

# California State Assembly



## Joint Informational Hearing Agenda

**Assembly Budget Subcommittee No. 2  
on Human Services**

**and**

**Assembly Budget Subcommittee No. 1  
on Health**

**Assemblymember Dr. Corey Jackson, Chair  
Assemblymember Dawn Addis, Chair**

**Wednesday, March 25, 2026  
1:30 P.M. – State Capitol, Room 444**

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### **Joint Informational Hearing**

**5180 Department of Social Services (DSS)**

**4260 Department of Health Care Services (DHCS)**

**4170 California Department of Aging (CDA)**

#### **Issue 1: Impacts of Federal and State Changes on Aging Californians**

- Jennifer Troia, Director, California Department of Social Services
- Michelle Baass, Director, and Yingjia Huang, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- Susan DeMarois, Director, California Department of Aging
- Yasmin Peled, Director, California Government Affairs, Justice in Aging
- Andrew Cheyne, Managing Director, Government Relations & Public Affairs, County Welfare Directors Association of California (CWDA)
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst's Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

#### **Issue 2: Governor's Proposal for Hours Cap and Cost Shift in the In-Home Supportive Services (IHSS) Program**

- Claire Ramsey, Chief Deputy Director, and Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Carlos Marquez III, Executive Director, County Welfare Directors Association of California
- Justin Garrett, Senior Legislative Advocate, California State Association of Counties (CSAC)
- Tiffany Whiten, Senior Government Relations Advocate, Service Employees International Union (SEIU) California
- Kristina Bas Hamilton, Senior Director of External Affairs, United Domestic Workers (UDW) - AFSCME Local 3930
- Hagar Dickman, Director, California Long-Term Services and Supports Advocacy, Justice in Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 3: Governor’s Proposal for Auto-Termination and Loss of Residual Coverage for Over 10,000 IHSS Consumers**

- Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Anna Leach-Proffer, Managing Attorney, Healthcare/Home and Community Based Services (HCBS), Disability Rights California
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 4: Governor’s Proposal to Eliminate the IHSS Back-Up Provider System (BUPS)**

- Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Kim Rothschild, Executive Director, California Association of Public Authorities (CAPA) for IHSS
- Willie Grays, IHSS Consumer, Stanislaus County
- Beth M. Gray, Vice-Chair, Marin County IHSS Public Authority Board of Directors
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**5180 Department of Social Services (DSS)**

**Issue 5: Community First Choice Options (CFCO) Penalties**

- Leora Filosena, Deputy Director, California Department of Social Services
- Emily Nicholl, IHSS Program Manager, Monterey County
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 6: Governor’s Trailer Bill (TBL) Proposal for IHSS For-Profit Organization Policy/Rules**

- Leora Filosena, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 7: Home Safe Program and Proposal to Clarify Home Safe Eligibility**

- Hanna Azemati, Deputy Director, California Department of Social Services
- Karol Schwartzlander, Executive Director, California Commission on Aging (CCoA)
- Feliza Gray, Deputy Director, Adults and Aging Services, Merced County Human Services Agency

- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 8: Housing Disability Advocacy Program (HDAP) and Supplemental Security Income/State Supplementary Payment (SSI/SSP) Program**

- Hanna Azemati, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Issue 9: Community Care Expansion (CCE) Program**

- Hanna Azemati, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**4170 California Department of Aging (CDA)**

**Issue 10: Older Californians Act and Older Americans Act Funding, including Area Agencies on Aging and Meals on Wheels Programs**

- Nicole Shimosaka, Chief Deputy Director (Interim), California Department of Aging
- Aneliza Del Pinal, Board President, California Association of Area Agencies on Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Issue 11: Recommendations to Create a “No Wrong Door” for Access to Senior Supports and Services**

- Susan DeMarois, Director, California Department of Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Issue 12: Trends of and Responses to Senior Rural Suicides**

- Sarah Steenhausen, Deputy Director, California Department of Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Public Comment will be taken (in person only) after the completion of all panels and discussion, and this Public Comment will be for all issues covered in the hearing, including issues in the Non-Presentation part of the agenda (under Issue 13).**

## Items To Be Heard

### Joint Informational Hearing

**5180 Department of Social Services (DSS)**

**4260 Department of Health Care Services (DHCS)**

**4170 California Department of Aging (CDA)**

#### Issue 1: Impacts of Federal and State Changes on Aging Californians

**Focus for the Subcommittees.** This first issue under the Joint Informational Hearing focuses on the impacts of federal and state changes, cumulatively, on vulnerable older adults who are aging in California. Changes and reductions to Medi-Cal and CalFresh, California's version of the Supplemental Nutrition Assistance Program (SNAP), will have an enormous impact on older adults reliant on these public programs for their health care needs and food. The intention of the Subcommittees is to learn about how the overlapping changes will impact these Californians and what can be done to mitigate the harm as part of the 2026 Budget. For reference, the Adult Protective Services (APS) program defines elder adults as 60 years and older.

At the state level, Medi-Cal is overseen by the Department of Health Care Services (DHCS) and CalFresh is overseen by the Department of Social Services (DSS). Locally, Medi-Cal and CalFresh are administered by county health and human services departments. Also represented on the panel is the California Department of Aging, which administers services for older adults through its network of Area Agencies on Aging and which serves as a lead agency in the implementation of California's Master Plan for Aging.

There is currently no analysis available on how all of the changes in Medi-Cal and CalFresh will impact the seniors who are recipients of one or both programs. This joint hearing issue is intended to raise these questions, discuss issues, such as the H.R. 1 new work requirements, that will impact a part of this population, and underscore the prevailing and current trends for this group of vulnerable Californians.

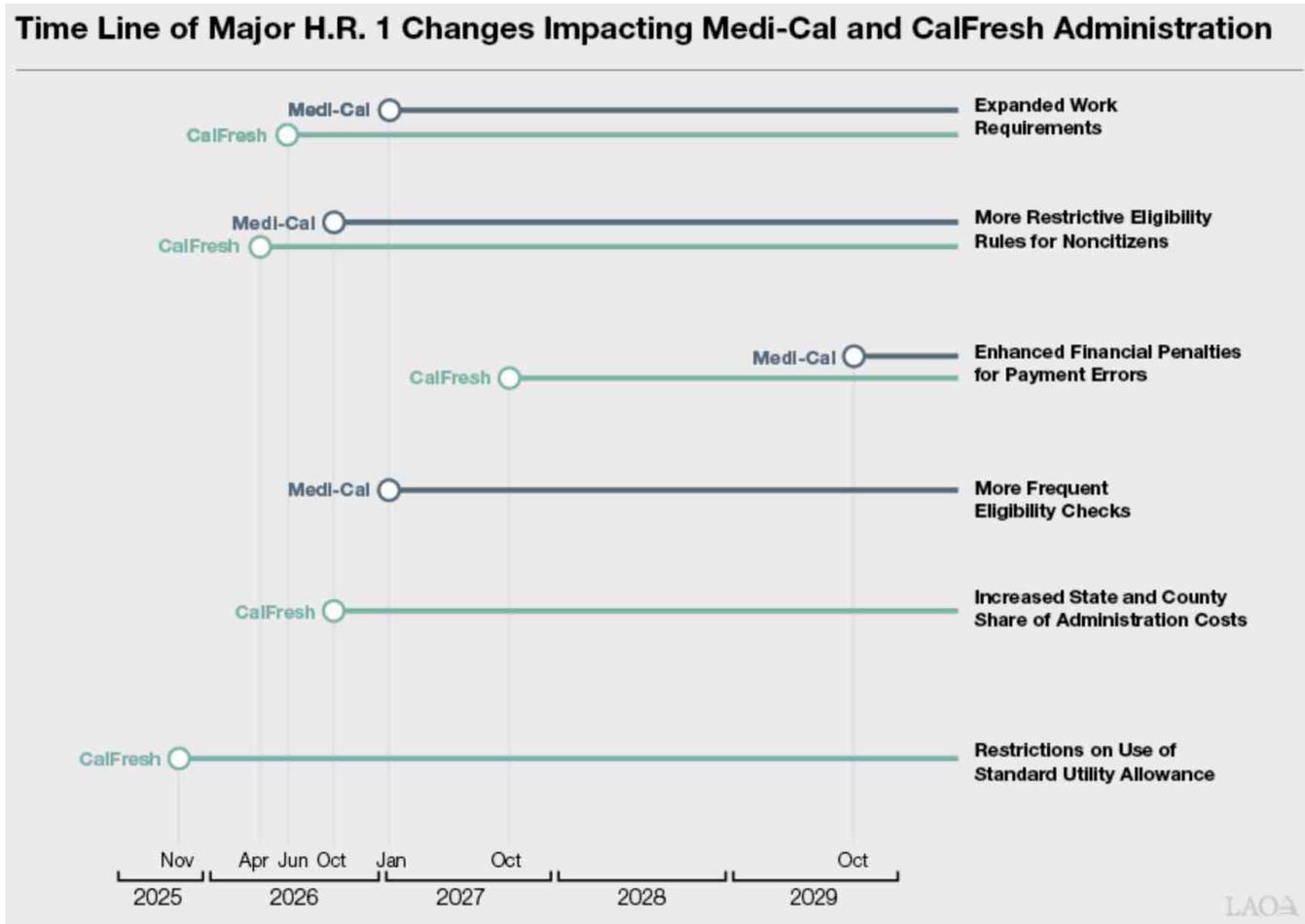
**Medi-Cal and CalFresh Background.** Medi-Cal is California's version of the federal Medicaid program. It provides health coverage to over 14 million low-income people, or more than one-third of all Californians. Total Medi-Cal spending in 2024-25 is estimated to have been \$179 billion, including \$37 billion from the General Fund. Of this amount, \$2.4 billion (\$629 million) was estimated to be for administrative costs.

CalFresh is California's version of the federal Supplemental Nutrition Assistance Program. It provided federally funded food assistance to about 5.5 million low-income Californians in 2024-25 with total benefits of over \$12.5 billion. The state also provides state-funded food assistance benefits that are the same as CalFresh to about 60,000 additional low-income legally present noncitizens who do not qualify for federal CalFresh benefits through the California Food Assistance Program (CFAP). CFAP benefits in 2024-25 were \$135 million. Administrative costs

for CalFresh and CFAP in 2024-25 are estimated to have been \$2.5 billion (\$925 million General Fund).

**H.R.1 Makes Historic and Broad Changes to Medi-Cal and CalFresh.** H.R. 1 was passed by Congress and signed by the President in July 2025. Medi-Cal and CalFresh are overseen by the state but are administered locally by counties, with a focus on eligibility determination. H.R. 1 introduces multiple significant changes to Medi-Cal and CalFresh that largely will result in lower enrollment in the programs. One significant area of change under federal H.R. 1 is the expansion and creation of community engagement requirements (generally, work requirements). These new work requirements, along with other changes, have significant impacts for counties' administration of the programs and will directly impact service and benefit delivery in these programs.

H.R. 1 changes for Medi-Cal and CalFresh will phase in over time, as shown in the figure below, which was provided by the Legislative Analyst's Office (LAO).



**Expanded Work Requirements.** H.R. 1 imposes a new work requirement in Medi-Cal and expands an existing work requirement in CalFresh (although until recently the state has had a waiver from the CalFresh requirement for several years). While the details of how these changes

affect each program vary, at a high level they require able-bodied, working-age adults without young dependent children to work or participate in other qualifying activities on a part-time basis (approximately 20 hours per week).

The table from the LAO below identifies the groups of individuals that H.R. 1 exempts from the requirements.

	Medi-Cal	CalFresh <sup>a</sup>
<b>What Is the Work Requirement?</b>	At least 80 hours monthly of work, education, or community service.	At least 20 hours weekly of work, certain work programs (which may include education), or community service.
<b>Who Is Affected?</b>		
Affected population before exemptions <sup>b</sup>	Adults age 19-64 in the ACA expansion eligibility group.	Adults age 18-64.
<b>Exemptions</b>		
Substance use disorder	✓	✓ <sup>c,d</sup>
Disabling mental health disorder	✓	✓ <sup>c</sup>
Significant physical, intellectual, or developmental disability	✓	✓ <sup>c</sup>
Serious or complex medical condition	✓	✓ <sup>c</sup>
Pregnancy	✓ <sup>e</sup>	✓
Caring for dependent children under age 14	✓	✓
Caring for a dependent with disabilities	✓	✓
High unemployment county <sup>f</sup>	✓	✓
Certain American Indians	✓	✓
Recently released from incarceration within the past 90 days	✓	
Current and former foster youth under age 26	✓	
Receiving unemployment insurance benefits		✓
Estimated affected individuals after exemptions <sup>b</sup>	About 3.5 million.	About 845,000.
Individuals estimated to be disenrolled	Between 1 million and 2 million.	About 665,500.
<sup>a</sup> CalFresh work requirement refers to the ABAWD work requirement, not the general work requirement (which is unaffected by H.R. 1). <sup>b</sup> An estimated 90 percent of CalFresh enrollees are also enrolled in Medi-Cal. The share of individuals affected by the CalFresh work requirement that is also affected by the Medi-Cal work requirement is unknown, but likely significant. <sup>c</sup> CalFresh does not have separate exemptions for these specific conditions. However, these conditions may fall under an exemption for those medically certified as physically or mentally unfit for employment. <sup>d</sup> Separate exemption for receiving substance abuse treatment. <sup>e</sup> Includes those receiving postpartum care. <sup>f</sup> For an exemption in Medi-Cal, a county's unemployment rate must be at least 8 percent or 1.5 times the national unemployment rate. In CalFresh, a county's unemployment rate must be above 10 percent. ACA = Patient Protection Affordable Care Act and ABAWD = able-bodied adult without dependents.		

After accounting for potential exemptions, an estimated 3.5 million people are expected to become subject to the work requirement in Medi-Cal beginning in January 2027. After accounting for exemptions, an estimated 950,000 people are expected to become subject to the expanded CalFresh work requirement beginning in June 2026. An unknown, but likely significant, share of individuals subject to the CalFresh work requirement will also be subject to the Medi-Cal work requirement.

Expanded work requirements create the need for counties to determine which enrollees are subject to the requirement and which are exempt, track the participation status of nonexempt individuals, and take action on their enrollment in accordance with that status. Among individuals who do not receive an exemption, some will have a harder time complying with the requirements than others. For example, nonexempt individuals who were previously incarcerated may have barriers to employment, making them more likely to lose Medi-Cal and CalFresh due to the H.R. 1 changes.

**Assembly Hearings Examine Impact of H.R. 1 and Lift Up Possible Responses.** The Assembly has held four hearings so far focused on this subject before this joint hearing. Agendas and other materials prepared for these hearings detail additional changes in H.R. 1 impacting both Medi-Cal and CalFresh programs. Please see those agendas and other materials (links are included below) for more comprehensive background information for each program.

- The Assembly Budget Subcommittee No. 1 held hearings on February 23 and March 9, 2026 on this subject, the agendas for which can be found [here](#).
- The Assembly Budget Subcommittee No. 2 held a hearing on February 25, 2026 focused on the CalFresh impacts, the agenda for which can be found [here](#).
- The Assembly Budget Subcommittee No. 7 held a hearing on March 11, 2026 on ABAWD work rules and harm reduction options, the agenda for which can be found [here](#).

The following are the principal findings from these prior budget hearings:

**More Restrictive Eligibility Rules for Noncitizens.** H.R. 1 disqualifies certain noncitizen groups—including asylees, refugees, and others—from being eligible for federally funded, full-scope Medi-Cal and CalFresh assistance. This change will take effect in October 2026 in Medi-Cal. The change in CalFresh was effective upon enactment of H.R. 1 but, due to the timing of federal guidance and the need to implement system changes and train county staff, is set to be implemented in California starting April 1, 2026. An estimated 200,000 individuals are expected to lose Medi-Cal and an estimated 72,000 are expected to lose CalFresh assistance due to this change.

**More Frequent Eligibility Checks in Medi-Cal.** Medi-Cal enrollees are currently subject to annual eligibility redeterminations. Beginning January 2027, H.R. 1 requires that the state perform twice annual redeterminations for one group of Medi-Cal enrollees—those who gained coverage through the Patient Protection and Affordable Care Act (ACA) expansion in 2014,

commonly referred to as “childless adults.” (This is the same group to which H.R. 1 applies the new Medi-Cal work requirement.) Doubling the frequency of redeterminations for this group, which includes an estimated 4.9 million individuals 2025-26, increases county administration workload.

**Counties Report That They Are Not Prepared for HR 1 Implementation.** With the implementation deadlines for the new work requirements quickly approaching, counties do not have the resources to be ready on day one of the new requirements. Significant new resources are necessary to enable the new workload required of counties and to provide the careful review of individual cases to prevent inappropriate disenrollment for eligible people currently on Medi-Cal and CalFresh.

**Two Program Changes, Often Simultaneously Impacting One Person.** While at the State level, DSS (CalFresh) and DHCS (Medi-Cal) are working in parallel, but separately, to implement both new set of rules, for counties, these two programs are intermingled, and a significant number of individuals will need to comply with the work and other rules for both programs.

**State Has Some Information Technology (IT) Solutions for Exemptions, but Expect It To Work Only 60 Percent of the Time.** DHCS has developed an IT solution to automatically find exemptions for some individuals without additional paperwork. However, the department estimates that 40 percent of the population will need follow-up work completed by counties to maintain eligibility. There is a similar outlook for CalFresh, as the state identified 2.7 million adults who are age 18-64 receiving CalFresh, of whom 1.8 million are expected to be exempt, leaving 950,000 adults whose exemption status is unknown at this time and who may be subject to the time limit. Of this number, DSS estimates that 665,000 may lose CalFresh eligibility at full implementation.

**State Has Already Missed Key Timelines to Staff Up to Support Implementation of New Rules.** Counties expect to need at least three months to retrain their existing workforces to implement the new rules. In addition, the new rules will require additional staff to implement, and typically hiring and training a cohort of new workers takes nine months. Given these realities, the counties will not be ready on June 1, for CalFresh, and January 1, for Medi-Cal.

**More Work, Not Enough Staff.** Counties do not have the resources or direction needed to have their systems in place before H.R. 1 work rules take effect. For Medi-Cal, CWDA expects the need for \$270 million in additional state funds for 2,000 new eligibility workers to provide 3.5 hours per client to, in part, screen for exemptions. For CalFresh, they are requesting \$103 million for 400 new workers to devote an additional 2.6 to 2.9 hours per recipient.

**Funds In the Current Year Not Released by the Department of Finance.** The 2025-26 budget allows DSS to allocate \$20 million General Fund to counties to assist with H.R. 1 implementation; the administration has not yet approved this allocation for release. The lack of additional county staffing will make it difficult for counties to provide any additional casework or follow-up for complicated cases that require exemptions.

**Conclusion: Disenrollments Likely Much Higher than Projected and Vulnerable Populations Are Most at Risk.** The estimate that 1.4 million Californians will lose health care coverage and 665,000 will lose food assistance likely undercounts the actual disenrollments the state will see given the lack of early state investment.

**County Workload Requests to Mitigate Harm of H.R. 1.** The table on the next page displays the county workload ask for CalFresh and Medi-Cal sponsored by the County Welfare Directors Association of California (CWDA) and the Service Employees International Union (SEIU). CWDA/SEIU developed these estimates to be consistent with instructions already provided to counties for the CalFresh workload proposal and is utilizing the most updated information given federal and state guidance for its estimates for the Medi-Cal program.

County Workload HR 1 CalFresh & Medi-Cal Requests (in Millions)					
	2025-26	2026-27	2027-28	2028-29	2029-30
<b>CalFresh H.R. 1 ABAWD implementation</b>					
Total Funds	\$ 26.9	\$ 213.6	\$ 110.3	\$ 110.3	\$ 110.3
General Fund	\$ 9.3	\$ 102.8	\$ 57.9	\$ 57.9	\$ 57.9
<b>Medi-Cal H.R. 1 work requirements + redeterminations*</b>					
Total Funds	\$ -	\$ 923.6	\$ 1,218.7	\$ 703.7	\$ 456.3
General Fund	\$ -	\$ 230.9	\$ 304.7	\$ 175.9	\$ 114.1
<b>Medi-Cal County Admin COLA restoration</b>					
Total Funds	\$ -	\$ 78.5	\$ 78.5	\$ 78.5	\$ 78.5
General Fund	\$ -	\$ 39.2	\$ 39.2	\$ 39.2	\$ 39.2
<b>TOTAL REQUEST</b>					
Total Funds	\$ 26.9	\$ 1,215.7	\$ 1,407.5	\$ 892.6	\$ 645.1
General Fund	\$ 9.3	\$ 372.9	\$ 401.8	\$ 273.1	\$ 211.2

\*Assumes 75% enhanced federal fund match based on existing federal policy.

**Senior Poverty, Homelessness, and Death.** The most recent 2024 census data shows that older adults have the highest poverty rate for any age group in California, at 21 percent. This is higher than the national percentage, which is 15 percent. The rates of older adult poverty are also higher for older adults of color.

Federal changes impacting Medi-Cal, IHSS, and CalFresh are likely to create instability for low-income older adults, particularly for individuals who are extremely rent-burdened, living on fixed incomes, and already at the margins of housing stability. These older adults, in particular, are likely to be at greater risk of homelessness as core safety net programs are being cut.

Nationally, approximately 146,150 people age 55 and older were experiencing homelessness in 2024, about 20 percent of the total homeless population. Older adults are the fastest-growing age group among people experiencing homelessness, and projections indicate that the older adult homeless population in major cities could nearly triple by 2030. A University of California at San Francisco (UCSF) study focused on California found that nearly half (48 percent) of single homeless adults in California are age 50 and older, with 41 percent of this group experiencing homelessness for the first time after age 50, often due to onset of a health crisis, new disability,

or change in family composition such as death of a loved one. Further, older adults experiencing homelessness are disproportionately Black (31 percent), compared to their representation amongst all older adults in California (6 percent).

According to the Harvard Joint Center for Housing Studies (JCHS), housing instability among older renters is widespread. In 2021, 5.9 million renters age 62+ were eligible for rental assistance (including public housing, Housing Choice Vouchers, project-based Section 8 vouchers, and Section 202 Supportive Housing for the Elderly), yet only 36.5 percent of eligible households received rental assistance as these programs are not entitlements and are unable to keep up with need. Furthermore, JCHS indicated among very low-income older renters without assistance, “worst-case housing needs” increased to 2.3 million households, a 60 percent rise over the past decade.

Research further shows that while many older adults exit homelessness, housing instability remains acute: In the HOPE HOME longitudinal study in Oakland, roughly 80 percent regained housing in a longitudinal study, but about half returned to homelessness within 1.5 years without durable subsidies. Additionally, according to the United States Interagency Council on Homelessness, nearly 46 percent of older adults experiencing homelessness are unsheltered, which compounds health risks for these individuals and increases overall costs to the public safety-net system. According to UCSF, older adults in their 50s and 60s who experience homelessness have similar health outcomes as individuals 20 years older in the general population.

In addition, the Center for American Progress (CAP) recently released an [analysis](#) on possible deaths as a result of the SNAP reductions. The CAP estimates that 69,600 deaths could result from the work requirement expansions by 2040 as more people become subject to the changes when they recertify their eligibility. As more families have their food assistance cut or eliminated, they are likely to experience worsening health outcomes and increased mortality.

## Panel

### Questions for the Panel:

- ◇ How will the federal and state cuts to CalFresh and Medi-Cal impact California’s vulnerable seniors? How much will this further exacerbate the trends we’re seeing in senior poverty, hunger, and homelessness?
- ◇ Are there characteristics for older adults that will make them more susceptible to being discontinued from Medi-Cal or CalFresh under the new rules?
- ◇ Please provide examples of the types of Medi-Cal and CalFresh recipients who will lose food benefits and health care, what the consequences will be for them personally, and what consequences that will have on systems and communities.

- ◇ What can the state budget do to help mitigate the potential loss of food benefits and health care for California’s vulnerable seniors reliant on CalFresh and Medi-Cal in the coming months? How can we stop the “bleeding”?
- ◇ What is the state’s reaction to the county workload/eligibility requests? Can the state, on a technical assistance basis, validate these needs for more appropriate administrative capacity (e.g. more minutes per case for workers to aid recipients to retain eligibility) to implement these new changes and provide the human assistance needed?
- ◇ What are the primary goals of the Master Plan for Aging for these populations? Are the state changes we control in alignment with the Master Plan for Aging?

**Panel:**

- Jennifer Troia, Director, California Department of Social Services
- Michelle Baass, Director, and Yingjia Huang, Deputy Director, Health Care Benefits and Eligibility, Department of Health Care Services
- Susan DeMarois, Director, California Department of Aging
- Yasmin Peled, Director, California Government Affairs, Justice in Aging
- Andrew Cheyne, Managing Director, Government Relations & Public Affairs, County Welfare Directors Association of California (CWDA)
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Karina Hendren, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

The Subcommittee Chairs and Members will likely have a series of additional questions and separate requests related to this issue. The Subcommittees may consider requesting an analysis from the Administration (by a date certain) on what the projected program drop-off for Medi-Cal and CalFresh means for the senior community, and what human and system impacts will likely result in California.

**Staff Recommendation:** Hold open.

**Issue 2: Governor’s Proposal for Hours Cap and Cost Shift in the In-Home Supportive Services (IHSS) Program**

**Focus for the Subcommittees.** This second issue under the Joint Informational Hearing provides background on the In-Home Supportive Services (IHSS) program, which is a Medi-Cal service (i.e. to receive IHSS services, a person must first have a Medi-Cal eligibility determination). The Department of Social Services (DSS) administers the IHSS program, and its sister agency, the Department of Health Care Services (DHCS) administers the primary program, Medi-Cal. DHCS is also the single state agency for Medi-Cal for purposes of compliance and communication with the federal government, namely the Centers for Medicare and Medicaid Services, regarding Medi-Cal and IHSS. Thus, when the state received inquiries recently regarding the IHSS program, DHCS responded [in this letter](#) to explain and justify the current IHSS program.

**IHSS Cuts in Governor’s Budget.** The Subcommittees are hearing IHSS as a major safety net program in California and because the Governor’s 2026-27 Budget proposes three reductions to IHSS. All three proposals are being heard as part of the joint hearing given the overlap in subjects, concern for the senior and persons with disabilities community, and the joint administering departments. These Governor’s Budget proposals include:

- A proposal to remove the state’s share of cost associated with any growth in IHSS hours per case starting next year, which cuts \$233.6 million General Fund in 2027-28, growing to \$805 million in 2029-30.
- A proposal to align IHSS eligibility timelines with Medi-Cal, which is estimated cuts \$86 million in 2026-27 and ongoing.
- A proposal to eliminate the IHSS Permanent Back-Up Provider System (BUPS), which cuts \$3.5 million in 2026-27 and ongoing.

**Multi-Year Reductions Projected for These Proposed Cuts.** DSS recently provided the out-year impacts of these cut proposals, included in this table:

<b>IHSS Proposals – GF Savings (dollars in millions)</b>	<b>2026-27</b>	<b>2027-28</b>	<b>2028-29</b>	<b>2029-30</b>
IHSS Assessed Hours/Cost Shift	-	233.6	499.5	805.0
IHSS Auto-Termination	86.0	181.3	197.3	214.3
IHSS BUPS Elimination	3.5	3.7	3.9	4.1

**Background on the In-Home Supportive Services (IHSS) Program.** People are eligible for the state’s In-Home Supportive Services (IHSS) program as a result of their Medi-Cal status/enrollment, and if they meet additional requirements unique to the IHSS program. The IHSS program provides personal care and domestic services to low-income individuals to help them remain safely in their own homes and communities. To qualify for IHSS, a recipient must be aged, blind, or disabled, and be low income. In most cases recipients have income below the level necessary to qualify for the Supplemental Security Income/State Supplementary

Payment (SSI/SSP) cash assistance program: for example, about \$1,234 a month for an aged and/or disabled individual living independently in 2025-26.

IHSS effectively functions as an entitlement program as all individuals who meet these requirements are eligible to receive IHSS services. IHSS recipients generally are eligible to receive up to 283 hours (maximum, based on specific indicators/requirements) per month of assistance with tasks such as bathing, dressing, housework, and meal preparation. Social workers employed by county welfare departments conduct an in-home assessment of an individual's needs to determine the amount and type of service hours to be provided. In most cases, the recipient is responsible for hiring and supervising a paid IHSS provider. The average number of service hours that will be provided to an estimated 875,344 IHSS recipients is projected to be 127 hours per month in 2026-27 (up from 125.1 in 2025-26).

**IHSS Budget.** The Governor's 2026-27 budget proposes approximately \$12.5 billion General Fund for IHSS, an increase of \$1.1 billion (9.7 percent) from the Governor's revised 2025-26 budget estimate. This increase would bring total program funding to \$33.4 billion total funds in 2026-27 (an increase of \$3 billion, or 10 percent, compared to revised estimates for 2025-26). The primary drivers of this year-to-year General Fund cost increase include continued estimated growth in the three primary IHSS cost drivers—caseload (8 percent), cost per hour (2.3 percent), and hours per case (1.5 percent).

**IHSS Cost Sharing.** IHSS costs are shared by the federal government, state, and counties. Since IHSS primarily is delivered as a Medi-Cal benefit, the federal share of cost is determined by the Medicaid reimbursement rate, which typically is 50 percent. The state receives an enhanced federal reimbursement rate for many IHSS recipients who receive services as a result of the Patient Protection and Affordable Care Act expansion (90 percent federal reimbursement rate) and the Community First Choice Option waiver (56 percent federal reimbursement rate). Overall, the effective federal reimbursement rate for IHSS is about 54 percent. The remaining nonfederal share of IHSS costs is covered by the state and counties. Historically, counties paid 35 percent of the nonfederal share of IHSS service costs and 30 percent of the nonfederal share of IHSS administrative costs.

Beginning in 2012-13, however, the historical county share-of-cost model was replaced with an IHSS county maintenance-of-effort (MOE), meaning county costs reflect a set amount of nonfederal IHSS costs (that may be adjusted annually by a growth factor and a portion of locally negotiated wage increases) as opposed to a certain percent of nonfederal IHSS costs. The state is responsible for covering the remaining nonfederal share of costs not covered by the IHSS county MOE.

While the vast majority of IHSS recipients are eligible for Medi-Cal and receive IHSS as a Medi-Cal benefit, the state also operates the IHSS-Residual program, which provides services to individuals not eligible for federally funded Medi-Cal benefits, but who meet all other IHSS eligibility criteria. Beginning in 2016, the IHSS-Residual program was also expanded over time to include individuals who are not eligible for Medi-Cal due to their immigration status (enrollment in this population of noncitizens has since been frozen as a budget solution in 2025-26).

Because the Residual program does not receive federal financial participation, the Residual program is funded with state General Fund only.

**Governor’s Proposal on Hours Cap and Cost Shift**

The Governor’s Budget proposes to shift costs associated with growth in IHSS hours per case to counties, beginning in 2027-28, with associated trailer bill language. Current growth in the hours per case is something that is paid for by the state and federal government. Counties currently do not experience added costs (above the annual 4 percent growth in county costs built into the county MOE) when hours per case grow. Beginning July 1, 2027, the Governor proposes to shift nonfederal costs associated with any increase in average hours per case to the counties. The administration estimates that this proposal would save approximately \$233 million General Fund in 2027-28 and grow to over \$800 million General Fund savings in 2029-30.

The Administration states that the proposed statutory changes align fiscal responsibility to counties for the non-federal share of costs associated with any increases in average authorized hours per case for IHSS recipients and is intended to help ensure accurate assessments. The proposed statutory changes would take effect July 1, 2027. Currently, IHSS assessments are the responsibility of the counties. IHSS program social workers complete an assessment for individuals joining the program and reassess current recipients annually. During these assessments, social workers apply Functional Index (FI) rankings with a range from 1-6 and indicate the level of assistance needed to perform tasks safely. A higher FI ranking generally indicates a higher level of assistance needed to complete a task. After assigning a rank in each service category and taking into consideration individual needs, the social worker will authorize time within or outside the established Hourly Task Guidelines (HTGs), which standardize how hours are authorized for each service. The Administration states that over the last several years, the average authorized hours per case began to grow year over year while FI rankings have generally remained flat. The Administration states that this increase has been more significant since adjustments were made to the state and county cost-sharing ratio, which required the state to support a larger share of IHSS program costs.

DSS states that it has worked with counties to address the growth in hours per case by requiring all social workers, quality assurance staff, supervisors, and program managers to attend training on how to accurately assess and apply the FI rankings and HTGs based on existing program rules and regulations. Additionally, DSS utilizes Quality Assurance staff to monitor cases and identify instances where there are opportunities for more accurate application of the FI rankings and HTGs. The Administration has been clear that this proposal would have no impact on the current hourly task guidelines or FI ranking process. Moreover, it would not prohibit increases in hours assessed as necessary by social workers.

Notwithstanding the above, DSS provided the chart on the next page to support their assertions about FI scores and assessed hours. It is important to state that there is significant dispute about the drivers of assessed hours within a static FI score. Principally, counties, labor, and aging advocates assert that the assessed hours increase for conditions that require protective supervision for the maintenance of health and safety of an IHSS consumer (e.g. for an autistic

person who requires guidance and supervision or a person experiencing cognitive decline) can justify increases in hours to the maximum allowable under state law and may not have a corresponding effect on FI score. In other words, it is possible for hours to increase for clinical and behavioral conditions that do not increase the FI score in some commensurate form.

Statewide	Auth Cases	Difference Between FYs	Avg Auth Hrs Per Auth Cases	Difference Between FYs	Avg FI Score Per Case	Difference Between FYs
FY 04/05	339,768		85.5		2.7	
FY 05/06	357,479	5.2%	86.0	0.6%	2.7	0.4%
FY 06/07	376,135	5.2%	86.3	0.3%	2.8	1.0%
FY 07/08	401,157	6.7%	87.5	1.4%	2.8	1.2%
FY 08/09	429,839	7.1%	88.0	0.6%	2.8	0.4%
FY 09/10	441,939	2.8%	87.9	-0.1%	2.8	1.3%
FY 10/11	441,037	-0.2%	86.6	-1.6%	2.9	0.5%
FY 11/12	437,852	-0.7%	86.2	-0.4%	2.8	-0.3%
FY 12/13*	443,403	1.3%	87.4	1.3%	2.8	0.2%
FY 13/14**	466,479	5.2%	85.7	-1.9%	2.8	-1.3%
FY 14/15	494,584	6.0%	89.7	4.7%	2.8	-0.7%
FY 15/16	519,625	5.1%	97.8	9.0%	2.8	-0.1%
FY 16/17	546,444	5.2%	100.0	2.3%	2.8	-0.2%
FY 17/18	569,912	4.3%	102.4	2.4%	2.8	-0.4%
FY 18/19	593,655	4.2%	105.6	3.1%	2.9	4.7%
FY 19/20	617,278	4.0%	108.4	2.7%	2.9	-0.2%
FY 20/21	641,593	3.9%	111.5	2.8%	2.8	-3.3%
FY 21/22	666,357	3.9%	113.1	1.4%	2.8	0.0%
FY 22/23	700,518	5.1%	114.5	1.3%	2.8	-0.3%
FY 23/24	754,332	7.7%	116.0	1.3%	2.8	-0.3%
FY 24/25	829,286	9.9%	117.3	1.1%	2.8	-0.4%

\*In August 2012, data for Merced and Yolo counties, and in September, October, November, December 2012 and January 2013, data for Merced, San Diego and Yolo counties is unavailable due to being pilot counties for the CMIPS II system conversion. The totals for the months mentioned are averages of the month prior and after when the data was available.

\*\*Beginning July 1, 2013, there was a 4.4 percent decrease in services hours for IHSS recipients. This decrease was on top of a previous 3.6 percent decrease, totaling 8 percent. The 8 percent service hours cut was decreased to 7 percent in July 2014 and completely removed on July 1, 2016. These service hours cut reduced the amount of Protective Supervision hours due to the nature of this service, and the need for ongoing supervision. Also in 2013, Coordinated Care Initiative legislation replaced the county share of IHSS costs with a county Maintenance of Effort.

DSS states that it plans to work with counties to establish a baseline of statewide IHSS authorized hours per case. It is anticipated that the counties will pay 100 percent of the nonfederal share of cost for statewide IHSS authorized hours per case that exceed the baseline. It is anticipated that all counties will participate in the share of cost regardless of whether or not a specific county's average falls below the baseline.

Below is a chart provided by the Administration on the costs in IHSS over time, part of its justification and rationale for this proposal.

Amounts in Billions	FY 19/20	FY 20/21	FY 21/22	FY 22/23	FY 23/24	FY 24/25	FY25/26*	FY 26/27*
Federal (Reimb.)	\$7.73	\$9.27	\$10.37	\$11.87	\$12.74	\$14.59	\$16.67	\$18.50
State	\$4.30	\$4.37	\$5.06	\$6.10	\$7.99	\$9.87	\$11.44	\$12.54
County (MOE**)	\$1.59	\$1.70	\$1.78	\$1.85	\$2.02	\$2.20	\$2.29	\$2.38
Total***	\$13.62	\$15.34	\$17.20	\$19.83	\$22.75	\$26.66	\$30.40	\$33.43

\*Projected in 2026-27 Governor's Budget

\*\*Maintenance of Effort

\*\*\*Totals may not add up due to rounding

\*\*\*\*Expenditures are based on revised current year estimates at the corresponding May revision, except for 2025-26 and 2026-27.

**LAO Comments.** The LAO states that although the administration is clear that the concept of this proposal, at a high level, is to shift the cost of increases in the average hours per case from the state to the counties, the mechanics of how this would actually work remain unclear at this time. As mentioned, the Administration is not seeking changes in how hours are assessed or increased and has also been clear that this proposal would have no impact on the current MOE structure. All costs that are shifted from the General Fund to the counties in relation to this proposal would lie outside of the established MOE agreement that is currently in place.

The Administration has provided several rationales for this proposal. However, primarily they have made one key point—because counties control and perform IHSS assessments, giving them a direct fiscal responsibility for the growth in hours per case will incentivize counties to

ensure accurate assessments. As context for this proposal, the administration has noted that, since the establishment of the 2019 MOE, the state has been taking on an increasing share of nonfederal IHSS costs. This proposal would shift the cost of some of this growth back onto the counties.

The LAO outlines additional areas for consideration, including background on IHSS cost growth, historical program changes, and caseload trends in their [recent analysis](#).

## Panel

### Questions for the Panel:

- ◇ What is the proposal and what problem is it trying to solve for? There is confusion about (a) it being a cost-shift to the counties, with or without capacity for counties to pay the shifted costs, (b) that it is in reaction to undue increases in hours that does not align to FI scores, and (c) that it is meant to suppress hours systemwide to contain costs.
- ◇ What will be the impact of the proposal if the counties cannot pay the amount being shifted to them (expressed as General Fund savings in the Governor's Budget)?
- ◇ What are the risks of harm for IHSS recipients under the proposal if the counties cannot pay? What are the risks for providers and for collective bargaining?
- ◇ How would the proposal potentially change the IHSS program across the state, and if it infringes on access to this care, where will the state see costs and consequences elsewhere in the system (e.g. for emergency rooms and skilled nursing facilities)?
- ◇ What are the reasons why assessed hours would increase while the Functional Index (FI) score remains the same?
- ◇ How is the proposal compatible, or not, with the Governor's February 17, 2026, response to the Centers for Medicaid and Medicare Services and the Master Plan for Aging?
- ◇ Is the proposal at its core a cost containment proposal, and if so, what does it mean for the direction of Home and Community-Based Services in California, the Master Plan for Aging, and the Master Plan for Developmental Services?

### Panel:

- Claire Ramsey, Chief Deputy Director, and Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Carlos Marquez III, Executive Director, County Welfare Directors Association of California
- Justin Garrett, Senior Legislative Advocate, California State Association of Counties (CSAC)

- Tiffany Whiten, Senior Government Relations Advocate, Service Employees International Union (SEIU) California
- Kristina Bas Hamilton, Senior Director of External Affairs, United Domestic Workers (UDW) - AFSCME Local 3930
- Hagar Dickman, Director, California Long-Term Services and Supports Advocacy, Justice in Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

Stakeholders have shared significant concerns about this proposal, across the aspects of the rationale, including assessed hours increases, IHSS caseload growth, significant funding deficiencies currently in IHSS administration, and extremely high caseloads for social workers today. Given that this proposal would not go into effect until 2027-28, and with these significant factual disputes about the historical trends and the current situation, the Subcommittees may wish to request that the Administration begin a series of workgroup meetings with stakeholders and legislative staff to talk through the future of IHSS. This workgroup could foster dialogue about the other cut proposals on the table for IHSS (Issues 3 and 4), as well as consideration of the related stakeholder proposals (Issue 5) and options/alternatives for all of these subjects in IHSS.

**Staff Recommendation:** Hold open.

**Issue 3: Governor’s Proposal for Auto-Termination and Loss of Residual Coverage for Over 10,000 IHSS Consumers**

**Governor Proposes to Automate Termination of IHSS Concurrent with Medi-Cal.** The Governor’s Budget proposes to automate the IHSS termination process for individuals who are terminated from Medi-Cal, starting in 2026-27. This would mean that recipients who are terminated from Medi-Cal due to Medi-Cal noncompliance (resulting from an issue with their Medi-Cal redetermination) will be automatically terminated from IHSS and not be enrolled in the IHSS-Residual program. As a result, some recipients who may have been enrolled into the IHSS-Residual program—allowing them to continue to receive IHSS services through this state funded program—would no longer receive IHSS services once terminated from Medi-Cal. This proposal would mean that all recipients who are terminated from Medi-Cal due to noncompliance would be treated the same (all terminated from IHSS) regardless of the county in which they reside. This proposal is not intended to impact recipients who utilize the IHSS-Residual program due to their immigration status.

The Administration states that its projected number of individuals who would lose IHSS services in the Residual program due to this proposal is 10,396 cases in 2026-27. The Administration is assuming that all of these people regain federal eligibility and re-establish their Medi-Cal and regular IHSS services. The Administration does not provide new resources for this re-establishment.

The General Fund savings amounts due to this cut are shown in the table below. The increasing dollar amounts indicate that the impacted number of people will increase over time, more than doubling in the second year. Typically, Medi-Cal recipients fail successful redetermination due to a paperwork error. Valid reasons to lose Medi-Cal during a redetermination include a change in income/assets, movement to another state, or death.

<b>IHSS Proposal - GF Savings (dollars in millions)</b>	<b>2026-27</b>	<b>2027-28</b>	<b>2028-29</b>	<b>2029-30</b>
IHSS Auto-Termination	86.0	181.3	197.3	214.3

As noted under Issue 2, the vast majority of IHSS recipients are eligible for Medi-Cal and receive IHSS as a Medi-Cal benefit, allowing the state to draw down federal funds to offset state IHSS costs. However, the state also operates the IHSS-Residual program, which provides services to individuals not eligible for federally funded Medi-Cal benefits, but who meet all other Medi-Cal and IHSS eligibility criteria. Costs for the IHSS-Residual program are fully covered by the state. Currently, the vast majority of those who enter the IHSS-Residual program are either (1) individuals who are not eligible for Medi-Cal due to their immigration status or (2) recipients who were terminated from Medi-Cal due to noncompliance (for example, failing to submit Medi-Cal re-determination paperwork or errors in the paperwork on the part of the county or the recipient).

The consequences for IHSS recipients terminated from Medi-Cal due to Medi-Cal noncompliance currently varies. In some counties, these recipients may also be terminated from IHSS because IHSS is a benefit of Medi-Cal. In other counties, these individuals may fall into the IHSS-Residual program as a sort of “safety net” until they get their Medi-Cal reestablished.

Whether a recipient is manually terminated from IHSS or is enrolled in the IHSS-Residual program is entirely dependent on the practices in the county they reside in.

If a recipient terminated from Medi-Cal is not manually terminated from IHSS the recipient is automatically enrolled into the IHSS-Residual program until the county worker updates the case. This means that a recipient's provider continues to receive service payments in real time. As a consequence, the state General Fund is responsible for covering all costs and cannot draw down federal funds until the recipient is reenrolled into Medi-Cal. Currently, there is no statutory limit to how long an IHSS recipient may remain in the IHSS-Residual program. Additionally, the state cannot retroactively draw down federal funds for payments made through the IHSS-Residual program during the recipient's gap in Medi-Cal eligibility.

If an IHSS recipient terminated from Medi-Cal is manually terminated from IHSS, the recipient needs to reinstate their Medi-Cal eligibility to receive paid services through the IHSS program again. As a result, if a recipient's provider continues to provide care, they will not receive payments for services until the recipient reinstates their Medi-Cal eligibility. Once the recipient reinstates their Medi-Cal eligibility, they are eligible to return to regular IHSS. Additionally, if Medi-Cal eligibility is re-instated within 90 days of termination, the state can retroactively draw down federal funds and pay IHSS providers for services provided during the gap in IHSS and Medi-Cal eligibility.

Under current statute, individuals eligible for federally funded Medi-Cal benefits are ineligible for the IHSS-Residual program. Only individuals not eligible for federally funded Medi-Cal benefits are eligible to receive services through the IHSS-Residual program. The Administration's interpretation of statute is that individuals who were once eligible for federally funded Medi-Cal benefits, but were terminated from Medi-Cal due to noncompliance, are ineligible for the IHSS-Residual program. Therefore, the Administration is not seeking trailer bill language associated with this proposal.

**LAO Comments.** *Implementing This Proposal at the Same Time as Upcoming Federal Changes May Present Additional Challenges.* Currently, Medi-Cal generally renews eligibility for beneficiaries every 12 months. However, beginning in January 2027, as a part of the new federal requirements of H.R. 1, the state will be required to renew eligibility every six months for recipients within the Medicaid expansion population under the Patient Protection and Affordable Care Act (ACA)—generally childless adults. The increased frequency of redeterminations will increase the risk these IHSS recipients lose Medi-Cal coverage. Under the Governor's proposal, these individuals would also be automatically terminated from IHSS. The Governor's budget estimates the IHSS ACA population to consist of roughly 42,000 average monthly cases in 2025-26.

*Governor's Budget Assumes All Terminated Cases Would Reinstate Medi-Cal and IHSS Eligibility.* Under the administration's proposal, recipients would be automatically reenrolled into IHSS if they reinstate their Medi-Cal eligibility within 90 days. (Recipients would be manually reinstated into IHSS if they reinstate their Medi-Cal eligibility after 90 days.) The Governor's budget assumes all recipients would be reinstated into Medi-Cal and IHSS within 90 days of termination and assumes all recipients would continue to receive services during the gap in

eligibility and providers would be retroactively reimbursed once the recipient is reenrolled into Medi-Cal and IHSS. As such, rather than the state paying for all service costs through the IHSS-Residual program, the administration estimates the state would be able to draw down federal funds to cover a portion of these service costs. As a result, the Governor's budget includes \$86 million net General Fund savings in 2026-27 and ongoing.

*Alternatives to Governor's Proposal.* This proposal has been before the Legislature (and rejected) a number of times over the years. As such, the Legislature may wish to consider the alternatives to the Governor's proposal as well as options that could mitigate the impacts of the proposal, were it adopted. It should be noted, however, that most of these alternatives would not save as much as the Governor's proposed change (and may, in some cases, result in up-front costs).

- Better Communication to Recipients. Currently, when IHSS recipients receive Medi-Cal re-determination materials or a notice of Medi-Cal termination, it may not be fully understood that losing Medi-Cal eligibility would also mean potentially losing IHSS services. As such, providing a clear written warning that any loss of Medi-Cal eligibility could result in a loss of IHSS services may decrease the number of IHSS recipients losing Medi-Cal eligibility due to noncompliance.
- Provide Administrative Funding to Prevent Medi-Cal Disenrollments. By providing county administrative staff with additional resources, counties may be better positioned to assist and provide outreach to IHSS recipients at risk of losing Medi-Cal eligibility. This could prevent IHSS recipients from losing Medi-Cal eligibility due to noncompliance. Or, if an IHSS recipient has been terminated from Medi-Cal, increased resources could allow county administrators to better assist recipients in re-enrolling into Medi-Cal on a timely basis—increasing the chances of retroactive payment and federal funding participation.
- Exclude Certain Populations from Automatic Termination. Certain IHSS recipients—for example, those with a high level of authorized hours—may have greater difficulty completing the administrative tasks required to remain in compliance with Medi-Cal. Excluding this population from the Governor's proposal may avoid adding undue hardship on those who require IHSS services the most and who would also likely have the greatest difficulty re-enrolling into Medi-Cal should they be terminated.
- Allow for a Standardized Grace Period. Currently, when an individual is terminated from Medi-Cal for noncompliance, they may be manually terminated from IHSS immediately, enrolled in IHSS-Residual for a period of time before being terminated from IHSS, or allowed to remain in the IHSS-Residual program indefinitely. An alternative to automatically terminating all IHSS recipients when they lose Medi-Cal eligibility (as proposed by the Governor) could be to allow all recipients who are terminated from Medi-Cal for noncompliance to enroll in IHSS-Residual for a certain period of time (for example six months) before being terminated from IHSS. This would allow recipients extra time to re-enroll into Medi-Cal before being terminated from IHSS. However, this alternative would result in less savings than the Governor's proposal, and could possibly result in no savings or additional costs compared to the status quo. This is because some

counties currently terminate IHSS recipients immediately and requiring those counties to allow recipients to remain in the IHSS-Residual program for longer than they otherwise would have would result in those cases costing more than is the case today.

The LAO's [recent analysis](#) on IHSS includes additional background, comments, and questions for the Legislature on this subject.

**Panel**

**Questions for the Panel:**

- ◇ This proposal has been rejected twice before by the Legislature because of concerns for the IHSS recipients who will lose services due to the auto-termination, when today they would continue to receive care. Why is this being proposed for a third time?
- ◇ How many IHSS recipients will lose IHSS services as result of this proposal in 2026-27 and in the out-years? What are the risks of harm for IHSS recipients under the proposal?
- ◇ Why might an IHSS recipient be discontinued from Medi-Cal? What percentage of these discontinuances are in error, with the case later cured? What are the typical reasons for disenrollment and what is the process to re-enroll?
- ◇ Does this Medi-Cal enrollment churn pose unique challenges for people who are older, suffering from disabilities, and potentially experiencing cognitive decline?
- ◇ What are some optional approaches to assure that more IHSS recipients retain their Medi-Cal coverage and to facilitate their successful completion of the Medi-Cal redetermination process?
- ◇ How is the proposal compatible, or not, with the Governor's February 17, 2026, response to the Centers for Medicaid and Medicare Services and the Master Plan for Aging?

**Panel:**

- Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Anna Leach-Proffer, Managing Attorney, Healthcare/Home and Community Based Services (HCBS), Disability Rights California
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

**Issue 4: Governor’s Proposal to Eliminate the IHSS Back-Up Provider System (BUPS)**

**Governor’s Budget Proposes to Eliminate State Back-Up Provider System.** The Governor’s budget proposes to eliminate the IHSS Back-Up Provider System (BUPS), resulting in an estimated \$3.5 million General Fund savings in fiscal year 2026-27 and ongoing.

<b>IHSS Proposal - GF Savings (dollars in millions)</b>	<b>2026-27</b>	<b>2027-28</b>	<b>2028-29</b>	<b>2029-30</b>
IHSS BUPS Elimination	3.5	3.7	3.9	4.1

The 2021-22 budget included \$5 million General Fund to create a permanent IHSS back-up provider system on January 1, 2022, contingent on a policy framework being adopted in statute. However, a policy framework for the BUPS program was not adopted within the 2021-22 budget period, resulting in the initial \$5 million allocation going unspent. The 2022-23 budget codified a policy framework for BUPS. Under BUPS, a recipient whose regular provider is not available, but who has an urgent need or whose health and safety will be at risk without a back-up provider, can receive up to 80 hours (if the recipient is non-severely impaired) or 160 hours (if the recipient is severely impaired) of back-up provider services per fiscal year. Additionally, back-up providers are paid \$2 above the local IHSS hourly wage rate.

Prior to the establishment of the statewide BUPS program, multiple counties had established their own local back-up provider programs, some of which continued to run alongside the statewide system. For example, the Los Angeles County Public Authority has and continues to run the Back-Up Attendant Program (BUAP) alongside the statewide BUPS program. While similar to BUPS, BUAP requires a recipient to have a minimum of 25 hours per week (BUPS has no minimum hour requirement), requires providers to have additional experience or certification compared to BUPS, and pays \$3 above the local wage (BUPS pays \$2 above the local wage).

**LAO Comments.** *Utilization of Back-Up Provider System Has Fallen Below Expectations Since Inception.* As seen in the figure below, the 2023-24 Budget Act appropriated a total of approximately \$18.4 million General Fund (\$15.7 million for services, \$2.7 million for administration) for BUPS. From October 2022 through June 2024 (the most recent month of available expenditures), less than \$900,000 total funds had been spent on Back-Up Provider services. Because utilization in 2023-24 was lower than expected, the 2024-25 Budget Act appropriation was reduced to approximately \$8.6 million General Fund (\$5.6 million for services, \$3 million for administration). However, the Governor’s 2026-27 budget includes updated estimates that BUPS will cost \$4.5 million General Fund in 2025-26. Most of the funding in 2025-26 is estimated to go towards administering the program (\$4.2 million) rather than the services themselves (\$298,000). The decreasing service costs reflect updated utilization estimates; however, the LAO is continuing to explore the reasons why estimated administrative costs for the program remain elevated relative to estimated service costs.

## Back-up Provider System Allocations Overtime

(In Millions)

	Services	Administration	Total
2023-24 <sup>a</sup>	\$15.7	\$2.7	\$18.4
2024-25 <sup>b</sup>	5.6	3.0	8.6
2025-26 <sup>c</sup>	0.3	4.2	4.5

<sup>a</sup>2023-24 Budget Act appropriation.  
<sup>b</sup>2024-25 Budget Act appropriation.  
<sup>c</sup>Estimate at 2026-27 Governor's Budget.

DSS recently provided the following chart on the utilization of the BUPS.

### In-Home Supportive services (IHSS)

Back-Up Provider System (BUPS)

Services	IHSS Monthly Avg Paid Caseload	Avg/Monthly Paid Backup Providers (BUPS)	Avg/Monthly Paid Hours (BUPS)	Total Service Expenditures (BUPS)	BUPS Revised Budget <sup>c</sup>	BUPS Utilization Rate
Avg Monthly FY 2022-23 <sup>A</sup>	619,277	45	1,404	\$ 250,307	\$ 34,343,000	1%
Avg Monthly FY 2023-24	663,930	93	2,407	\$ 565,329	\$ 18,395,000	3%
Avg Monthly FY 2024-25	732,270	116	2,535	\$ 641,061	\$ 955,000	67%
Avg Monthly July 2025 - Dec 2025 <sup>B</sup>	786,519	124	2,342	\$ 295,193	\$ 678,000	44%

**Notes**

A) FY 2022–23 BUPS data reflects Oct 2022 - June 2023

B) FY 2025–26 caseload and hourly data reflect activity from July 2025 through December 2025.

C) Total funding reflects state General Fund and federal reimbursements included in prior May Revisions for FY 2022-23, FY 2023-24, FY 2024-25, and 2026-27 Governor's Budget for FY 2025-26.

D) Includes federal reimbursement and state General Fund expenditures.

**Key Questions for Legislative Consideration.** Given the current budget challenges, and the notable low utilization of the program, the Legislature may wish to consider the trade-offs associated with this proposal. In doing so, the Legislature could ask the administration the following questions:

- What have been the main challenges that have led to the lower-than-initially-expected utilization of the program?
- Is lower-than-expected utilization due to challenges in finding available providers? Does the administration have information on how often a back-up provider is requested but not provided?
- Are there ways to reduce the administrative costs? Could a more centralized model be considered?
- Are there opportunities for the state to better support local county back-up programs?
- Last year, the administration indicated it was going to work to educate and inform more recipients of the program. Did that effort ever occur?

**Panel**

**Questions for the Panel:**

- ◇ What is the proposal and what is the justification for the elimination of the IHSS Back-Up Provider system?
- ◇ What will be lost under the proposal and what are the risks of harm for IHSS recipients?
- ◇ How many cases and what percentage of the IHSS caseload have protective supervision? What does this mean if a provider is unavailable for a consumer who requires protective supervision for medical and/or behavioral needs?
- ◇ What are the alternatives for an IHSS consumer who is unable to access their provider and cannot go without services for day or multiple days, putting their health and safety in danger?
- ◇ Could the public authority registries be equipped to operate like a back-up provider system, with partial savings compared to the Governor’s elimination proposal?
- ◇ How is the proposal compatible, or not, with the Governor’s February 17, 2026, response to the Centers for Medicaid and Medicare Services and the Master Plan for Aging?

**Panel:**

- Leora Filosena, Deputy Director, California Department of Social Services
- Michelle Baass, Director, Department of Health Care Services
- Kim Rothschild, Executive Director, California Association of Public Authorities (CAPA) for IHSS
- Willie Grays, IHSS Consumer, Stanislaus County
- Beth M. Gray, Vice-Chair, Marin County IHSS Public Authority Board of Directors
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

## 5180 Department of Social Services (DSS)

### Issue 5: Community First Choice Options (CFCO) Penalties

Community First Choice Option (CFCO) is a federal program within IHSS that is aimed at serving those with the highest needs for assistance in their homes. The IHSS cases eligible for the CFCO program receive the regular base Federal Medical Assistance Percentage (FMAP) of 50 percent, plus an additional enhanced FMAP of 6 percent (for a total FMAP of 56 percent). However, if counties do not conduct timely, federally required reassessments of CFCO recipients, those particular cases are no longer eligible to receive the additional 6 percent FMAP. The cost of this lost 6 percent FMAP must then be reimbursed to the federal government. Since 2017, the cost of this lost 6 percent FMAP (also referred to as the CFCO late penalty) has been paid for with the General Fund and has grown over time—totaling \$63.2 million in 2023-24.

The 2025-26 Budget Act shifted half of the cost of the CFCO late penalty to counties in 2025-26 (estimated in Governor’s budget to save \$40.5 million General Fund) and the full cost of the CFCO late penalty beginning in 2026-27 and ongoing. The Governor’s budget estimates the savings to be \$92 million General Fund in 2026-27. However, if counties comply with the CFCO reassessment requirements, they will not incur a penalty and will therefore not have additional costs.

**Timely CFCO Reassessments May Come at the Expense of Other County Workload Priorities.** Counties have communicated that the number of CFCO cases in noncompliance has decreased since the enactment of this policy, and as such, the cost to the counties, as a result of this policy, may be lower than the Governor’s budget estimates. Counties additionally report that that prioritizing the CFCO cases due to the penalty cost shift has had an adverse impact on other IHSS reassessments, workload, and timeliness. Counties state that as a result of counties shifting workload to prioritize the reassessment of CFCO cases, the number of applications that take over 90 days to be processed has grown from 1,600 to 4,600 in the first six months of the CFCO penalty policy being in effect.

**County Budget and Trailer Bill Language (TBL) Requests for CFCO Penalties.** The County Welfare Directors Association (CWDA) urges a maintenance of the 50/50 cost-sharing between the state and the counties for IHSS CFCO penalties. To maintain the 50/50 cost split, CWDA estimates the total General Fund impact to be approximately \$16 million in 2026-27 (as opposed to a cost of \$92.1 million) as counties have worked diligently to improve timely reassessments of CFCO cases. While this is significantly less than the Administration’s projected costs, this improvement comes at the expense of other IHSS applicants and recipients, due to the severe and chronic underfunding of IHSS social workers, who are the gateway to these services.

	2025-26	2026-27	2027-28	2028-29	2029-30
<b>Maintain IHSS CFCO penalties 50/50*</b>	\$ -	\$ 16.00	\$ 16.00	\$ 16.00	\$ 16.00

\*Cost is estimated to be no greater than \$16 million General Fund in FY 2026-27 based on actual invoices incurred in FY 2025-26 thus far. Out years may fluctuate based on caseload.

The following chart was recently provided by DSS on the trends of late reassessments, noting that a case is counted every month as long as it remains overdue.

<b>State Fiscal Year</b>	<b>Overdue Reassessments</b>	<b>Gross Amount Paid</b>	<b>CMS Reimbursement (Loss of 6% FFP)</b>
2017-2018 (October 2017 to June 2018)	132,700	\$263,161,162.63	\$15,789,669.76
2018-2019	214,021	\$447,879,768.76	\$26,872,786.13
2019-2020	244,357	\$560,875,553.67	\$33,652,533.22
2020-2021	248,188	\$480,355,127.94	\$28,821,307.68
2021-2022	247,946	\$522,830,331.31	\$31,369,819.88
2022-2023	266,323	\$794,461,813.23	\$47,667,708.79
2023-2024	335,668	\$1,053,634,149.82	\$63,218,048.99
2024-2025	362,237	\$1,182,401,062.12	\$70,944,063.73
2025-2026 (July 2025 to January 2026)	95,292	\$312,848,104.72	\$18,770,886.28

CWDA states that this approach would improve access to care for IHSS recipients and applicants, reduce overwhelming social worker workload, and more appropriately reflect the shared responsibility of the state and counties in supporting the administration of the IHSS program. The TBL request from CWDA proposes to (1) maintain the current 50/50 cost-sharing arrangement, (2) make county penalty payments contingent on DSS providing specific information to counties to allow for county-level financial reconciliation and documentation, (3) exempt cases that move counties or return from leave from penalty calculations for 30 days after notifying the county of the status change, and (4) exempt cases that move counties or return from leave from penalty calculations for 30 days after notifying the county of the status change.

**Panel**

**Questions for the Panel:**

- ◇ What have been the impacts of the 50/50 penalty split between the state and counties in the current year?
- ◇ How have late assessments for CFCO cases changed in the current year and what are the estimated penalties for 2026-27 (or budget year) as a result?
- ◇ What are the expected consequences of moving to 100% counties’ payment for the penalties in 2026-27 and ongoing, based on experiences this year?
- ◇ What are the expected consequences of maintaining the 50/50 penalty split for the budget year?
- ◇ What are the average social worker caseloads statewide and what should they be ideally?

- ◇ What are the requirements for assessments and reassessments and where are we across the counties, on average?
- ◇ What is the empirical assessment of the county administrative shortfall in IHSS for the current year and for budget year? In other words, what is the county workload deficit currently?

**Panel:**

- Leora Filosena, Deputy Director, California Department of Social Services
- Emily Nicholl, IHSS Program Manager, Monterey County
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

**Issue 6: Governor’s Trailer Bill (TBL) Proposal for IHSS For-Profit Organization Policy/Rules**

The Governor’s Budget includes a trailer bill language (TBL) proposal for statutory changes to add guardrails related to for-profit organizations that represent In-Home Supportive Services (IHSS) applicants and recipients. The proposed statutory changes define rules for for-profit organizations including establishing a maximum fee that IHSS recipients and applicants are charged, permitting the state to suspend and penalize for-profit organizations for malpractice, and affirms existing authority for the Department of Health Care Services (DHCS) to investigate their conduct(s), as specified in existing statute.

IHSS applicants and recipients have the right to request an administrative hearing if they disagree with an adverse action, including a denial, a termination, or a reduction in hours, and to representation by an advocate or an attorney during the appeal and hearing process. IHSS recipients are also able to assign an individual, which could include an advocate or an attorney, to be their Authorized Representative for the purpose of acting on the behalf of the IHSS recipient to assist in the management of program services.

The Department of Social Services (DSS) understands that both non-profit and for-profit non-attorney advocates can represent IHSS applicants and recipients. However, many for-profit organizations are charging IHSS applicants and recipients upwards of \$10,000 - \$20,000, sometimes more, to represent them. Unlike licensed attorneys, these for-profit advocates do not have any guardrails or rules ensuring their ethical behavior and there are no legal protections for IHSS applicants and beneficiaries when it comes to the services provided.

The proposed statutory changes help ensure IHSS applicants and recipients are protected when they decide to hire a for-profit advocate to represent them throughout the IHSS administrative appeal processes, including an IHSS administrative hearing, or to assist in managing program services. The proposal mirrors similar federal rules that were implemented by the Social Security Administration for Supplemental Security Income and establishes rules to mitigate any unethical and fraudulent activities.

The proposed rules will not impact non-profit legal advocates and will help make sure IHSS applicants and beneficiaries are protected.

There are no budget change proposals or local assistance fiscal impacts associated with this proposal. DSS states that this proposal results in potential cost avoidance from reduced administrative costs for both counties and DSS.

**Panel**

**Questions for the Panel:**

- ◇ Please explain this trailer bill proposal. What is it seeking to accomplish and what is the background that led to this proposal?

- ◇ How aligned (or not) is this proposal with the federal rules that were implemented by the Social Security Administration for Supplemental Security Income to mitigate unethical and fraudulent activities?
- ◇ How will the department determine if this policy, if enacted, is effective in regulating for-profit organizations that represent IHSS applicants and recipients?
- ◇ What stakeholder engagement has the Administration engaged in and does the department have a support/opposition list to share for this language?
- ◇ What consultation has the Administration done with legislative colleagues in policy areas like public safety, judiciary, and business and professions, who may also have interest in this subject?
- ◇ What is the budget nexus for this trailer bill proposal? What has been the cost of not having a policy like this in place for the state?

**Panel:**

- Leora Filosena, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

The Subcommittee could request written responses to the questions raised around (1) the alignment of these proposed guardrails with federal rules for other programs, (2) a support and opposition list for the proposed TBL, and (3) the results of consultations with other issue cohorts in both houses of the Legislature who have natural jurisdictional interest in this policy proposal.

**Staff Recommendation:** Hold open.

**Issue 7: Home Safe Program and Proposal to Clarify Home Safe Eligibility**

Home Safe, which was established in 2018 and has no ongoing funding, has received multiple rounds of one-time funding, most recently in 2021-22, 2022-23, and 2025-26. Home Safe provides housing assistance and supports to adults in the Adult Protective Services (APS) program. Funding from 2021-22 was available through December 2025, and funding from 2022-23 remains available through June 30, 2026. In 2024-25, 15 counties had exhausted available funds and/or closed programs while 35 reduced operations or planned program closures. The Budget Act of 2025 (Chapter 5, Statutes of 2025, Assembly Bill 102) appropriated \$83.8 million in new one-time funding, available through June 30, 2028.

The additional 2025-26 funding supports the continuation and reopening of programs in impacted jurisdictions. Upon enactment of the Budget Act of 2025 (Chapter 5, Statutes of 2025, Assembly Bill 102), CDSS immediately notified counties of the availability of the new Home Safe funding and encouraged them to continue or resume program operations. Following release of the 2025-26 allocations, 56 counties accepted Home Safe funding (non-participating counties are Sierra and Yuba).

DSS recently provided the following chart, showing the expected quarter when the current allocations are expected to be exhausted for Home Safe.

Home Safe								
<i>This projection demonstrates the pace that which counties will be able to spend down all FY25/26 funding, inclusive of available funding from prior one-time tranches and newly appropriated one-time funds. FY 2025-26 Q2-Q4 projection is based on the percent increase from FY 2023-24 since FY 2024-25 spending patterns were impacted / constrained due to exhaustion of available funds. If the same projection is applied to outyears, available funding is expected to be exhausted by Q2 of FY 2027-28. Highlighted spending / quarter indicates the quarter when funds are exhausted and spending could be constrained based on available funding.</i>								
Fiscal Year	Available Funding	Q1	Q2	Q3	Q4	Total Expenditures	Unspent	
FY 2025-26 <sup>1</sup>	\$ 92,691,268	\$ 3,833,884	\$ 7,002,986	\$ 6,558,365	\$ 12,593,986	\$ 29,989,222	\$ 66,535,931	
FY 2026-27	\$ 66,535,931	\$ 7,472,164	\$ 13,648,682	\$ 12,782,123	\$ 24,545,430	\$ 58,448,399	\$ 8,087,532	
FY 2027-28	\$ 8,087,532	\$ 7,472,164	\$ 615,368	\$ -	\$ -	\$ 8,087,532	\$ -	
FY 2028-29	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
FY 2029-30	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	

1. Quarter 1 in FY 2025-26 reflect actual expenditures.

**Role of Home Safe and APS for Housing Unstable and Homeless Seniors.** California faces an escalating crisis at the intersection of two urgent challenges: a quickly growing aging population and the nation's largest homeless population, with approximately 187,000 unhoused individuals, which account for nearly a quarter of all unhoused Americans. Importantly, the demographic composition of this population has shifted dramatically. In recent decades, the proportion of single homeless adults in Californian aged 50 or older has grown from 11 percent in 1990 to nearly 50 percent today. Research from the University of California at San Francisco (UCSF) projects the share aged 65 and older to triple between 2017 and 2030. Economic pressures seem to be accelerating this trend as roughly 6 in 10 older California renter households are rent-burdened, adults without dependent children are ineligible for many cash assistance programs, and homelessness itself frequently results from financial exploitation, abuse, and abandonment that APS is designed to address. The health consequences of being unhoused can be severe and tragic. We know that people 55 and older account for more than

three-quarters of California's hypothermia deaths, and 38 percent of older homeless adults who sought shelter were unable to access it.

**Proposal to Clarify Home Safe Eligibility.** Under current law, the state's primary protective mechanism for vulnerable older adults, APS, is not explicitly required to serve elders who are homeless or at imminent risk of homelessness unless a distinct abuse allegation has also been made. This gap produces a patchwork of county responses, leaving the most vulnerable without a reliable safety net. This proposal would amend the APS mandate and expand the Home Safe Program to explicitly cover homeless older adults and those at imminent risk of homelessness, ensuring that counties are required to provide protective services regardless of whether a formal abuse allegation exists. As APS agencies already receive over 15,000 reports of elder abuse monthly, with an estimated 24 unreported cases for every known one, this targeted, cost-effective expansion is both a moral imperative and a necessary step to stabilizing California's most at-risk aging residents.

### Panel

#### Questions for the Panel:

- ◇ How many counties currently extend APS services to homeless older adults in the absence of a documented abuse allegation, and does the state track that data consistently across counties?
- ◇ Can the Administration provide a full cost estimate for what a proposed full expansion of the APS mandate would cost? Also, have any organizations modeled what a statewide Home Safe expansion would require in terms of staffing and funding?
- ◇ UCSF projects the population of homeless Californians aged 65 and older will triple (from 2017 PITs) by 2030, is the Commission on Aging's long-term planning for aging services accounting for that scale of growth?
- ◇ Have we identified best practices from other states that have expanded APS authority to cover homeless older adults that California should consider modeling?
- ◇ What level of funding is needed for 2026-27 to "hold the line" on current services and supports being offered through Home Safe today?

#### Panel:

- Hanna Azemati, Deputy Director, California Department of Social Services
- Karol Schwartzlander, Executive Director, California Commission on Aging (CCoA)
- Feliza Gray, Deputy Director, Adults and Aging Services, Merced County Human Services Agency
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

This issue is a priority for Chair Jackson. The Chair’s office will be in contact with the Department of Social Services and the Department of Finance to further discuss this and garner estimates on funding that may be necessary to advance the cause of amending the APS mandate and expand the Home Safe Program to cover homeless elderly adults and those at imminent risk of homelessness.

**Staff Recommendation:** Hold open.

**Issue 8: Housing Disability Advocacy Program (HDAP) and Supplemental Security Income/State Supplementary Payment (SSI/SSP) Program**

The Housing and Disability Advocacy Program (HDAP), which was established in 2018, received significant one-time funding augmentations in 2021-22 and 2022-23. HDAP was created as a support for older adults likely eligible for the Supplemental Security Income/State Supplementary Payment (SSI/SSP) program. (SSI/SSP is additionally covered under this issue.) The 2021-22 one-time HDAP funds alongside the 2023-24 and 2024-25 ongoing funds, were available through December 2025. The 2022-23 one-time funds are available through June 30, 2026; however, the Budget Act of 2024 (Chapter 22, Statutes of 2024, [Assembly Bill 107](#)) reduced the 2022-23 one-time appropriation from \$150 million to \$100 million. In 2024-25, 20 counties had exhausted available funds and/or closed programs while 28 counties had reduced operations or planned program closures.

The Budget Act of 2025 (Chapter 5, Statutes of 2025, [Assembly Bill 102](#)) appropriated \$44.6 million in new one-time funding, available through June 30, 2028. HDAP also receives \$25 million in annual, ongoing funding, most recently appropriated through the Budget Act of 2025 (Chapter 5, Statutes of 2025, [Assembly Bill 102](#)) and available through June 30, 2026. [The Governor’s Budget for FY 2026-27](#) proposes continuation of the \$25 million ongoing appropriation, available through June 30, 2027. Upon enactment of the Budget Act of 2025 (Chapter 5, Statutes of 2025, [Assembly Bill 102](#)), CDSS immediately notified counties of the availability of the new HDAP funding and encouraged them to continue or resume program operations. Following the release of the 2025-26 allocations, 55 counties accepted HDAP one-time funds (non-participating counties are Marin, Sierra, and Yuba). In the same year, 54 counties accepted HDAP ongoing funds (non-participating counties are Alpine, Marin, Sierra, and Yuba). Alpine County accepted HDAP one-time funding for the first time in 2025-26.

DSS recently provided the following chart, showing the expected quarter when the current allocations are expected to be exhausted for HDAP.

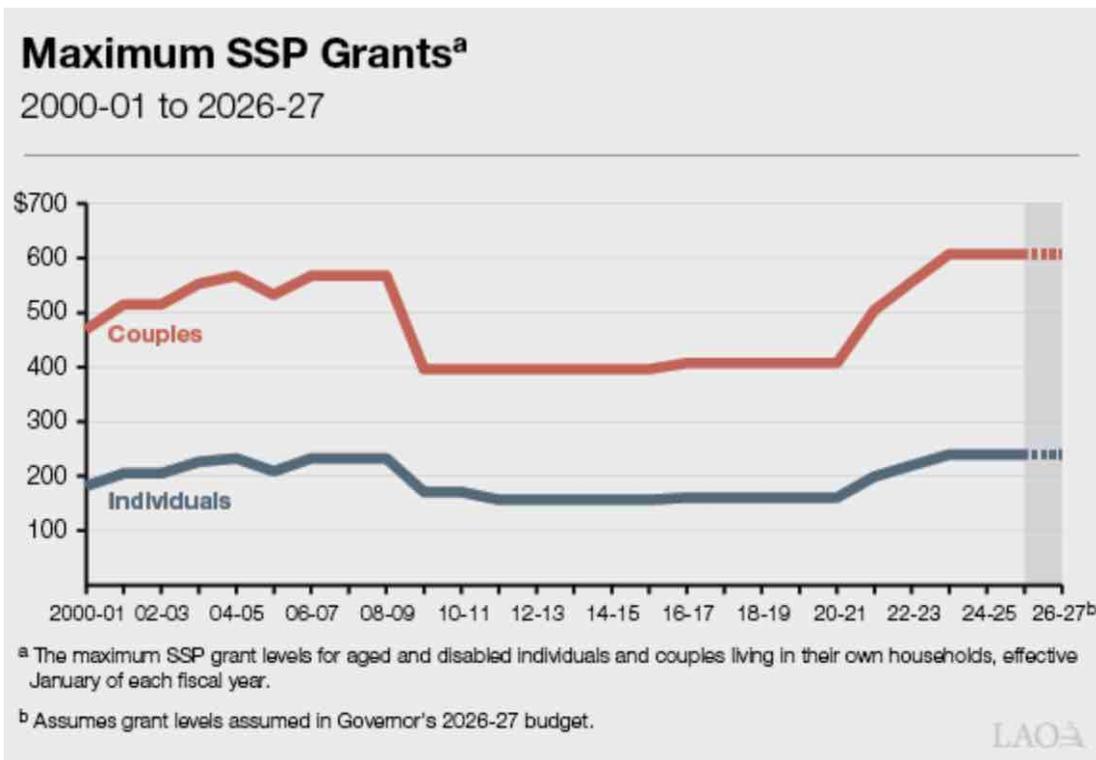
Housing and Disability Assistance Program							
<i>This projection demonstrates the pace that which counties will be able to spend down all FY25/26 funding, inclusive of available funding from prior one-time tranches, newly appropriated one-time funds, and FY 25/26 ongoing funds. FY 2025-26 Q2-Q4 projection is based on the percent increase from FY 2023-24 since FY 2024-25 spending patterns were impacted / constrained due to exhaustion of available funds. If the same projection is applied in the outyears, available funding is expected to be exhausted by Q1 of FY 2026-27. Highlighted spending / quarter indicates the quarter when funds are exhausted and spending could be constrained based on available funding.</i>							
Fiscal Year	Available Funding <sup>2</sup>	Q1	Q2	Q3	Q4	Total Expenditures	Unspent
FY 2025-26 <sup>1</sup>	\$ 66,832,242	\$ 8,209,980	\$ 7,943,552	\$ 17,143,294	\$ 30,772,363	\$ 64,069,189	\$ 10,973,033
FY 2026-27	\$ 10,973,033	\$ 10,973,033	\$ -	\$ -	\$ -	\$ 10,973,033	\$ -
FY 2027-28	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
FY 2028-29	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
FY 2029-30	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
1. Quarter 1 in FY 2025-26 reflect actual expenditures.							
2. The table only includes appropriated funding as of Sep-2025 and does not include the ongoing \$25M annual funding after FY 2025-26; however, an ongoing annual FY 2026-27 appropriation would extend the exhaustion of one-time funds as the FY 2026-27 expenditures would draw down any annual funding before utilizing the one-time multi-year balance.							

**SSI/SSP Program.** For 2026-27, the Governor’s budget proposes \$3.6 billion from the General Fund for the state’s share of SSI/SSP, an increase of \$94 million (2.7 percent) from the Governor’s revised 2025-26 budget estimate. This increase would bring total program funding

to \$11.5 billion (\$3.6 billion from the General Fund and \$7.9 billion federal funds) in 2026-27. While the year-over-year change in General Fund costs for the program is relatively flat, it is increasing slightly despite the fact that caseload is expected to decline and the average state cost for grants is remaining flat. This is due to a technical adjustment to the current year.

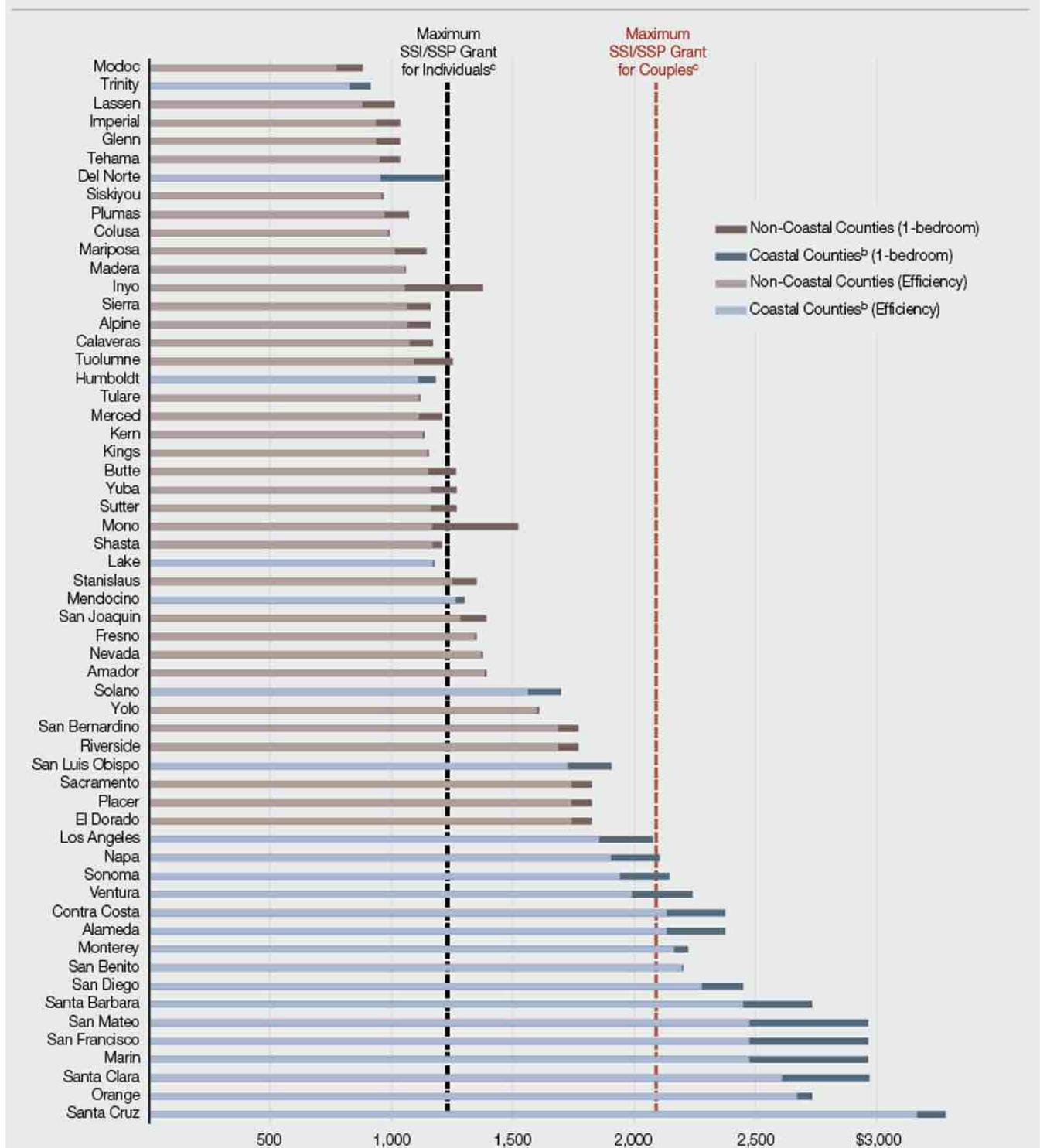
The SSI/SSP program provides cash grants to low-income aged, blind, and disabled individuals. Grant levels for SSI/SSP are determined by both the federal government and the state. Specifically, the federal government pays for the SSI portion of the grant while the state pays the SSP portion of the grant. The federal government is required to provide an annual COLA each January to the SSI portion of the grant. The federal COLA is based on the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). In years that the CPI-W is negative (as was the case in 2010, 2011, and 2016), the federal government does not decrease SSI grants, but instead holds them flat.

The state has full discretion over whether and how to provide increases to the SSP portion of the grant. Until it was ended in 2011, the state had a statutory annual COLA. These COLAs generally reflected whole-grant COLAs. Whole-grant COLAs worked by applying the California Necessity Index (CNI) to the total SSI/SSP grant. If the federal SSI COLA was not enough to increase total SSI/SSP grants to CNI-adjusted levels, then the SSP portion of the grant was increased by the remaining amount. Despite the state statutory COLA, there were many years prior to 2011 when the COLA was not provided due to budget constraints. After the Great Recession, SSP grants occasionally were increased by applying the CNI only to the SSP portion of the grant (in 2016-17 and 2021-22). Additionally, while not COLAs, SSP grant increases were provided in 2021-22, 2022-23, and 2023-24.



This chart from the LAO displays the grant levels against fair market rents in the 58 counties.

### County Level Fair Market Rents Compared to Maximum SSI/SSP Grants<sup>a</sup>



<sup>a</sup> Fair Market Rents are from the department of Housing and Urban Development.

<sup>b</sup> Includes counties on the coast of California.

<sup>c</sup> The maximum monthly grants for aged and disabled individuals and couples living in their own households, effective as of January 2026.

The figure below shows how 2024-25 maximum SSI/SSP grant levels compare to 2025-26 maximum SSI/SSP grant levels and the administration’s estimates of the 2026-27 federal SSI grant increase. The projected increases to maximum SSI/SSP grant levels in 2026-27 are entirely due to the estimated federal SSI COLA. The Governor’s budget estimates that the federal COLA for the SSI portion of the grant will be 3.1 percent in 2026-27, increasing maximum SSI grants by \$30 for individuals and \$46 for couples on January 1, 2027 (the actual federal SSI COLA will not be known until fall 2026). The Governor’s budget does not propose any change in the maximum SSP grants for 2027.

### SSI/SSP Monthly Maximum Grant Levels<sup>a</sup>

	2024-25 (Actual)	2025-26 (Actual)	2026-27 (Projected)
<b>Maximum Grant—Individuals</b>			
SSI	\$967.00	\$994.00	\$1,024.00
SSP	239.94	239.94	\$239.94
<b>Totals</b>	<b>\$1,206.94</b>	<b>\$1,233.94</b>	<b>\$1,263.94</b>
Percent of federal poverty level <sup>b</sup>	93%	93%	91%
<b>Maximum Grant—Couples</b>			
SSI	\$1,450.00	\$1,491.00	\$1,537.00
SSP	607.83	607.83	607.83
<b>Totals</b>	<b>\$2,057.83</b>	<b>\$2,098.83</b>	<b>\$2,144.83</b>
Percent of federal poverty level <sup>b</sup>	117%	116%	114%

<sup>a</sup>The maximum monthly grants displayed refer to those for aged and disabled individuals and couples living in their own households, effective as of January 1 of the respective calendar year.

<sup>b</sup>Compares grant level to federal poverty guidelines from the U.S. Department of Health and Human Services for 2025 and 2026. Estimates of federal poverty guidelines for 2027 are based on the LAO Consumer Price Index for All Urban Consumers (CPI-U) projection. The 2027 federal poverty guidelines will not be finalized until fall 2026.

#### Panel

#### Questions for the Panel:

- ◇ What services and supports for homeless and housing unstable adults has the Housing Disability Advocacy Program (HDAP) offered?
- ◇ How many people does the program assist currently and what have been the trends on the number of people assisted?
- ◇ What is the current state of the program across counties given the past allocations, utilization (and exhaustion) of those funds, and the recent one-time investment (atop the ongoing base of \$25 million) in the 2025 Budget of \$44.6 million General Fund?

- ◇ What level of funding is needed for 2026-27 to “hold the line” on current services and supports being offered through HDAP today?

**Panel:**

- Hanna Azemati, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

For HDAP, Chair Jackson will request what level of funding is needed for 2026-27 to “hold the line” on current services and supports being offered through HDAP today.

**Staff Recommendation:** Hold open.

**Issue 9: Community Care Expansion (CCE) Program**

The Community Care Expansion (CCE) Program funds the acquisition, construction, and/or rehabilitation of adult and senior care facilities that serve applicants and recipients of Supplemental Security Income/State Supplementary Payment (SSI/SSP) or Cash Assistance Program for Immigrants (CAPI), who are at risk of or experiencing homelessness. Funds are also available to preserve residential care settings, including through operating subsidies for existing licensed adult and senior care facilities currently serving SSI/SSP or CAPI recipients.

CCE, which was established in 2021, is supported through one-time, multi-year funding and has no ongoing appropriation. The Budget Act of 2021 (Chapter 21, Statutes of 2021, [Assembly Bill 128](#)) appropriated \$805 million in one-time funding to support the acquisition, construction, and rehabilitation of housing with care and supportive services for older adults and individuals with disabilities. The Budget Act of 2022 (Chapter 45, Statutes of 2022, [Assembly Bill 178](#)) provided an additional \$55 million in one-time funding for operational subsidies. CCE funds are available for encumbrance and expenditure through June 30, 2027, with liquidation and reversion deadlines extending through June 30, 2029. The program has achieved and is on track to exceed its goal of creating or preserving 7,000 beds or units of housing with care and supportive services.

DSS has provided the following detail regarding the Community Care Expansion (CCE) Program Expenditures. DSS report that the CCE program is expected to meet and exceed its goal of creating or preserving at least 7,000 beds or units for the CCE population.

**CCE Expansion.** Pursuant to the DSS announcement in September 2024, nearly all \$570 million available for CCE Expansion was awarded to 61 projects to create over 3,100 beds/units. Projects are at various stages of implementation, including contracting with BDO GS (the CDSS third -party administrator for CCE – note that they were formerly named HORNE and were recently acquired by BDO GS), completing acquisitions, breaking ground, finishing construction or rehabilitation, and initiating and completing occupancy. Some funds are reallocated over time across projects, based on project needs. As of January 2026, 13 of the 61 CCE projects, representing 679 new beds/housing units, have completed construction and are in the process of initiating move-in. An additional 14 projects, representing 1,036 beds/housing units, have broken ground. CCE grantees can request and receive fund disbursements from their awards as they achieve key milestones in their projects after they provide necessary documentation. As of January 2026, of the \$570 million awarded, \$217.6 million has been disbursed to Project Sponsors. More than 100,500 individuals are expected to be housed through the CCE Capital Expansion Program, accounting for the 20-30 year use restriction periods of projects.

**CCE Preservation.** DSS has made \$249.5 million available to counties through CCE Preservation and \$247 million was accepted across 34 participating counties. Counties are at various stages of implementing their programs, including identifying facilities serving the CCE population and at risk of closure, contracting with selected eligible facilities for Capital Projects (CP) and Operating Subsidy Payments (OSP) funds, and then disbursing OSP and CP funds to facilities that are in contract. Note that the CCE Preservation Program is the first-ever program of its kind, requiring counties to plan and establish the needed staff, infrastructure, and systems

coordination in order to operate. To date, 27 counties have finalized contracts with 204 facilities that were at risk of closure and preserved 6,031 beds.

As of January 2026, of the \$107 million in operating subsidy funds allocated, \$23 million has been disbursed to counties who are providing these funds to contracted facilities serving the CCE qualified residents. Further, of the \$142 million in capital project funds allocated, \$44.8 million has been disbursed to counties who are providing these funds to contracted facilities that are serving the CCE qualified residents.

<b>CCE Capital Expansion</b>		
<b>Awards</b>	<b>Funding Awarded</b>	<b>Beds/Units Created as of January 2026</b>
61 projects	\$570 million (Including \$28.5 million to tribal entities)	3,100 beds/units to be created - 13 projects with 679 beds/units completed. - 14 projects with 1,036 beds/units broken ground
<b>CCE Preservation</b>		
<b>Awards</b>	<b>Funding Awarded</b>	<b>Beds Preserved as of January 2026</b>
34 counties	\$247 million	6,031 beds to be preserved across 204 licensed care facilities at risk of closure that have contracted with 27 counties

For more information on CCE Capital Expansion and Preservation programs, please visit the [CCE data dashboard](#).

For an in-depth look at CCE funded projects, DSS provides these videos:

- [The Ranch House in Nevada County](#)
- [‘The Phoenix’ in Oakland](#)
- [Northern Circle Indian Housing Authority Elder Village in Ukiah](#)

**Panel**

**Questions for the Panel:**

- ◇ What services and supports for homeless and housing unstable adults has the Community Care Expansion (CCE) program provided?
- ◇ How many people does the program assist currently and what have been the trends on the number of people assisted?

- ◇ What is the current state of the program across counties given the past allocations and utilization (and/or exhaustion) of those funds?
- ◇ When is it projected that the CCE funds will be exhausted and what is the plan for continuing the preservation component after then? What are the likely consequences for the facilities and residents benefiting if CCE funds are not replenished in some way?

**Panel:**

- Hanna Azemati, Deputy Director, California Department of Social Services
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Thomas Locke, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

## 4170 California Department of Aging (CDA)

### Issue 10: Older Californians Act and Older Americans Act Funding, including Area Agencies on Aging and Meals on Wheels Programs

**Issues for Subcommittee Consideration.** This issue provides an overview of programs administered by the California Department of Aging (CDA) chiefly through the 33 Area Agencies on Aging. The following background information was provided by the Administration.

#### **Aging Network Entities.**

**Area Agency on Aging.** CDA provides funding and oversight to the State's 33 Area Agencies on Aging (AAAs) responsible for covering all 58 counties. The AAA network is comprised of county-run, joint-powers authority, non-profit, and one city-run organization. Each AAA is responsible for providing programs and services to their Planning and Service Area (PSA). A PSA is a geographical area comprised of one or more counties. The AAAs administer Older Americans Act (OAA) and Older Californians Act (OCA) programs. CDA provides administration, programmatic oversight, monitoring, auditing, and continued collaboration with the AAA network.

**Office of the Long-Term Care Patient Representative (General Fund).** Under state law, ([Health and Safety Code 1418.8](#)), skilled nursing and intermediate care facilities may convene an interdisciplinary team to make medical decisions that require informed consent for residents who lack capacity and have no legal surrogate. These teams include the resident's physician, a registered nurse responsible for the resident's care, and other appropriate staff. In the past, the teams also sometimes included patient representatives, but this was not required. As the result of a court case, skilled nursing and intermediate care facilities are required to include a patient representative when they convene an interdisciplinary team. There are 1,191 skilled nursing and intermediate care facilities throughout the state. For FY 25-February 2026 there have been 703 requests for interdisciplinary team reviews; 311 reviews have been conducted.

**OAA Long-Term Care Ombudsman (Title III B and VII).** The Long-Term Care Ombudsman Program identifies, investigates, and resolves complaints made by or on behalf of residents of long-term care (LTC) facilities that impact the residents' health, safety, welfare, or rights. In California, the Program also receives and investigates reports of suspected elder and dependent adult abuse occurring in various types of LTC facilities, including residential care facilities (also known as board and care homes and assisted living facilities) and skilled nursing facilities. There are 35 LTC Ombudsman sites that contract with the 33 AAAs. In 2025, there were 9,295 licensed facilities representing 326,268 LTC beds.

**Caregiver Resource Centers (General Fund).** Founded in 1984, the California Caregiver Resource Centers are made up of a network of 11 nonprofit centers covering all 58 California counties serving family caregivers who are providing support for someone affected by chronic and debilitating health conditions including dementia, Alzheimer's disease, cerebrovascular diseases (such as stroke or aneurysms), degenerative diseases such as Parkinson's, Huntington's and multiple sclerosis, or traumatic brain injury (TBI), among others. California was

the first state in the nation to establish a statewide network of support organizations for caregivers. Each CRC provides Specialized Information and Referral, Family Consultation and Care Planning, Respite Care, Short-Term Counseling, Support Groups, Professional Training, Legal and Financial Consultation, and Education services to families and caregivers at low or no cost.

**Aging and Disability Resource Connections (General Fund).** The Aging and Disability Resource Connection (ADRC) initiative began as a collaborative effort between the State of California, the federal Administration for Community Living (ACL), the Centers for Medicare & Medicaid Services (CMS) and the Veterans Administration (VA), though there are no federal dollars in support of the initiative. The ADRC's purpose is to provide a single coordinated system for people seeking reliable information and access to Long-Term Services and Supports (LTSS). This purpose is achieved by building community partnerships, providing services using a person-centered approach, and reducing the number of barriers for accessing services. There are currently 24 ADRCs with three more emerging.

**Older American Act (OAA) Programs.**

The OAA enables older individuals to maintain their well-being through locally developed community-based systems of services. CDA contracts with a statewide network of 33 AAAs to plan, develop, coordinate, and administer services to assist older adults, adults with disabilities, and their caregivers.

Older adults aged 60 and over are eligible for most OAA programs regardless of their income level. However, since the federal OAA funding is not an individual entitlement, the OAA requires targeting of these services to individuals who experience the greatest social and economic needs which includes income, race, ethnicity, and rural isolation among other factors.

**OAA Supportive Services (Title III B).** The Supportive Services Program provides a variety of services to address functional limitations, maintain health and independence, and promote access to services. Services provided may include, but are not limited to, Information and Referral Services, In-home Services, Legal Services, Outreach, Respite Care/Respite Care Registries, and Transportation. There are more than 30 authorized services that local AAAs can fund through Title III B. For many AAAs, the Title III B Information and Assistance (I&A) Program is considered the entry point to services in a Planning Service Area which enables staff to assess individuals' needs, make referrals to local services or programs in the community, and follow-up with individuals to find out if service needs were met.

**OAA Congregate Nutrition (Title III C-1).** The Congregate Nutrition Program serves healthy meals in a group (congregate) setting to individuals aged 60 or older, their spouses, and, in some cases, their caregivers and/or persons with disabilities who are not older individuals, but who reside in housing facilities occupied primarily by older individuals at which congregate nutrition services are provided. Congregate nutrition sites present opportunities for social engagement, health and wellness activities, and meaningful volunteer roles, all of which contribute to health and well-being. These sites may also provide nutrition education, nutrition risk screening and nutrition counseling.

**OAA Home-Delivered Nutrition (Title III C-2).** The Home-Delivered Nutrition Program provides nutritious meals, nutrition education, and nutrition risk screening to individuals aged 60 or older who are homebound. The program serves frail, food-insecure or isolated individuals and also provides a safety check via face-to-face contact or conversation with meal delivery staff and volunteers.

Assembly Bill 1476 (Chaptered 2025) updates the OAA Title III-C Nutrition Program Act to require increased oversight and support of the AAAs administering the Title III-C1 and Title III-C2 programs, particularly pertaining to the implementation of to-go meals. To-Go Meals are defined as meals picked up at a local congregate site by participants 60 years of age or older (or their agent), or meals delivered to participants 60 years of age or older who prefer to not dine in a congregate meal setting. While to-go meals are allowable under both the Title III-C1 and Title III-C2 programs, AAAs have the discretion based on community need to decide if To-Go meals are offered within their Planning and Service Area. Under the Title III-C1 program, To-Go meals may be served in a virtual congregate setting to complement, not replace, in-person congregate meal dining.

**OAA Disease Prevention and Health Promotion (Title III D).** The Disease Prevention and Health Promotion Program provides evidence-based preventive health and health promotion services. These services assist older adults in preventing or better managing chronic conditions.

**OAA Family Caregiver Support (Title III E).** The Family Caregiver Support Program provides various services to assist informal, unpaid family caregivers. The Program provides support to eligible adult family members (18+) or another individual who is an informal provider of in-home and community care to:

- an older adult (60+), regardless of income level
- an individual with Alzheimer's disease or related neurological and organic brain dysfunction, regardless of age and income level

In addition, support may be provided to older relatives (55+) who are parents (or not), living with and providing care to:

- a child (under age 18) whom they are identified as the primary caregiver through legal or informal arrangement, regardless of income
- an individual with a disability (age 18-59); regardless of income

**Department of Labor, Senior Community Service Employment (Title V).** The Senior Community Service Employment Program provides part-time, work-based training opportunities for older workers in local community service agencies to assist them in obtaining unsubsidized employment. Participants receive a variety of supportive services, such as personal and job-related counseling, job-related training to prepare for their community service assignments, and job search/referral assistance.

**OAA Elder Abuse Prevention (TITLE VII).** The Elder Abuse Prevention Program provides services to develop, strengthen, and implement programs for the prevention, detection, assessment, and treatment of elder abuse.

## Older Californians Act Community-Based Services.

**Health Insurance Counseling and Advocacy Program (HICAP).** HICAP provides free, confidential one-on-one counseling, education, and assistance to individuals and their families on Medicare, LTC insurance, other health insurance related issues, and planning ahead for LTC needs. The program also provides legal assistance or legal referrals in dealing with Medicare or LTC insurance related issues. There are 26 HICAPs statewide that provide services in every county. HICAP serves approximately 57,000 clients per year. The Governor's Budget includes a Budget Change Proposal regarding HICAP, which is covered under Issue 10 of this agenda.

## Medi-Cal Programs.

**Multipurpose Senior Services Program (MSSP).** MSSP provides both social and health care management services to assist frail individuals aged 60 or older to remain in their own homes and communities. To be eligible for MSSP, these individuals must be Medi-Cal eligible and meet the criteria for skilled nursing facility care.

While most of the program participants also receive In-Home Supportive Services, MSSP provides on-going care coordination, links participants to other needed community services and resources, coordinates with health care providers, and purchases needed services that are not otherwise available in an effort to prevent or delay institutionalization. The total combined annual cost of care management and other services must be lower than the cost of receiving care in a skilled nursing facility.

There are 36 MSSP sites throughout the state with a capacity of 11,595 slots. The average number of participants served for FY 2024-25 is 10,151. The recent CMS Medicaid waiver renewal permits the program to operate statewide and lowered the age for eligibility from 65 to 60.

**Community-Based Adult Services (CBAS).** CBAS is a community-based day health program that provides services to older adults and adults with chronic medical, cognitive, or behavioral health conditions and/or disabilities that place them at risk of needing institutional care.

The CBAS Program is an alternative to institutional care for Medi-Cal beneficiaries who can live at home with the aid of appropriate health, rehabilitative, personal care, and social services.

Under an interagency agreement, the CBAS Program is jointly administered by the Department of Health Care Services, the California Department of Public Health, and CDA. CDA certifies licensed Adult Day Health Care centers as Medi-Cal CBAS providers. Currently, there are 318 licensed centers in 28 counties, serving approximately 43,170 participants per year.

## Other.

**Medicare Improvements for Patients and Providers Act (MIPPA).** One important provision within MIPPA provides funding to HICAP to help low-income and rural Medicare beneficiaries learn about and apply for two valuable benefits:

- The Medicare Part D Extra Help/Low-Income Subsidy, which helps pay for Medicare Part D Prescription Drug Benefit premiums and reduces the cost of prescriptions at the pharmacy; and
- The Medicare Savings Program (MSP) which helps pay for Medicare Part B Medical Insurance.

**Supplemental Nutrition Assistance Program Education (SNAP-Ed).** The SNAP-Ed Program provides evidence-based nutrition education and obesity prevention services to older adults aged 60 or older at eligible Title III C congregate nutrition sites and other venues. CDA received \$11.5 million annually in federal reimbursements for this program. As a result of H.R. 1, this program will end after the current fiscal year.

CalFresh Healthy Living (also referred to as SNAP-Ed) is a program that provides funding to the Area Agencies on Aging for low-income older adults for a variety of nutrition focused efforts and educational opportunities. There is a focus on making healthy food choices on a limited budget, increasing the consumption of fruits and vegetables, and choosing a physically active lifestyle focused on improving strength, balance, and flexibility. Specific activities include the Farmer's Market initiative, focused on stretching your dollars at local farmers markets and providing Farmers Market Nutrition Program coupons, providing nutrition courses, providing physical activity education courses, supporting community gardens, and more.

**CalFresh Outreach.** The CalFresh Expansion program serves California older adults that are at least 60 years old and have low-income who may also receive SSI or SSP benefits. The program provides much needed monthly food assistance to California older adults and economic benefit to local communities. The CalFresh Healthy Living Program will end in 2026-27 due to federal reductions. The CalFresh Expansion program is also impacted by increased local and state match requirements.

This program is funded both from federal reimbursement from CDSS and General Fund. The prior year funding levels were \$870,000 federal reimbursement and \$1.13 million General Fund with 56 percent of state match required. This was a total of \$2 million for the CalFresh Outreach program. H.R. 1 now requires a higher percentage of state match, 77 percent. As such, CDA has decreased federal reimbursement to \$383,000 and has retained the \$1.13 million General Fund match. This is a revised total of \$1.513 million for the CalFresh Outreach program. As a result of H.R. 1, CDA lost \$487,000 in federal reimbursement funding for the program.

This program focuses on providing outreach and assistance for older adults that are eligible for CalFresh benefits.

**Division of Policy, Research, and Equity.** The Division of Policy, Research and Equity (DPRE) collaborates with state partners and stakeholders in advancing California's Master Plan for Aging (MPA). Through policy development, research, and stakeholder engagement, DPRE focuses on imbedding equity within all MPA policies, programs and initiatives that impact older adults, people with disabilities and caregivers. Specifically, the division is responsible for overseeing stakeholder engagement of the [six MPA Advisory Committees](#) and organizing the bi-annual [Day of Action](#) to inform the MPA initiative updates. Additionally, the division manages

a number of key MPA policy initiatives including the Home and Community- Based Services Gap Analysis and Roadmap, the LTSS Financing and Affordability Initiative, the Data Dashboard for Aging, the LGBTQIA+ older adult study, and several pilots including Calz Connect, CalCompass, and the CalCARES caregiver initiative.

**Master Plan for Aging.** In June 2019, Governor Newsom signed Executive Order N-14-19, which called for the development of the [California Master Plan for Aging \(MPA\)](#), a ten-year blueprint to prepare for the year 2030 when one in four Californians will be age 60 or older, totaling 10.3 million older adults statewide. Since the launch of the MPA, the California Health and Human Services (CalHHS) Agency and the California Department of Aging (CDA) have been coordinating and facilitating six stakeholder committees who advise the Administration, CalHHS, and CDA on the implementation of the MPA and related aging, disability and caregiving issues, programs, and policy.

California’s MPA is a nationally recognized blueprint for building communities for all ages and abilities. Since its launch in January 2021, the Newsom Administration and the Legislature have committed billions of dollars in unprecedented investments to advance the MPA, including strengthening existing programs and launching new services, as evidenced in the [Fourth Annual Report released in January 2025](#).

California’s MPA:

- Leads with Equity
- Focuses on the Person
- Engages Diverse Stakeholders
- Advances Home and Community Care Choices
- Embraces a Whole-of-Government Framework
- Ensures Accountability

[Aging and Disability Lived Experience Advisory Board](#): In September 2025, the Department of Aging launched the Aging and Disability Lived Experience Advisory Board which seeks to gather input from older adults, people with disabilities, and caregivers to help inform the advancement of California’s Master Plan for Aging (MPA). AD-LEAB works alongside the [six MPA stakeholder advisory committees](#) to highlight important issues, challenges, and opportunities for California’s growing and diverse population of older adults, people with disabilities, and caregivers.

[The 5<sup>th</sup> Annual Report of the MPA](#) was released in January 2026.

The comprehensive funding table on the next page was provided by CDA.

CY and BY Budget Comparison  
2026-27 Governor's Budget

(Dollars in Thousands)

Total Funding	FY 2025-26	FY 2026-27	Difference
General Fund	\$ 197,697	\$ 163,619	\$ (34,078)
State HICAP Fund	\$ 4,851	\$ 8,342	\$ 3,491
Federal Trust Fund	\$ 235,388	\$ 235,719	\$ 331
Special Deposit Fund	\$ 4,236	\$ 4,236	\$ -
Reimbursements	\$ 25,085	\$ 25,100	\$ 15
State Department of Public Health, Licensing & Certification Pgm Fund	\$ 400	\$ 400	\$ -
Home & Community-Based Services American Rescue Plan Fund	\$ -	\$ -	\$ -
<b>TOTAL</b>	<b>\$ 467,657</b>	<b>\$ 437,416</b>	<b>\$ (30,241)</b>

Program Code	Local Assistance Funding	FY 2025-26	FY 2026-27	Difference	Description of Difference
3890100	Congregate Nutrition	\$ 72,890	\$ 72,890	\$ -	
3890200	Home Delivered Nutrition	\$ 173,135	\$ 141,679	\$ (31,456)	ModOCA General Fund - Unspent funds from FY 2024-25 were added into 2025-26, technical budget adjustment artificially inflating funding
3890300	CalFresh	\$ 10,748	\$ 10,748	\$ -	
3895	Senior Community Employment Services	\$ 7,339	\$ 7,339	\$ -	
3900100	Supportive Services	\$ 53,509	\$ 53,509	\$ -	
3900200	Ombudsman & Elder Abuse Prevention	\$ 19,372	\$ 19,372	\$ -	
3900300	Patient Representative	\$ 1,311	\$ 1,311	\$ -	
3900400	Aging & Disability Resource Connection	\$ 10,000	\$ 10,000	\$ -	
3900500	Family Caregiver Services	\$ 24,943	\$ 24,943	\$ -	
3900500	Caregiver Resource Centers	\$ 14,918	\$ 14,918	\$ -	
3900600	Preventive Health Services	\$ 4,473	\$ 4,473	\$ -	
3905100	Health Insurance Counseling	\$ 14,402	\$ 17,642	\$ 3,240	Health Insurance Counseling and Advocacy Program Modernization BCP
3905200	Alzheimer's Grants (CalzConnect/Administration on Community Living)	\$ 511	\$ 511	\$ -	
3905300	Medicare Improvements for Patients & Providers Act (MIPPA)	\$ 3,329	\$ 3,329	\$ -	
3910100	Multipurpose Senior Services Program (MSSP)	\$ -	\$ -	\$ -	
3910300	Community Based Adult Services (CBAS)	\$ -	\$ -	\$ -	
3915100	Policy & Planning	\$ -	\$ -	\$ -	
3915200	Master Plan for Aging	\$ 534	\$ -	\$ (534)	Older Adults Behavioral Health - Unspent funds from FY 2024-25 were added into 2025-26, technical budget adjustment carry in.
	<b>TOTAL</b>	<b>\$ 411,414</b>	<b>\$ 382,664</b>	<b>\$ (28,750)</b>	

Program Code	State Operations Funding	FY 2025-26	FY 2026-27	Difference	Description of Difference
3890100	Congregate Nutrition	\$ 3,774	\$ 3,999	\$ 225	Meal program: Senior Citizens (AB 1476)=\$152K. Budget Letter adjustments for employee compensation, retirement etc.
3890200	Home Delivered Nutrition	\$ 3,552	\$ 3,654	\$ 102	
3890300	CalFresh	\$ 1,875	\$ 1,879	\$ 4	
3895	Senior Community Employment Services	\$ 456	\$ 409	\$ (47)	
3900100	Supportive Services	\$ 5,271	\$ 5,243	\$ (28)	
3900200	Ombudsman & Elder Abuse Prevention	\$ 2,966	\$ 3,013	\$ 47	
3900300	Patient Representative	\$ 2,350	\$ 2,352	\$ 2	
3900400	Aging & Disability Resource Connection	\$ 2,497	\$ 2,485	\$ (12)	
3900500	Family Caregiver Services	\$ 1,743	\$ 1,774	\$ 31	
3900500	Caregiver Resource Centers	\$ 552	\$ 553	\$ 1	
3900600	Preventive Health Services	\$ 65	\$ 65	\$ -	
3905100	Health Insurance Counseling	\$ 2,574	\$ 2,842	\$ 268	Health Insurance Counseling and Advocacy Program Modernization BCP= \$250K. Budget Letter adjustments for employee compensation, retirement etc.
3905200	Alzheimer's Grants (CalzConnect/Administration on Community Living)	\$ -	\$ -	\$ -	
3905300	Medicare Improvements for Patients & Providers Act (MIPPA)	\$ 662	\$ 680	\$ 18	
3910100	Multipurpose Senior Services Program (MSSP)	\$ 7,660	\$ 7,602	\$ (58)	
3910300	Community Based Adult Services (CBAS)	\$ 10,772	\$ 9,572	\$ (1,200)	Bridge to Recovery technical adjustment carry in from Prior Year reflected in 2025-26, Budget Letter adjustments for employee compensation, retirement etc.
3915100	Policy & Planning	\$ 7,791	\$ 7,791	\$ -	
3915200	Master Plan for Aging	\$ 1,683	\$ 839	\$ (844)	Behavioral Health technical adjustment carry in from Prior Year reflected in 2025-26. Budget Letter adjustments for employee compensation, retirement etc.
	<b>TOTAL</b>	<b>\$ 56,243</b>	<b>\$ 54,752</b>	<b>\$ (1,491)</b>	

**Panel**

**Questions for the Panel:**

- ◇ What budget changes are occurring in the system/programs supervised by the California Department of Aging (CDA) in the current year and in 2026-27?
- ◇ What budget reductions should the Legislature be aware of either currently or on the horizon?
- ◇ What is the state of the network of 33 Area Agencies on Aging? Is the network weakening? What is its capacity to the needs of seniors, especially in the face of the reductions we discussed under Issue 1?
- ◇ What are the needs in the system and how can the 2026 Budget respond?

**Panel:**

- Nicole Shimosaka, Chief Deputy Director (Interim), California Department of Aging
- Aneliza Del Pinal, Board President, California Association of Area Agencies on Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

**Issue 11: Recommendations to Create a “No Wrong Door” for Access to Senior Supports and Services**

Supplemental Report Language (SRL) was adopted with the 2025 Budget Act requesting that CDA prepare and provide a report to the Legislature on options to create a “No Wrong Door” system. The SRL is included below and a high-level summary of the recently received report is included after.

**No Wrong Door (NWD) and Aging and Disability Resource Connections (ADRCs).** It is the Legislature’s intent to continue moving toward the development and implementation of the NWD system for long-term services and supports for older adults and people with disabilities, including, but not limited to, efforts through ADRCs. In pursuit of this goal, on or before, March 1, 2026, the California Department of Aging (CDA) shall provide the Legislative Analyst’s Office and the fiscal committees of the Legislature with a report detailing the various options and next steps for implementing a NWD system, and what steps would be necessary to build out a sustainable ADRC network in California, including any existing funds or alternative funding options for supporting these efforts. The report shall identify any challenges to implementing the NWD system and identify ways of addressing those challenges. The report shall also provide estimated costs for implementing each portion of the NWD system, including expanding the (ADRC network to cover all areas of the state and integrating the ADRC program into a broader NWD system for long-term services and supports including any existing funds or alternative funding options for supporting these efforts. Any request for resources to implement the system will be subject to review and approval through the annual budget process. Additionally, the report shall discuss the process for establishing Memorandums of Understanding (MOU) with the various government agencies that may participate in the NWD system, and a summary of what objectives each MOU could substantively include, which entities could be involved for each, and the timing possibilities to realize the objectives of each. The report shall also include updates and outcomes on CDA’s existing initiatives regarding the NWD system, including, but not limited to, the following:

- (a) Updates on the progress of the consultant hired in 2024 to research the best practices for developing, implementing, and operating a NWD system in other states.
- (b) Updates on the development of the State Leadership Council consisting of the CDA, Department of Health Care Services, Department of Rehabilitation, Department of Social Services and Department of Developmental Services—established to develop the policies, operational standards and procedures, and configuration of the NWD system and the NWD resource hub.
- (c) Updates on the data repository currently under development (and funded by leveraging ADRC funds) to centrally store and publicly report information about aging programs.
- (d) Summarize the findings of the ADRC strengths, weaknesses, opportunities, and threats analysis and the resulting business plan.

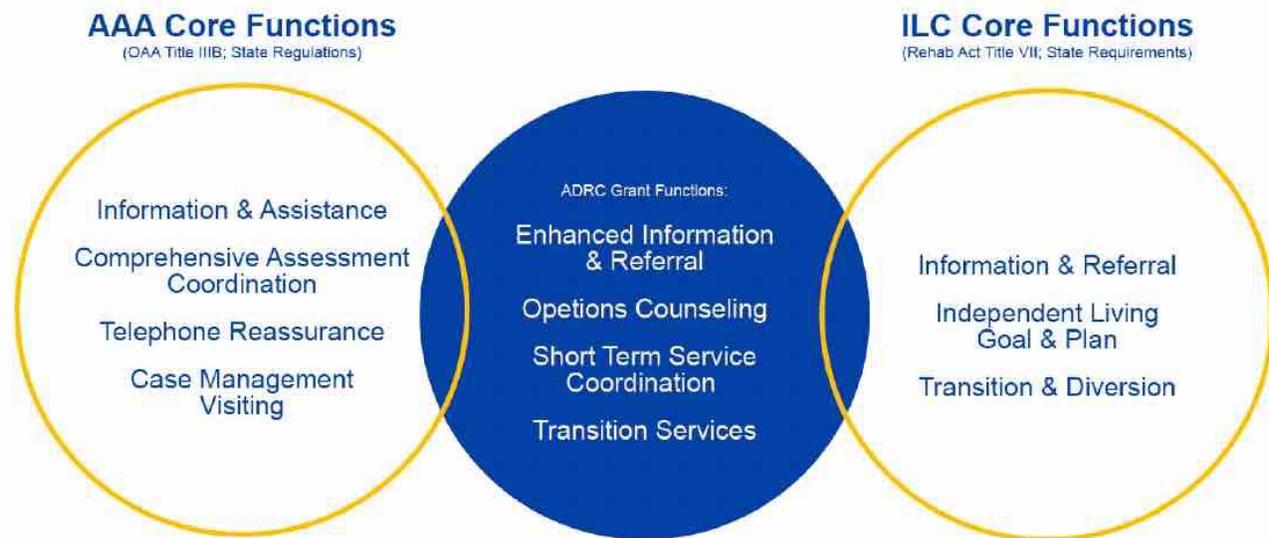
The recent report from CDA states that even with strong legislative intent and Administration leadership, California is still in the conceptual stage of a NWD system. CDA-led research, in collaboration with other key state departments and stakeholders, revealed the depth and breadth of planning – and investment – needed to design, develop and implement a NWD system. The

report encourages further discussion and action to solidify California’s vision by considering the three questions below:

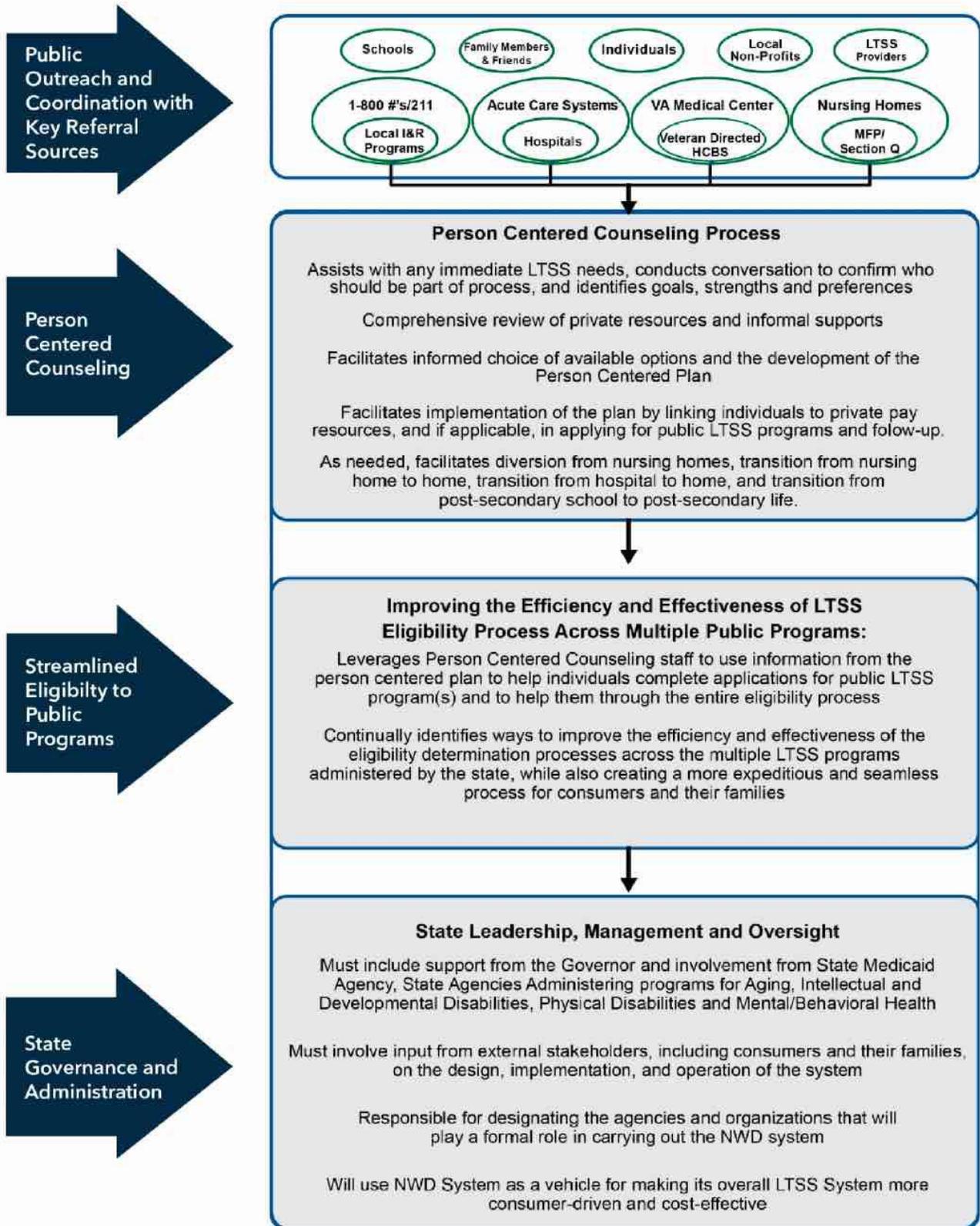
1. As California contemplates next steps, a decision needs to be made as to whether it is a mandated NWD “system” or a voluntary NWD “approach?”
2. Is the NWD intended to be a centralized point of entry, a “one-stop” shop where a wide range of consumers and providers can access all of their information needs in one place, or is information intended to be distributed among multiple, reliable community partners and platforms to encourage consumer choice and ease of access?
3. Who is the NWD system designed to support?

The report states that developing a true NWD system requires far more than goodwill and coordination. To move forward on large-scale system change, California will need to address the critical requirements of an effective NWD system, with each additional requirement potentially bringing new state and local costs.

Below are a few of the schematics included in the report.



### No Wrong Door Schematic



**Panel**

**Questions for the Panel:**

- ◇ What are the main recommendations in the recently-released No Wrong Door report?
- ◇ Which of the recommendations in the report rise to priority level, particularly given the challenges discussed under Issues 1 and 10?
- ◇ Are there no-cost or low-cost options in the report that can be activated in the short-term?
- ◇ What are critical follow-up steps to ensure that we make progress on No Wrong Door, which is intended to facilitate, increase, and streamline access to needed public supports and services?

**Panel:**

- Susan DeMarois, Director, California Department of Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst's Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Staff Comments**

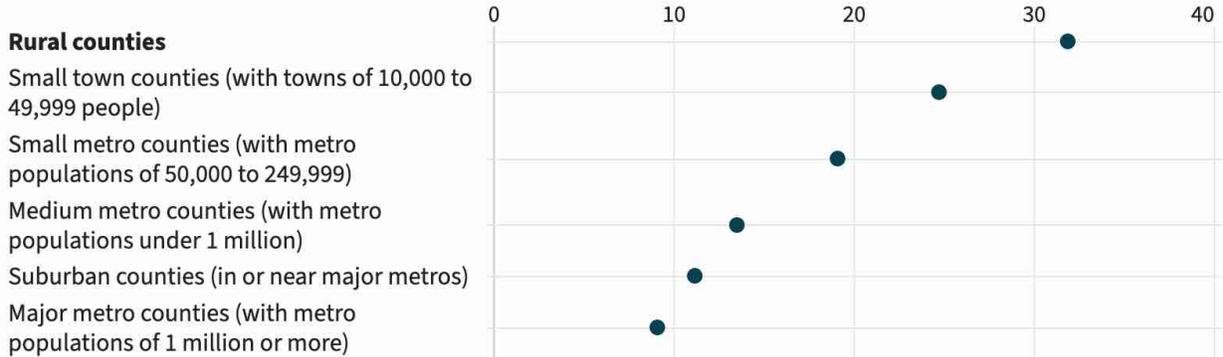
**Staff Recommendation:** Hold open.

**Issue 12: Trends of and Responses to Senior Rural Suicides**

A *CalMatters* December 22, 2025 [article](#) titled, “Remembering Papa: Northern California’s elderly face hidden epidemic of gun suicides,” reported on senior Californians in rural communities dying by suicide at troubling rates—struggling with pain, cut off from doctors and mental health care, with guns at hand. Access to care and safety planning would help, experts say. The following two charts were included in the article.

**Rural counties have the highest rates of gun suicide among older adults**

Gun suicide rates per 100,000 residents aged 70 or older are higher in **rural California counties**. These areas have higher gun ownership rates and more limited access to medical and mental health services.

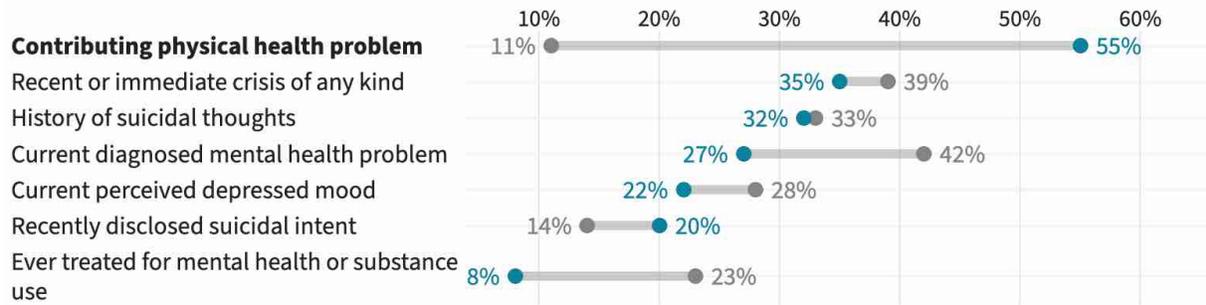


Note: Rates for gun suicides among older adults are calculated from 2009 to 2023. County data is aggregated by CDC urban–rural classifications; categories have been simplified for clarity.

Chart: Natasha Uzcátegui-Liggett, CalMatters • Source: [The Trace](#) analysis of data from the [Centers for Disease Control and Prevention](#) • [Embed](#)

**Many older adults who died by gun suicide had a contributing physical health problem**

Among people who died by gun suicide, **those 70 and older** were much more likely to have a contributing physical health problem than **people under 70**, according to 2021 data from 31 California counties.



Note: Chart includes data from 31 counties that participated in the California Violent Death Reporting System (CalVDRS) and is not representative of all suicide deaths statewide. Data is limited to suicide deaths for which at least one circumstance is known from the law enforcement or coroner and medical examiner reports provided to CalVDRS.

Chart: Natasha Uzcátegui-Liggett, CalMatters • Source: [California Violent Death Reporting System](#) • [Embed](#)

The following information was provided by the California Department of Aging (CDA).

CDA's Director is an active member of the CalHHS Agency Behavioral Health Task Force, the DHCS-led California Behavioral Health Planning Council, and the 988 Policy Workgroup. In addition, CDA contracts with the Institute on Aging to support Friendship Line California, which receives close to 16,000 calls each month from older adults seeking warm line support.

The CalMatters article referenced reflects the tragedy of older adult suicide, particularly among older men with access to guns, and the isolation often faced among those living in rural areas. California also witnessed two tragic and unthinkable mass shooting events in [Monterey Park](#), [Half Moon Bay](#), as well as in [Laguna Woods](#), which put a harsh light on the growing epidemic of gun violence, but also of an invisible behavioral health crisis that is significantly impacting older adults. The shooter in Monterey Park was a 72-year-old male, the Half Moon Bay shooter was a 66-year-old male, and the Laguna Woods shooter was a 68-year-old male. Tragically, the majority of the 18 victims were in their 50s, 60s and 70s.

**Guns and Older Adults.** According to the Pew Research Center, approximately [one third of Americans over age 65 own a gun](#), and an additional 12 percent of them live with someone who does. Further, nearly 33 percent of people who die from firearm injuries in the U.S. are over aged 50. Despite the fact that the [vast majority of mass shooters are under age 45](#), gun violence among older adults is real – and it is the reflection both of a gun violence epidemic and an endemic behavioral health crisis facing the population.

**Unmasking a Crisis in the Shadows.** The intersection of gun violence and behavioral health points to a growing crisis for older adults, which is rarely brought to light. Suicide is a major driver of gun deaths in older adults with approximately 84 percent of firearm deaths among older adults attributed to suicide. In 2018, [suicides by firearms was the third leading cause of injury deaths in those 65 years of age and older](#). Of concern, suicide rates [have also climbed](#), up 28 percent from 1999 to 2016. More than 8,200 older adults committed suicide in 2016, according to the Centers for Disease Control and Prevention. Among men, those over age 65 [are the likeliest to take their lives](#), and three-quarters of them use a gun. The suicides point to evidence of a growing behavioral health crisis impacting California's older adults.

**Older Adult Suicides in California.** The California Department of Public Health (CDPH) reported a total of 4,497 suicide deaths among California residents in 2018. Of these, 21 percent (962 suicides) were among older adults, for a rate of 16.3 deaths per 100,000 Californians aged 65 and older. Approximately 83 percent of older adult suicides were males; 46 percent of those were among Veterans. For males, the rate of suicide increased with age and was nearly 10 times the rate of females in individuals aged 85 and older. CDA continues to work closely with CDPH's Office of Suicide Prevention to understand trends in older adult suicide and determine what can be done through a whole-of-government and whole-of-society approach to address the issue.

**Unmet Behavioral Health Needs.** According to the [UCLA Center for Health Policy Research](#), close to half of all Americans will have experienced a diagnosable behavioral health disorder by the age of 75—and yet, less than one-third of those older adults in need of mental health services receive appropriate care. In California, a relatively small proportion of older adults with

behavioral health needs receive the services and supports they need. A 2018 report of the UCLA Center for Health Policy Research identified unmet behavioral health needs and geographic disparities in access to services across California, with few programs or outreach efforts tailored to meet the complex care needs of older adults. In addition, there are critical equity considerations to elevate, with Black/Latino/Indigenous/Asian Pacific Islander older adults more likely than their white counterparts to report high levels of psychological distress and serious mental illness (SMI). Likewise, data strongly suggests that LGBTQ+ older adults experience higher rates of mental distress than heterosexuals of similar age.

**The Epidemic of Older Adult Isolation and Loneliness.** Experts note the growing crisis of gun [violence can also be driven by an epidemic of isolation and loneliness](#). In at least one of the recent shootings, it appears tied to a perpetrator who may have exhibited signs of social isolation and/or violent behavior, according to authorities. According to the [federal Centers for Disease Control](#), loneliness and social isolation in older adults presents a serious health risk, putting them at risk for dementia and other chronic conditions. In California, changing family systems have exacerbated isolation among older adults, due to the [growing childless older adult population](#), as noted in a recent report by the US Census.

Further, a [report](#) from the National Academies of Sciences, Engineering, and Medicine (NASEM) notes that nearly one-fourth of adults aged 65 and older are considered socially isolated. This increased risk for isolation and loneliness is due to many factors including living alone, the loss of family or friends, chronic illness, and hearing loss. Those older adults most vulnerable to isolation include immigrants, LGBTQ, people of color, and victims of elder abuse. The CDC notes that Latino immigrants, for example, “have fewer social ties and lower levels of social integration than US-born Latinos.” First-generation immigrants experience stressors that can increase their social isolation, such as language barriers, differences in community, family dynamics, and new relationships that lack depth or history. Similarly, gay, lesbian, and bisexual populations tend to have more loneliness than their heterosexual peers because of stigma, discrimination, and barriers to care. According to California’s Aging Data Dashboard, statewide one in five of adults aged 60 or older live alone.

**Alignment with the Master Plan for Aging.** As California’s population ages and becomes increasingly diverse with 1 in 4 people aged 60 and over by 2030, it is important to develop systems needed to prepare for and respond to the increasing need for behavioral health services. California’s MPA reimagines how older adults access health care, including mental health and behavioral health services. The MPA further prioritizes equity and inclusion, not isolation, as older adults – especially Black, Latino, Asian Pacific Islander, and Indigenous older adults – emerge from the impacts of the COVID-19 pandemic.

The epidemic of older adult suicide – including older adults living in rural areas as illustrated in the Cal Matters report – is central to the MPA’s efforts to raise awareness about the behavioral health needs of older adults. The 2023-24 enacted budget included a [\\$50 million initiative to address older adult behavioral health](#). Among other provisions, this initiative would have launched the Older Adult Behavioral Health Community Capacity Building Grant Program, which would have also targeted rural areas. However, due to budget constraints, the initiative was later

eliminated. For the 2025-26 MPA initiatives, MPA Goal 2, Health Reimagined, includes four initiatives for 2025-26 (Initiatives 35-38) to address older adult behavioral health.

#	Theme	Initiative	Agency/Department
35	Older Adult Behavioral Health	Include the specialized needs of older adults in developing and implementing the behavioral health workforce components of the California Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT) Demonstration and Behavioral Health Services Act (BHSA)/Proposition 1 (2024).	CalHHS: HCAI, CDA
36	Older Adult Behavioral Health	Incorporate older adults into population-based behavioral health prevention strategies.	CalHHS: CDPH, CDA
37	Older Adult Behavioral Health	Develop a stakeholder educational toolkit to inform local partners of the needs of older adults through the implementation of the Behavioral Health Services Act (BHSA)/Proposition 1 (2024).	CalHHS: CDA
38	Older Adult Substance Use Disorder	Focus on the unique needs of older adults who have substance use disorder in the Statewide Overdose Safety (SOS) Workgroup and overdose prevention strategies.	CalHHS: CDPH

To see progress in advancing the above initiatives, please see [the MPA Implementation Tracker](#). Additionally, [CDA's Older Adult Behavioral Health website](#) offers resources for stakeholders including a county toolkit to inform local partners about opportunities through the Behavioral Health Services Act (MPA initiative 37).

**Panel**

**Questions for the Panel:**

- ◇ Is CDA aware of these trends in senior rural suicides?
- ◇ What specific steps is the state taking to reduce these incidents and address underlying issues for the senior community?
- ◇ Is there more that can be done to stem these tragedies, and how do these trends relate to the other issues discussed in this hearing?

**Panel:**

- Sarah Steenhausen, Deputy Director, California Department of Aging
- Juwan Trotter, Fiscal and Policy Analyst, Legislative Analyst’s Office
- Jennifer Ramirez, Finance Budget Analyst, Department of Finance

**Staff Comments**

**Staff Recommendation:** Hold open.

## Non-Presentation Items

The following proposals do not require a formal presentation from the Administration, allowing the Subcommittee to focus time in the hearing on the most significant issues. Members of the Subcommittee may ask questions, make comments, or request a presentation by the Administration on these proposals, at the discretion of the Subcommittee Chair. Members of the public can provide public comment on these items during the Public Comment period, after discussion on the issues to be heard has concluded.

### 5180 Department of Social Services (DSS)

### 4170 California Department of Aging (CDA)

#### Issue 13: Related Governor's Budget Change Proposals (BCPs)

- ◇ DSS Permanent Position Authority for Housing and Homelessness Programs BCP
- ◇ DSS Ensuring Access to Medicaid Services (Access Rule) BCP
- ◇ CDA Health Insurance Counseling and Advocacy Program Modernization BCP
- ◇ CDA Meal Program: Senior Citizens (AB 1476) BCP

A description of each of these proposals in the Governor's Budget is included here. Please see the [Department of Finance's website for more detailed information](#).

**DSS Permanent Position Authority for Housing and Homelessness Programs BCP.** The proposal is for 11 permanent positions to oversee housing and homelessness programs, fulfill legislative mandates, and provide critical services to individuals and families at risk of or experiencing homelessness. The requested positions in this proposal are for the continuation of existing positions that require permanent ongoing authority, including some limited-term resources that are set to expire beginning June 30, 2026.

**DSS Ensuring Access to Medicaid Services (Access Rule) BCP.** The proposal requests \$2,820,000 (\$374,000 General Fund and \$2,446,000 reimbursements) in fiscal year 2026-27 and \$5,336,000 (\$1,444,000 General Fund and \$3,892,000 reimbursements) in 2027-28 and ongoing, and 27 permanent positions to manage the workload associated with implementing the Centers for Medicare and Medicaid Services (CMS) Ensuring Access to Medicaid Services Final Rule (CMS-2442-F).

**CDA Health Insurance Counseling and Advocacy Program Modernization BCP.** The proposal requests \$3.49 million in 2026-27 and \$5.52 million ongoing Health Insurance Counseling and Advocacy Program (HICAP) Fund to (1) make permanent existing state and local resources included in the 2021 Budget Act in 2021-22, and (2) hire additional HICAP counselor positions and improve and standardize HICAP training statewide. This request would strengthen the HICAP modernization efforts to hire, train, and coordinate the activities of paid staff and volunteers to serve more Medicare beneficiaries and improve service quality through standardized statewide training and access, and improve cultural competency and services to diverse and underserved communities. At the CDA level, the resources would support 3

positions that provide local HICAP training, fiscal technical assistance, and data collection and analysis.

**CDA Meal Program: Senior Citizens (AB 1476) BCP.** The proposal requests \$152,000 General Fund in 2026-27 and ongoing to support 1 position for increased oversight responsibilities for the Older American’s Act Title III-C Nutrition Program pursuant to Chapter 302, Statutes of 2025 (AB 1476).

**Staff Comments**

These BCPs remain under review by Subcommittee No. 2.

**Staff Recommendation:** Hold open.

This agenda and other publications are available on the Assembly Budget Committee’s website at: [Sub 2 Hearing Agendas | California State Assembly](#). You may contact the Committee at (916) 319-2099. This agenda was prepared by Nicole Vazquez.