenancy and Sustaining Services (HTSS), which provide ongoing support to help residents maintain their tenancy. Community Supports also include Recuperative Care, Short-Term Post-Hospitalization Housing, and nine other services. Community Supports are optional: MCPs choose which to offer, and members are not entitled to them. MCPs are separately required to offer Enhanced Care Management (ECM), which coordinates medical, behavioral, dental, and social services for members with complex needs.

The State pays MCPs a set amount each month for every member enrolled, and that payment is expected to cover all of a member's care, including Community Supports. MCPs then contract with housing and service providers to serve Medi-Cal-eligible individuals with high service needs who are homeless or at risk of homelessness. Those contracts set the payment rates, which are negotiated rather than based on what the services actually cost. MCPs authorize services for a set number of days or months, and providers must request reauthorization to keep being paid beyond that period.

constraints. At the federal level, **H.R. 1** cuts funding for Medicaid, and imposes work requirements and more frequent eligibility checks beginning in January 2027. The changes will make it harder for people to access Medicaid benefits, while sharply reducing the federal contribution to Medi-Cal.[3] Medi-Cal enrollment has already **fallen by 730,000** between June 2025 and March 2026. Together, researchers project **up to three million fewer Californians** will be enrolled in full-scope Medi-Cal by 2028. State budget cuts are compounding the federal ones, including a **$26.9 million reduction** to Community Supports and $41.4 million to ECM in 2026-27. The State proposes to achieve these savings in part by **limiting the initial authorization period** for housing tenancy sustaining services to six months—in addition to a **freeze on Medi-Cal enrollment** for undocumented adults beginning in January 2026.

These losses fall hardest on the people the Housing Trio was designed to serve. Most Medi-Cal enrollees experiencing homelessness or living in PSH are covered through the Affordable Care Act expansion population that H.R. 1's work requirements target, and the Centers for Medicare & Medicaid Services **(CMS) have stated** that homelessness itself is not grounds for an exemption. Many would qualify as **medically frail** through a disabling mental disorder, substance use disorder, or disability, but the burden of documenting it falls on the enrollee and their service provider.[4] MCPs, the health plans the State pays to deliver Medi-Cal benefits, are absorbing these pressures as well, and are looking for ways to reduce costs.

Amid these fiscal constraints, both the State and MCPs are evaluating and adjusting how they pay for housing-related Community Supports. There is evidence that investing in upstream housing interventions saves the health care system money over the long-term—for example, through fewer hospitalizations and emergency room visits[5]—but the MCPs still need to cover the short-term costs of care. Some plans are already **reporting losses** on these services.

In response to these pressures, some MCPs are changing their Community Supports policies, with significant implications for organizations providing supportive services in PSH. This brief describes those shifts and their potential impacts, drawing on interviews conducted between March and September 2026 with 21 housing and homelessness professionals and documentation of provider experiences produced by industry groups. We focus on PSH operations, in particular, because supportive housing depends on services being available continuously, over many years. However, these changes are also affecting interim housing and street outreach providers, which we take up in forthcoming work.

Not every MCP has changed its policies or is planning to, but these changes point to risks in the system and shed light on the need for the State to ensure that policy changes and funding cuts do not undermine recent successes in integrating housing and health care systems for people experiencing homelessness.

The Status of the CalAIM Waiver

CalAIM's **federal waivers**—time-limited federal approvals that let a state use Medicaid funds in ways the rules would not otherwise allow—expire in December 2026, but ECM and almost all Community Supports, including the Housing Trio, do not depend on them. The Housing Trio services are authorized instead as "in lieu of services" under federal managed care rules, which do not expire. Only the Community Supports that pay for Recuperative Care, Short-Term Post-Hospitalization Housing, and Transitional Rent require waiver authority and renewal.

Federal support for these services has nonetheless narrowed. In March 2025, the federal Centers for Medicare & Medicaid Services (CMS) **withdrew the guidance** encouraging states to use Medicaid for housing needs—part of a broader federal retreat from Housing First and from recognizing housing as a social determinant of health—raising concerns about the future of these services. In January 2026, CMS **demanded a program integrity plan** from California that named housing-related services as high risk. Providers report that this scrutiny is reaching them through more frequent audits and expanded documentation requirements.

Changes to CalAIM

Reduced payment rates

In response to concerns over costs, some MCPs are lowering their payment rates for housing navigation and tenancy sustaining services, which reduces how much funding PSH providers have to deliver supportive services. MCPs have latitude in setting their payment rates, and because the Housing Trio is optional, they may also choose to stop offering these services altogether. DHCS publishes **non-binding pricing guidance** with low, midpoint, and high benchmarks. Even before more recent cuts, many providers found that the payment guidance and rates were set at levels below the costs of delivering services. For example, a Corporation for Supportive Housing (CSH) survey in 2026 found that providers' costs exceeded their payments from CalAIM by roughly $224 per member per month for housing navigation and $210 per member per month for tenancy sustaining services.[6]

Some plans are now setting rates below that baseline. One MCP shifted its payment standards from the midpoint to the low end of the range: the housing navigation rate fell from $386 to $324 per member per month and the tenancy sustaining rate from $444 to $413.[7] While nominally small, these decreases add up at the property level, leaving providers short of what they need to staff services.

Changes in how services are paid for

In addition to cutting payment rates, some MCPs are changing how payments are structured. Providers have typically been paid a set amount per enrollee per month (PEPM), earned by documenting at least one service that month.[8] Interviewees shared that some MCPs are now requiring more encounters before the full rate is paid, and declining to pay for contact with residents beyond a set number.

This shift has the potential to give MCPs a clearer picture of what services are

delivered, how often, and to whom. When a single documented contact with a resident earns the full monthly rate, a provider is paid the same whether they see a member once or 20 times. One consultant who advises both plans and providers said that some plans felt they were "flying blind" about what they were paying for, since the rate drew no distinction between an intensive month of support and a single check-in call.[9] Tying payments to encounters can also help with cost containment, especially when the total billable number of encounters is capped. For example, one county is shifting to a model where providers delivering tenancy sustaining services will need to document three direct encounters per member per month to receive the full rate of approximately $620 per month; one encounter yields roughly a third of that amount, two encounters yield two-thirds, and contacts beyond the third are not compensated.[10]

Despite the oversight and cost savings advantages of tying payment to encounters, this approach may not adequately support the necessary work that occurs outside of the direct interactions between residents and providers. Providers are concerned that the shift "reflects a fundamental misunderstanding of what housing support services entail."[11] A significant share of providing supportive services happens behind the scenes: advocating with a landlord on behalf of a tenant in order to avoid a lease violation or eviction; calling to enroll someone in benefits; or making repeated attempts to contact either a resident, or a third-party service provider or agency involved in their care, who is difficult to reach. Residents may also go through a period of crisis or withdrawal, when they are less likely to respond to outreach attempts; if they cannot be reached, the provider is not paid, since the time spent on those failed attempts is not counted.[12]

The consequence of this can be significant for a services budget and have negative impacts on the member, who may fall back into homelessness without these services. One provider shared that the new encounter requirements would reduce their CalAIM revenue by roughly 40 percent under current service patterns—enough to make its CalAIM program unsustainable.[13] Another provider projected an annual loss of at least $360,000 under the new model.[14]

Narrow interpretation of eligibility and authorization

Federal and state eligibility shifts and efforts to reduce costs are also reshaping who receives these services. The State has not changed who qualifies, but MCPs are applying existing criteria more narrowly and authorizing services less readily, particularly at reauthorization. Plans make two separate decisions about each member: whether to authorize services at the outset, and whether to renew that authorization when it expires. **State guidance** makes members eligible for tenancy sustaining services if they are prioritized for PSH or a rental subsidy through the local Coordinated Entry System, among other pathways—what providers call "situational eligibility." Recently, one plan clarified that situational eligibility applies to initial authorizations only, not ongoing support.[15] Yet evidence suggests that residents need these services well beyond an initial authorization period, and services can be crucial for ensuring that residents remain in their new homes.[16]

Another plan's policy only authorizes tenancy sustaining services for one member per household, even if services are being delivered to two or more people in the household. A loss of 10 secondary household members would be approximately

$49,000 a year, assuming payment at the minimum DHCS pricing benchmark.[17]

Providers report that some MCPs are requiring medical diagnosis codes to authorize housing navigation and tenancy sustaining services. This creates an additional administrative burden since housing providers often do not have access to clinical data on their residents. Case managers must first secure HIPAA releases from residents and then request medical documentation from a medical provider or clinic. Staff at one organization had previously been able to describe a resident's conditions and needs in a written narrative. That provider described the shift in what their MCP required: "All of a sudden we start getting, 'You need to show proof, not just tell us what's going on with this person'…It feels violating to get all this information just to qualify for services."[18]

Providers also face a second documentation challenge. Continued authorization depends partly on showing that a resident has an ongoing need for supportive services to help avoid lease violations and landlord disputes, while also showing that the services were effective. The onus is on providers to document the tenant's behaviors, the provider's interventions, the tenant's responses, and the provider's follow-up plans. In other words, the documentation must show how the provider helped the tenant avoid lease violations and landlord disputes that would have occurred without supportive services. Documenting interventions and client responses in this way is standard practice among behavioral health care providers who bill Medi-Cal, but it is new to supportive housing providers in California, who are building that capacity from scratch.[19]

Some MCPs have also closed their networks to new Community Supports providers. One organization already contracted to provide housing-related Community Supports in a few counties spent more than two years seeking a contract in another county, and was turned down.[20]

Greater scrutiny over eligibility and a constantly shifting policy landscape have also increased administrative burden. Nearly every provider we interviewed raised this issue, describing staff time absorbed by documentation, appeals, and resubmissions rather than service delivery.[21] In one county, providers report that some staff spend up to 80 percent of their time reviewing and appealing rejection notices.[22] One provider shared that her program manager is now spending his time "just looking at claims, ticking off the boxes rather than supervising case managers."[23] At another organization, a plan denied reauthorizations for tenancy sustaining services without clear justification, noting that the housing support plan "did not sufficiently identify resolvable/actionable barriers," and that it did not demonstrate "transition planning toward self-sustainability," terms and standards the plan never defined.[24] The provider said that the plan justified the denials with an internal policy that the provider had never seen. As another provider put it, plans are "managing by denial."[25]

Mismatch between Health Care and Housing Models

Even before these changes, one of the barriers to using CalAIM in homelessness and housing programs was a mismatch between a medical model of health care delivery and the practice of providing supportive services. Medical documentation and assessments are designed for encounters with discrete diagnoses, procedures,

and durations, while ensuring long-term housing stability among people with complex physical and behavioral health needs is an individualized, relational, and ongoing process.

This mismatch has intensified. For example, one housing provider was denied payment for helping a single mother find childcare during working hours, on the grounds that it was unrelated to housing stability, even though the childcare was what allowed her to work, pay her share of the rent, and move toward the self-sufficiency the plan itself was asking her to demonstrate.[26] Another PSH provider shared that their plan denied authorization requests for tenancy sustaining services after they submitted documentation that the residents were living in PSH units. Essentially, coverage was denied on the grounds that members were no longer homeless—treating the stability from living in PSH as evidence that support was no longer needed.[27]

Providers also raised concerns over codifying how long it takes to stabilize someone in PSH. Adjusting to living independently is rarely linear, especially for people who have experienced chronic homelessness or who have behavioral health challenges.[28] Chronic homelessness is defined in part by having a disability, which is unlikely to change in six months. In July 2026, **DHCS proposed** standardizing authorizations for navigation and tenancy sustaining services at six months—even as the same document notes that members' tenancy support needs "can fluctuate over time due to changes in life circumstances, behavioral health acuity, or aging," and that "a minimum of 12 months of housing tenancy services is often needed to help Members achieve housing stability and shift health care utilization patterns."

Shortening authorizations may also undercut the health care savings these changes are meant to produce, because it cuts off support before people have achieved the stability that drives those savings. It also leaves providers without the stable funding needed to staff service programs and PSH properties over the long term.

The DHCS proposal would require MCPs to discontinue services once a member has "remained stably housed without incident" for an authorization period—demonstrated, for example, by no lease violations, no landlord or neighbor disputes, and the ability to meet lease obligations.[29] Providers argue that the absence of a tenancy crisis shows the services are working, not that they are no longer needed.

Providers might absorb any one of these changes by drawing on other funding, as many already do—braiding county, state, Continuum of Care, city, and philanthropic dollars to cover what Medi-Cal does not. But those sources are contracting at the same time. Some counties and cities have **reduced homeless assistance funding** on the assumption that providers can shift to CalAIM billing, and federal homelessness funding is moving **away from permanent housing**. Meanwhile **rising costs** for insurance, maintenance, staffing, and security are outpacing available subsidies, threatening the financial stability of California's PSH units.

Policy Implications

The CalAIM demonstration was designed to build a systems approach to addressing the complex health needs of California households, including people experiencing homelessness. Early **DHCS evidence** showed the promise of

housing-related Community Supports—including that members who received at least one of the Housing Trio services had fewer emergency room visits and hospital admissions—and **Terner Center case studies** showed that some housing providers were building the capacity to deliver these services to residents living in PSH.

Federal actions and state budgetary pressures are now compounding barriers that providers were already facing, threatening CalAIM's potential. Although these shifts are not occurring universally across MCPs, they do signal a potential risk for the State's efforts to better align housing and health care systems. The variation is also a concern in itself: access to these services now depends on which county a person lives in and which plan they are enrolled in. The combination of changes is having a significant impact on organizations that have invested in the **staffing, data systems, and billing infrastructure** needed to leverage CalAIM. Together, rate reductions, narrower interpretations of eligibility, and more denials will undermine their service models and resident outcomes. These changes are also making it harder for new providers to stand up CalAIM programs.

While many of these changes will lower costs, they are poorly aligned with the needs of people experiencing and exiting homelessness. Continuing to bolster the infrastructure will require building, rather than stepping back from, CalAIM's vision. DHCS gave MCPs considerable flexibility during the demonstration; it could now use its authority to set stronger standards.

Create clearer eligibility criteria that align with the often ongoing needs of people exiting homelessness. **DHCS acknowledges** that a minimum of 12 months of tenancy services is often needed to achieve housing stability, and that residents' needs fluctuate with life circumstances, behavioral health acuity, and aging. Interviewees recommended that DHCS strengthen its guidance to align with that evidence and clearly state that living in PSH is not by itself grounds for ending services, publish a standardized eligibility assessment and an explicit list of acceptable documentation, and allow non-clinical evidence to establish eligibility for services designed to address social needs.

In addition, more research is needed to better understand how long residents in different circumstances need housing-related services. Some people stabilize and need less support over time. Others, particularly those who have disabling conditions and are exiting chronic homelessness, may require sustained support. Research could help the State identify strategies to direct resources in the most effective way.

Establish minimum payment rates grounded in what services cost. DHCS could provide stronger guidance on what activities count toward delivering the Housing Trio. DHCS is currently reviewing its Community Supports **pricing guidance**, which hasn't been updated since 2021. Updating it based on current cost evidence, including data on the gap between payments and the cost of delivery,[30] would give both plans and providers an evidence-based approach to setting rates. DHCS could establish a minimum level of payment instead, but this may require additional State funding. Overall, more research is needed to understand the costs of providing the Housing Trio across regions and program models, as well as evaluate the impacts of these supports on

housing stability and health care utilization. At a minimum, MCPs should establish clear and predictable rate policies, so that providers can plan their service budgets accordingly.

Require advance notice and transparency. Constant policy changes heighten risk and uncertainty for organizations, particularly small community-based nonprofits. DHCS should require plans to publish rate changes and provider-facing policies with defined and longer notice periods for changes. For example, DHCS's **July proposal** lets MCPs adopt the six-month authorization standard even before the State's own deadline, with only 30 days' notice to providers. The result is that the same policy takes effect at different times in different counties, and fails to give organizations adequate time to respond, leading to gaps in residents' care.

Bring housing providers, homelessness service organizations, and people with lived experience into the policy conversation. California's efforts to integrate health care and housing have intensified in recent years, through CalAIM and reforms to the behavioral health system under the **Behavioral Health Services Act** (BHSA, or Proposition 1). However, health care agencies and MCPs still have limited knowledge and visibility into how PSH is financed and operated. In one county, for example, the county and the MCP negotiated the new payment model over nine months without involving the providers who would deliver the services.[31] Those providers later proposed an acuity-weighted model that would pay differently for residents with different levels of need, an option that surfaced only after the new payment model has been set.

Homelessness service and housing providers should have a formal role in shaping CalAIM and BHSA policy at the state and county level, along with staff from the state agencies that finance supportive housing, whose regulatory agreements set the caseload and service commitments these organizations must meet. DHCS could add supportive housing and homelessness services providers to its **Stakeholder Advisory Committee**, which advises on CalAIM. The State could also fund peer-to-peer learning among providers and support the participation of advisory members with lived experience of homelessness.

Conclusion

Supportive services are critical to the long-term stability of PSH, and for the providers who built the infrastructure to deliver the Housing Trio, the recent changes to CalAIM are already making it more difficult to meet residents' needs. Over the longer-term, the integration of Medicaid funding and PSH holds significant promise, but the State will need to invest in provider capacity and better align its health care and housing systems for it to succeed. A key question for the State is how to ensure that PSH has a sustainable source of financing to provide the supportive services critical to the success of the model. This will require both continued investment in ensuring that Medicaid can serve as an accessible and durable source of funding for PSH providers and an assessment of whether other financing models, such as dedicated state funding, are also needed to ensure that supportive services are integrated with the capital and operating structure of PSH.

ENDNOTES

1. CalAIM also introduced **Enhanced Care Management** (ECM), which coordinates medical, behavioral, dental, and social services for members with the most complex needs. Unlike Community Supports, ECM is a required benefit that every managed care plan must offer to eligible members.
2. More than 528,000 Medi-Cal members have received at least one Community Support since 2022. Uptake of the Housing Trio remains low relative to need: the California Health Care Foundation **estimates** that of roughly 165,000 people experiencing homelessness likely eligible in 2023, 15 percent received housing transition navigation, 10 percent received housing tenancy and sustaining services, and fewer than 1 percent received housing deposits.
3. Medicaid is jointly financed. States pay providers and the federal government reimburses a share, set by the Federal Medical Assistance Percentage. California's rate is 50 percent for most enrollees and 90 percent for the Affordable Care Act expansion population, which covers most adults enrolled through Medi-Cal without dependent children—including most people experiencing homelessness. HR 1 reduces the federal contribution two ways: fewer enrollees means less federal match, and new limits on provider taxes constrain how California raises its own share. **https://www.chcf.org/resource/2025/01/22/medi-cal-federal-government/**
4. HR 1 provides an exemption from work requirements and medical checks for people who are medically frail, listing qualifying conditions that include substance use disorder, disabling mental disorder, and disability. In its **June 2026 interim final rule**, CMS narrowed the exemption beyond the statute: a qualifying condition is no longer sufficient on its own, and enrollees must also show that it significantly impairs their ability to meet the work requirement. Twenty-six states, **co-led by California**, have challenged the rule in federal court; a preliminary injunction was denied, and the rule remains in effect while the case proceeds.
5. DHCS's own **evaluation** shows that housing navigation and deposits are already demonstrating cost-effectiveness, while tenancy sustaining services are showing cost reductions and expected to become cost-effective over time.
6. Corporation for Supportive Housing (CSH). (2026). "HTNS/HTSS Service Costs: Understanding the Gap." Survey of 29 California service providers, including 16 with HTNS or HTSS contracts. Most providers in the CSH survey reported braiding one or two additional funding sources to cover what Medi-Cal payments do not.
7. Interview, April 1, 2026.
8. Per enrollee per month (PEPM) is often confused with a per member per month (PMPM) rate. PMPM is capitation: the plan pays a fixed amount whether or not a service is delivered. PEPM is a fee-for-service payment that a provider earns by documenting a minimum number of encounters.
9. Interview, April 8, 2026.
10. Interview, March 4, 2026.
11. Nonprofit Alliance of Housing and Homelessness Providers of Alameda County. (2026). "Urgent Concerns Regarding Proposed CalAIM HCS Program Changes." Letter to Alameda County Health, Housing and Homelessness Services, March 24, 2026.

ENDNOTES

12. When plans require a minimum number of encounters to pay the full rate, providers earn less for residents they cannot reach. Holding revenue steady would mean serving more residents per case manager. But the California Department of Housing and Community Development (HCD) **recommends a caseload** of no more than 15 residents per case manager in units restricted to people exiting homelessness, which is aligned with the **evidence base for quality supportive housing** and U.S. Department of Housing and Urban Development **(HUD) guidance** for people with mid- to high-acuity supportive service needs in PSH.
13. Interview, March 4, 2026.
14. Nonprofit Alliance of Housing and Homelessness Providers of Alameda County. (2026). "Urgent Concerns Regarding Proposed CalAIM HCS Program Changes." Letter to Alameda County Health, Housing and Homelessness Services, March 24, 2026.
15. Interview, July 2, 2026.
16. Housing loss is concentrated early in a PSH tenancy. In **Terner Center research**, supportive housing operators reported higher rates of rental delinquency and exits from housing in the first six months after placement, and described the first six months to a year as critical to stabilizing new residents.
17. Interview, April 15, 2026.
18. Interview, April 14, 2026.
19. See the Progress Notes section of the Outpatient Specialty Mental Health Services (SMHS) Clinical Documentation Guide. **https://www.calmhsa.org/wp-content/uploads/2025/04/SMHS-Clinical-Documentation-Guide-4.25.2025.pdf**
20. Interview, September 18, 2026.
21. Interviews, March 4, April 1, April 8, April 14, April 15, and September 18, 2026.
22. Nonprofit Alliance of Housing and Homelessness Providers of Alameda County. (2026). "Urgent Concerns Regarding Proposed CalAIM HCS Program Changes." Letter to Alameda County Health, Housing and Homelessness Services, March 24, 2026. For comparison, organizations incorporating Medi-Cal billable productivity expectations typically budget 20 to 30 percent of frontline staff time for documentation, including treatment and housing support plans, assessments, and progress notes. See **CSH, Services Budgeting Tool Guide**, p. 20.
23. Interview, September 18, 2026.
24. Interview, July 2, 2026.
25. Interview, September 18, 2026.
26. Nonprofit Alliance of Housing and Homelessness Providers of Alameda County. (2026). "Urgent Concerns Regarding Proposed CalAIM HCS Program Changes." Letter to Alameda County Health, Housing and Homelessness Services, March 24, 2026.
27. Interview, April 15, 2026.
28. SAMHSA's (Substance Abuse and Mental Health Services Administration) **working definition of recovery** holds that "recovery is non-linear, characterized by continual growth and improved functioning that may involve setbacks," and that setbacks are "a natural, though not inevitable, part of the recovery process."

ENDNOTES

29. Sixty-nine organizations and individuals, including people with lived experience of homelessness, signed a joint comment letter opposing the six-month standard and recommending 12-month initial authorizations. Failing that, the letter asked that members living in or referred to supportive housing be presumptively reauthorized at six months. If adopted, the changes take effect January 1, 2027, though MCPs may implement them sooner with 30 days' notice to providers.
30. Corporation for Supportive Housing (CSH). (2026). "HTNS/HTSS Service Costs: Understanding the Gap." Survey of 29 California service providers, including 16 with HTNS or HTSS contracts.
31. Nonprofit Alliance of Housing and Homelessness Providers of Alameda County. (2026). "Urgent Concerns Regarding Proposed CalAIM HCS Program Changes." Letter to Alameda County Health, Housing and Homelessness Services, March 24, 2026.

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