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Building Systems of Care:

Jamboree's Use of CalAIM to Advance Housing and Health

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Introduction

In 2022, California launched California Advancing and Innovating Medi-Cal (CalAIM), an ambitious effort to improve its Medi-Cal system. Medi-Cal is the state's Medicaid program that insures 40 percent of California's residents, including the majority of people experiencing homelessness. CalAIM is a five-year demonstration initiative (2022–2026) that allows housing and other service providers to bill Medi-Cal for interventions that seek to address the social determinants of health, such as housing.

One of the potential benefits of CalAIM is that organizations that build and operate permanent supportive housing (PSH) can use Medi-Cal funding to provide a Housing Trio of Community Supports—Housing Transition Navigation Services, Housing Deposits, and Housing Tenancy and Sustaining Services (HTSS)—as well as more intensive case management through Enhanced Care Management.

Many people who have experienced chronic homelessness would benefit from these types of support as they move from being unhoused into permanent housing, but often there isn't enough funding to provide them. CalAIM therefore offers a promising new source of funding—based on Medi-Cal reimbursements—that can help PSH providers increase staff levels for supportive services, which in turn leads to better outcomes for residents.

As of June 2025, all of the state's Managed Care Plans (MCPs)—the entities that contract with the State to provide Medi-Cal benefits to their members—have elected to offer the Housing Trio. The pilot has led to significant investment in the housing needs of people experiencing homelessness across California. In 2024, approximately 77,400 people received Housing Transition Navigation Services, 29,100 received Housing Tenancy and Sustaining Services, and 9,000 received Housing Deposits.

This represents a significant expansion of resources for people experiencing homelessness, and early evidence suggests that these services are having a positive impact. A recent evaluation released by the California Department of Health Care Services (DHCS) found that people who used at least one Housing Trio support saw a 13 percent reduction in emergency department visits and a 24 percent reduction in inpatient admissions in the six months that followed the service(s).

Despite this measurable progress, there remain several barriers that prevent many PSH providers from benefiting from CalAIM, including lack of standardization across MCP policies and challenges in adapting to a Medi-Cal billing and reimbursement model. As the demonstration phase of CalAIM is in its fourth year, highlighting how organizations have overcome these barriers—as well as unresolved challenges—can help to inform future policies and ensure that the promise of CalAIM is realized.

This brief presents a case study of Jamboree Housing Corporation (Jamboree), which has built out an innovative CalAIM model, including using a nonprofit hub to centralize back-office functions. Jamboree is also partnering with CalOptima Health (CalOptima), the largest MCP in Orange County, on a new pilot designed to demonstrate that Medi-Cal could become a sustained funding source for PSH. Jamboree's implementation of CalAIM offers important lessons for the field, as well as for policymakers as they seek to strengthen the links between housing and health services.

Common Acronyms

CalAIM: California Advancing and Innovating Medi-Cal

DHCS: California Department of Health Care Services

ECM: Enhanced Care Management

HHCA: Housing for Health California

HHIP: Housing and Homelessness Incentive Program

HHOC: Housing for Health Orange County

HIPAA: Health Insurance Portability and Accountability Act

HTSS: Housing Tenancy and Sustaining Services

MCP: Managed Care Plan

PSH: Permanent Supportive Housing

WPC: Whole Person Care pilot

Paving the Way for CalAIM Implementation

Founded in 1990, Jamboree is a nonprofit, affordable housing developer and operates approximately 1,220 PSH units across 24 apartment communities, with another 226 PSH units in the development pipeline. Jamboree works throughout California, with offices in Orange County, Santa Clara County, San Diego County, and Sacramento.

In 2010, Jamboree merged with HOMES, Inc. (Helping Our Mentally Ill Experience Success), a nonprofit dedicated to providing housing and support for people with psychiatric disabilities. This merger, alongside the increased emphasis on addressing homelessness in State housing programs, has made PSH a strategic priority within Jamboree's affordable housing portfolio.

Prior to CalAIM, Jamboree had already been a partner in Orange County's Whole Person Care program, a precursor pilot to CalAIM, which included a small contract for housing navigation, deposits, and tenancy sustaining services. Four organizations—Jamboree, Mercy House, Friendship Shelter, and American Family Housing—came together to share lessons and increase their organizational capacity to provide these services and address rising homelessness in the county.

During the COVID-19 pandemic, it became clear that there needed to be stronger coordination and alignment of services across Orange County, especially given the influx of Emergency Housing Vouchers and opportunities to expand the supply of PSH under Homekey.

This need led the four organizations to formally establish a nonprofit, Housing for Health Orange County (HHOC). HHOC was designed to help coordinate and establish referral pathways for people experiencing homelessness, as well as support the founding organizations with administrative functions associated with the wide range of homelessness services they were providing. With the launch of CalAIM, CalOptima established CalAIM contracts with HHOC, initially just for Community Supports but later adding Enhanced Care Management (ECM). HHOC sub-delegates the delivery of these services to Jamboree.

Jamboree's CalAIM Model

Unlike many other PSH providers, Jamboree began by providing Community Supports and ECM to unhoused people in the broader community, not their own residents. Prior to 2020, most of the residents living in Jamboree's PSH properties had been housed for at least a few years, making them ineligible to receive tenancy supportive services. Jamboree's senior vice president for community operations explained, "While we had a few PSH properties already in our portfolio, most of those were stabilized and so the residents wouldn't have been eligible for Community Supports, even if some of them might have benefitted from more intensive case management."

As Jamboree's portfolio of PSH grew, and as they realized that residents needed higher levels of support, they began to grow their capacity to offer HTSS, as well as ECM, both in the community and for residents at their own sites. Jamboree's vice president of supportive housing noted, "Based on our experience, we knew newly housed individuals required a higher level of support."

CalAIM reimbursements for the Housing Trio and ECM are now a critical component of Jamboree's service model, accounting for about 20 percent of services funding at their properties, though they are planning for higher levels at some of their new PSH properties. These funds are particularly critical for properties that include PSH units without dedicated supportive services funding, such as those developed using the State's Homekey program. Only around half of Jamboree's PSH units include a county Mental Health Services Act (MHSA) contract or Veteran Supportive Housing (VASH) voucher—two sources of supportive services funding often layered into PSH properties.

Jamboree recognized that if they were only to rely on their operating budgets—which come from housing funding sources such as the Low-Income Housing Tax Credit (LIHTC) program and project-based vouchers—they could only staff PSH properties at a ratio of one case manager to 40 residents. A program manager shared that this staff-to-resident ratio is too high for PSH: "We know that's not going to lead to good outcomes. Given residents' needs, properties really need one case manager for 15 to 20 residents at most."

The funding that Jamboree receives from Medi-Cal billing has allowed them to expand their staffing in two critical ways. First, it has allowed them to bring staffing ratios down to one-to-20 residents, as well as hire for specialized positions, such as a workforce development specialist and health clinician. Second, they have been able to hire staff with more direct experience working with unhoused populations. Before CalAIM, supportive services staff were focused primarily on programming and activities, such as health information sessions or social gatherings.

With CalAIM, Jamboree has been able to increase the number of case managers who are trained in harm reduction and have more experience providing intensive case management for people with higher levels of acuity. A senior leader shared that "all of these positions are funded through the additional revenue received through CalAIM. It allows us to provide supportive services at a level closer to what a full-service partnership would typically provide for our MHSA or VASH units."

One of the unique aspects of Jamboree's model is that even as their own PSH portfolio has expanded, staff have continued to provide services to people experiencing homelessness in the broader community. Senior leadership noted that this is not

typical of many PSH operators: "It's a real culture shift, as a housing person, to see yourself as providing services to people who are not your own residents."

Known as the "CalAIM team," Jamboree employs staff who deliver housing navigation, deposits, and post-hospitalization services across the county. CalOptima sends direct referrals—lists of Medi-Cal members eligible for either ECM or Community Supports—to this team. At any given time, they work with around 100 CalOptima referrals. In these cases, a CalAIM case manager explained that they "identify the person's housing needs and get them into Coordinated Entry. If they have a voucher, Jamboree staff help them understand how it works and provide housing navigation, housing deposits and make sure they have furniture."

This model of providing services outside of Jamboree's own properties has distinct advantages.

Financially, it ensures that Jamboree will receive sufficient Medi-Cal reimbursements to sustain staffing levels at a specific property. One major challenge housing providers face with CalAIM is that residents may not be re-authorized for HTSS—for example, if they have successfully stabilized their housing. But a property has a fixed number of residents. If a provider is counting on the revenue from a certain number of residents receiving HTSS to pay for a case manager at a specific property, a denied re-authorization or other shift in resident eligibility can lead to a significant funding shortfall at the site.

By offering services beyond its own properties, Jamboree can ensure a certain level of revenue through its external referrals. Their senior vice president explained, "We did the financial analysis, and found that for a case manager, we would need to be able to bill for 18 to 20 people receiving ECM per month. We may not get that at a property, but when we have around 25 members receiving ECM each month, then we can add staff and feel comfortable that the revenue will cover it."

In addition, Jamboree's model allows them to have staff who can provide supportive services earlier on in the lease-up process—while the person is still living in a shelter or on the street—which can smooth the transition into permanent housing. With the CalAIM funding for community or "external" referrals, Jamboree hires staff intended for a new PSH property a few months before the property opens. This allows them to reach out to prospective residents (coming from Coordinated Entry) before move-in.

A senior program manager shared, "We've found it's really important to start meeting with people earlier in the process so we can start to build trust. It's important for engagement." Once the property is placed in service, the external staff then transition to working onsite, contributing to a continuity of care for residents.

Improving Person-Centered Care

Jamboree staff see noticeable benefits from having the lower staffing ratios and the more intentional check-ins required to bill for housing-related services. They have created an intake assessment with different categories—such as physical health, mental health challenges, connection to services—that helps staff identify potential barriers to housing stability. Residents often come with significant unmet needs that contribute to overall instability and difficulty sustaining housing, including undiagnosed physical or mental health conditions.

A senior program manager noted that each resident is unique: "We're providing tailored interventions. For some, it is connecting them to disability benefits or general assistance; for others, it's ensuring that they have a primary care provider and can get to appointments."

CalAIM has also increased coordination and communication among team members. In addition to bi-weekly staff meetings at each PSH property, the staff have bi-weekly cross-property "CalAIM meetings" that ensure that all staff know of policy changes and can learn best practices from each other. The senior program manager who runs those meetings also holds "office hours" to answer questions, noting that "there are constant changes with CalAIM policies, so it's important that we are constantly communicating and developing different strategies for the team so they don't feel the pressure of the changes." In addition, Jamboree's director of clinical services hosts case conferences focused on specific residents to ensure stronger coordination of care.

One of the benefits of CalAIM and expanded staff capacity is that when a resident is ready to engage, they can access a broad range of services. One of the senior staff shared an example of a resident who had experienced chronic homelessness—living in her car and shelters for over 10 years. "She worked with her case manager every week, first to set goals, but then to help her achieve them, like updating her resume, teaching her how to use a computer, how to ride the bus while her car was being fixed," she explained. "When we have the time to help people, it really works." The resident now works part-time for the County.

Staff still note significant hurdles in engaging people who have experienced the trauma of being unhoused. One challenge is enrolling people into Community Supports or ECM in the first place. A program manager shared that people hear "enrollment" and think it's just a few minutes of someone's time, but it can take several trips: "There's so many forms, and there's a lot of distrust. Getting people who are unhoused or in a shelter to take the time to sign up is hard. You have to explain everything multiple times. And then the forms ask the same things over and over. They are so tired of telling their story, sharing data, and having nothing come of it."

Another challenge can be ensuring that case managers can make the necessary documented contacts with residents, often referred to as "touches." One of the case managers explained that "reaching people is difficult; they won't answer the door, or don't want to participate. I think policymakers underestimate how hard this work is, how much time it takes to do an individualized, harm reduction approach. There's no magic wand; it requires deep, sustained trust building and engagement."

A Nonprofit Hub Model for CalAIM Billing

Another unique aspect of Jamboree's model is that rather than billing CalOptima directly, all of the back-office functions related to interacting with the MCP are administered by the nonprofit Housing for Health Orange County (HHOC), which is now Housing for Health California (HHCA. For Jamboree and the other founding organizations, implementing CalAIM through a collaborative hub was more financially feasible than having each set up billing infrastructure on their own. In addition, since it is the entity that holds

the CalAIM contracts, HHCA streamlines communication with CalOptima, and supports the "translation" function between the housing and health care sectors that often can be difficult.

Jamboree relies on HHCA to process all referrals, authorizations, and reimbursement claims. If a claim is denied, HHCA works with Jamboree to clarify or fix the required documentation, but it handles the dispute resolution. Having a third party with deep expertise in the reporting systems and claims processes reduces the risk that claims are rejected entirely, ensuring that the expected revenues come in. HHCA has been able to resolve most rejected claims, especially when denials are due to an incomplete submission.

The chief administrative officer for HHCA said that providing that centralized capacity can be critical for smaller nonprofits who may not have the administrative infrastructure to take on billing on their own: "We quickly saw that a lot of nonprofits couldn't manage the Medi-Cal billing system. Some organizations have also struggled to adapt to a reimbursement, instead of a grant, model."

HHCA operates on a fee-for-service model, retaining 10 percent of the Medi-Cal reimbursements for Community Supports and ECM to cover its operations. While this has allowed HHCA to adequately staff its work, HHCA staff noted that this fee can pose a challenge to some providers: "CalAIM reimbursement rates don't always cover their costs, even without our fee, especially when they aren't providing services at scale. So that's a structural barrier for some of them."

HHCA is exploring whether they might be able to adopt a "pay for performance" model, in which service providers whose paperwork has fewer errors—reducing the workload for HHCA staff—would pay a lower rate. HHCA is also expanding into more areas of California, including Sacramento, Kern, and Bakersfield and is establishing CalAIM contracts with other MCPs, including Health Net, Anthem, and Kaiser Permanente. HHCA leadership said that as more MCPs have realized the potential benefits of Community Supports and ECM for their members, "there has been a growing interest in having this type of hub model available in other counties, especially rural areas." A nonprofit hub model may be particularly helpful if it can take on the responsibility of working with multiple MCPs across counties.

Even though they are working with HHCA for many of the back-office functions, the newness of CalAIM means that Jamboree is continually learning and improving their data management and record-keeping systems to comply with Medi-Cal reporting requirements. Ensuring that staff have the right training and know what they need to include in their documentation is especially important.

A program manager explained the process: "It's a lot of work. You have to enter everything into CalOptima's system, and there are constant quality checks. Our CalAIM case managers check everything, and we have a data analyst in-house who also oversees the notes each week when they're submitted. HHCA will also review, and then CalOptima will periodically do a full audit." Jamboree also needs to undergo annual certification that their data systems are Health Insurance Portability and Accountability Act (HIPAA) compliant at a Business Associate level.

Jamboree estimates that about 50 percent of CalAIM staff time is spent providing services, while the rest is taken up by administrative reporting. The program manager continued, "It's important to remember we're now working with a

medical entity that has its own set of regulatory requirements from the State. How we do our work and what they need on their end don't always align. The re-authorizations, the different required documents, the four touches. I get the intention, but in practice, it's not always easy from a housing provider's point of view."

Partnering with CalOptima

In addition to establishing a nonprofit hub model, Jamboree has also been working with CalOptima in Orange County to develop a pilot to demonstrate the long-term outcomes associated with providing HTSS and ECM at their properties. CalOptima was committed to actively participating in the CalAIM demonstration initiative from the beginning, hiring a team of experienced nonprofit leaders to run their program.

The executive director of CalOptima's Medi-Cal/CalAIM program explained that "when CalAIM rolled out, we were the only MCP in Orange County. So CalOptima felt a responsibility to offer all 14 Community Supports right from the start."

CalOptima recognized that they would have to build up the capacity of local housing and service providers to offer Community Supports and ECM to their members. To build that capacity, CalOptima took advantage of the state's Housing and Homelessness Incentive Program (HHIP), which offered incentive funds for building partnerships with homelessness systems of care. CalOptima secured $72.9 million in HHIP funding; CalOptima also committed $87.4 million from its own reserves to support these ongoing efforts.

Approximately 40 percent of this funding was dedicated to building organizational capacity and collaboration across the county to provide housing-related supportive services. The rest—$93.3 million—was committed to addressing the lack of sufficient transitional, affordable, and permanent supportive housing by providing grants for capital projects to build more housing, including a $4.7 million grant to Jamboree.

CalOptima approached CalAIM implementation in the spirit of it being a demonstration project, recognizing that they would make mistakes and learn along the way. A member of CalOptima's Medi-Cal/CalAIM team explained, "From the beginning, leadership gave us the flexibility to launch new services, build new partnerships, and develop new models of care. We are constantly working to analyze outcomes, learn from any mistakes, and continually improve these services for our members."

CalOptima currently has a robust network of providers, including 122 organizations that provide one or more Community Supports, 51 providing ECM, and 21 providing community health worker services. CalOptima has seen an increase in the number of providers who are able to bill them directly, but staff acknowledged that it might be more challenging to work directly with MCPs—as opposed to using a hub model—if a PSH provider works across multiple counties.

CalOptima has also adjusted their policies along the way in response to provider concerns. For example, it initially required that Housing Trio providers have the same level of insurance coverage as their other Medi-Cal providers, such as community health centers. But they found that nonprofit providers couldn't afford that level of insurance, and given the services they were providing (e.g. housing navigation versus direct health care),

these organizations also didn't face the same risks. With leadership support, they reduced the required insurance levels for providers, and then increased their own insurance policy to make up the deficit. CalOptima's Medi-Cal/CalAIM director noted, "We would never have known that was an issue had our providers not brought that to our attention, and we had a Board that was willing to approve that."

CalOptima also set aside funding for "systems-change" grants. CalOptima's Medi-Cal/CalAIM executive director shared, "We knew that it would take more to take the lower case, faded 's' in PSH (for "supportive') and make it capitalized and bolded (Supportive)." As part of its systems-change efforts, CalOptima has decided to evaluate whether providing the right level of supportive services in PSH, in a trauma-informed manner, will reduce returns to homelessness and ensure better health outcomes for their members. She continued, "If we can do that, then we can justify making HTSS a permanent benefit for people living in PSH units, and that would in turn give developers a guaranteed revenue stream," she said.

This concept has led to a pilot initiative with Jamboree at three of its properties. At these properties, Jamboree will add staff roles that they believe will lead to better outcomes for residents, including a community rehabilitation specialist and workforce development position. While these roles initially will be supported by grant funding, the objective is to develop a staffing model that could be sustained by the revenue Jamboree receives for HTSS.

The Corporation for Supportive Housing will evaluate the pilot to assess whether this increased supportive service model leads to better outcomes in residents' housing stability, physical and mental health, employment, and interpersonal connections. If the outcomes are positive, it helps to build the case for providing ongoing HTSS to people living in PSH. CalOptima sees this work as critical to improving long-term outcomes for people who have experienced homelessness.

Conclusion

Jamboree's experiences with CalAIM implementation hold important lessons for policymakers focused on addressing the long-term costs of homelessness. The current approach to building PSH without layering in sufficient funding for supportive services that meet the level of residents' needs is unlikely to be sustainable over the long-term. Jamboree's senior vice president highlighted the key challenge: "We need to change how we finance PSH developments. If we're stuck within the current system, and what lenders and investors will underwrite, we'll never have enough funding to get to the case manager ratios we need."

If Medi-Cal funding is the State's long-term solution to funding for services within PSH, policymakers will also need to pay attention to PSH providers' experiences with the CalAIM demonstration. There are several actionable steps the State can take to ensure that PSH providers can successfully deliver and scale health-related services to residents.

Providing capacity-building grants

The State should fund additional rounds of capacity-building grants—such as Providing Access and Transforming Health (PATH) CITED and Housing and Homelessness Incentive Program (HHIP) funds—to help affordable housing and service providers strengthen their internal systems and staffing models. CalOptima's use of HHIP funding to

expand Jamboree's staff capacity illustrates how critical these resources are in bridging the gap until Medi-Cal reimbursements reach sustainable levels.

As one CalOptima staff member explained, it is unrealistic to expect providers to stand up Community Supports or ECM without initial grant or bridge funding: "It's not like organizations have additional staff capacity to provide HTSS or ECM at the outset; they need funding to build their programs so that they can transition into a reimbursement funding model." Without additional HHIP or PATH CITED funding, it will be difficult for CalAIM to scale to a broader set of PSH providers.

Capacity grants could also help to seed or grow nonprofit hub models like HHCA, which could reduce some of the barriers PSH providers face in building their internal systems to bill Medi-Cal or negotiate contracts with multiple MCPs.

Standardizing policies and practices

Jamboree's experiences with CalAIM also point to needed policy shifts if the waiver is extended, and especially if Community Supports become a Medi-Cal benefit. In the initial demonstration period, DHCS gave MCPs a lot of flexibility in designing their own CalAIM programs. However, the lack of standardization in policies and practices has posed an administrative challenge for CalAIM providers, especially when residents fall under different MCP plans. Plans vary in their reimbursement rates, the number and length of touches they require for different Community Supports, their willingness to re-authorize services, and their documentation and data entry systems. Establishing clearer statewide standards would reduce administrative inefficiencies and allow PSH providers to focus on service delivery rather than navigating conflicting requirements.

Investing in systems change

At the same time, the State should incentivize MCPs to pilot systems-change projects that test scalable models of health and housing alignment.

Additional demonstration projects—like the Jamboree/CalOptima Health pilot—could provide the evidence base needed to make Medi-Cal reimbursements a sustained source of service funding for residents living in PSH, which could also lead to expanding the field's capacity to build more units. As the CalOptima leadership team explained: "We're trying to make the case that if someone's eligible to live in permanent supportive housing, they also meet the eligibility criteria for tenancy sustaining services." Clarifying and reinforcing these linkages through additional demonstration projects could accelerate the alignment of housing and health systems across diverse county contexts.

Leveraging insights from PSH providers

Finally, policy development should more intentionally incorporate the perspectives of PSH providers. While the lack of standardization is a challenge not unique to PSH providers, housing developers face a distinct set of challenges when contracting directly with MCPs. Financing and maintaining affordable housing properties over the long-term surfaces different financial and operational risks, especially when reimbursement or re-authorization denials, unplanned services costs, or disruptions in tenancy jeopardize a property's financial stability.

To address these challenges, DHCS should convene and/or directly solicit feedback from PSH providers to inform their evaluation of CalAIM and the development of policy guidance. Such engagement will be especially important as new investments, including those under Proposition 1, seek to leverage CalAIM to build stronger housing-health connections. Ensuring that PSH providers' expertise is reflected in decisions is critical to the State's long-term strategy for addressing homelessness.

Together, these steps—capacity-building, standardization, systems change, and provider engagement—would create the foundation for scaling CalAIM in a way that is responsive to PSH realities. By aligning Medi-Cal with the operational needs of housing providers, the State can ensure that its efforts under CalAIM not only expand access to health services, but also strengthen the long-term stability of permanent supportive housing.

Resources for Understanding CalAIM

CalAIM is a broad, complex undertaking to improve California's Medi-Cal system, with too many program elements and regulations to cover in this case study. Here are resources for more background information:

The Corporation for Supportive Housing has an online Medi-Cal Academy with training for housing and homeless service agencies interested in contracting with managed care plans to provide housing-related Community Supports. >>Access the site

The California Health Care Foundation publishes articles updating the field on issues related to CalAIM implementation. >>Read the articles

The California Department of Health Care Services maintains a website with policy guidance and resources related to CalAIM, as well as a Housing for Health page with updates on various DHCS-led housing-focused initiatives within and outside Medi-Cal.
>>Access the site | >>Access the page

ENDNOTES

1. Reid, C. (2023). "Permanent Supportive Housing as a Solution to Homelessness: The Critical Role of Long-Term Operating Subsidies," Terner Center for Housing Innovation, University of California, Berkeley. Retrieved from: **https://ternercenter.berkeley.edu/research-and-policy/psh-homelessness-cost/**

2. For more information on CalAIM Community Supports by Managed Care Plan, see **https://www.dhcs.ca.gov/Documents/MCQMD/Community-Supports-Elections-by-MCP-and-County.pdf**. Other Community Supports include interventions such as day habilitation programs, respite services for caregivers, asthma remediation, and medically tailored meals. As of July 2025, transitional rent is also an eligible service. For the full list, see: **https://www.dhcs.ca.gov/CalAIM/Documents/DHCS-Medi-Cal-Community-Supports-Supplemental-Fact-Sheet.pdf**

3. California Department of Health Care Services. (2025). ECM and Community Supports Quarterly Implementation Report. Data reflect the number of unique members who utilized Community Supports by service in the last 12 months of the reporting period, which ended December 2024. Retrieved from: **https://storymaps.arcgis.com/collections/a07f998dfefa497fbd7613981e4f6117?item=6**

4. California Department of Health Care Services. (2025). Community Supports, or In Lieu Of Services (ILOS), Annual Report: Department of Health Care Services (DHCS) 1915(B) Waiver Report to the Centers for Medicare & Medicaid Services (CM) for Calendar Year (CY) 2024. Retrieved from: **https://www.dhcs.ca.gov/Documents/MCQMD/DHCS-1915b-Annual-Report-on-ILOS-STC-B20-2025.pdf**, pp. 72-73.

5. Wilkins, C. et al. (2024). "Understanding CalAIM Implementation Across California." Terner Center for Housing Innovation, University of California, Berkeley. Retrieved from: **https://ternercenter.berkeley.edu/wp-content/uploads/2024/02/CalAIM-Brief-February-2024.pdf**

6. Starting in January 2024, Kaiser Permanente operates across the state, but they only have around 50,000 members in Orange County in comparison to CalOptima Health's 950,000 members.

7. The case study draws on document review and on interviews with Jamboree staff; representatives from Optima Health, the primary MCP in Orange County; and the leadership of Housing for Health California, a nonprofit hub that serves as the back office for Jamboree's CalAIM implementation.

8. Whole Person Care (WPC) pilots were implemented through a federal Section 1115 Medicaid demonstration waiver—known as "Medi-Cal 2020"—to provide counties with funding and authority to coordinate health, behavioral health, and social services for high-need Medi-Cal beneficiaries. **https://www.chcf.org/blog/whole-person-care-pilots-set-stage-calaim**/

ENDNOTES

9. The Emergency Housing Voucher (EHV) program, created during the pandemic under the American Rescue Plan Act, provides tenant-based rental assistance to rapidly house vulnerable individuals and families experiencing or at risk of homelessness, including people fleeing domestic violence. **https://www.hud.gov/helping-americans/housing-choice-vouchers-emergency**

10. Homekey is a California Department of Housing and Community Development (HCD) initiative, launched in 2020, that funds the acquisition and conversion of hotels, motels, and other existing buildings into permanent or interim housing for people experiencing or at risk of homelessness. See **https://ternercenter.berkeley.edu/blog/homekey-unlocking-housing-opportunities-homelessness/**

11. CalOptima Health provides all 14 Community Supports, ECM, Community Health Worker Services, and Doula Services.

12. Jamboree had already been providing Housing Transition Navigation Services under a Full Service Partnership (FSP), a program funded by the Mental Health Services Act. It also operates a transitional housing site that provides a bridge to permanent housing for five to six residents at a time. Jamboree also provides recuperative care and serves as a partner for Be Well Orange County, a regional center that coordinates short-term hospitalization and psychiatric treatment for people with mental illness.

13. Full-Service Partnerships are recovery-focused, community-based programs. They offer a full range of supports—including mental health treatment, peer services, housing assistance, and crisis intervention—to people with severe mental illness who are experiencing homelessness or at risk of homelessness. For more information, see: **https://bhsoac.ca.gov/initiatives/full-service-partnerships/**

14. A Business Associate under HIPAA is any individual or organization that performs functions or activities on behalf of a covered entity—such as health care providers, health plans, or health care clearinghouses—and, in doing so, handles or discloses protected health information (PHI). These functions can include billing, data analysis, IT support, or any service that requires access to PHI. Because Business Associates are not part of the covered entity's workforce, they are required to sign a Business Associate Agreement (BAA) that outlines their responsibilities for safeguarding PHI and ensuring compliance with HIPAA's privacy and security rules.

15. For more information on the funding CalOptima received and the organization's investments, see: **https://cop-p-001.sitecorecontenthub.cloud/api/public/content/9ccdd69e01c74bae820965f27744994b?v=238ebd63**

16. Assembly Bill 804 would make Housing Trio services a covered Medi-Cal benefit—subject to appropriation and federal approval—so that any Medi-Cal enrollee experiencing or at risk of homelessness could access them under the State Plan. See: **https://legiscan.com/CA/bill/AB804/2025**

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ABOUT THE TERNER CENTER

The Terner Center formulates bold strategies to house families from all walks of life in vibrant, sustainable, and affordable homes and communities. Our focus is on generating constructive, practical strategies for public policymakers and innovative tools for private sector partners to achieve better results for families and communities.

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