March 12, 2026

To: The Honorable Caroline Menjivar
Chair, Senate Budget Subcommittee No. 3

Honorable Members
Senate Budget Subcommittee No. 3

The Honorable Dr. Corey A. Jackson
Chair, Assembly Budget Subcommittee No. 2

Honorable Members
Assembly Budget Subcommittee No. 2

From: Carlos Marquez III, Executive Director, CWDA

RE: IN-HOME SUPPORTIVE SERVICES (IHSS) BUDGET PROPOSALS

The County Welfare Directors Association of California (CWDA) respectfully urges the Legislature to reject proposed reductions to the In-Home Supportive Services (IHSS) program included in the Fiscal Year (FY) 2026-27 Governor's Budget that would have grave consequences for consumers, and to adopt statutory changes that preserve the current 50/50 cost-sharing arrangement between the State and counties for Community First Choice Option (CFCO) penalties. These actions are essential to ensure older adults and people with disabilities retain safe, reliable access to in-home care through the IHSS program, a critical component of California's long-term services and supports system.

IHSS is Essential to Meet the Need of California's Aging and Disabled Population. As of January 2026, IHSS enables nearly 900,000[1] older adults and people with disabilities to live safely in their homes (already exceeding the FY 2026-27 caseload projection in the Governor's Budget), supported by almost 800,000 trusted caregivers. The program enables older adults to age with dignity and independence in their own homes. It helps with daily and domestic tasks such as housework, meal preparation, laundry, personal care services, and accompaniment to medical appointments, allowing recipients to remain in their community and live independently. Without IHSS, many individuals would be forced into institutional settings

[1] IHSS_Program_Data-Jan2026.xlsx

that are three to four times more expensive[23], leading to higher long-term state costs. IHSS enhances quality of life by making it easier to live at home and reduces the time and financial burdens placed on family and friend caregivers.

Demand for IHSS continues to rise rapidly as California's population ages. Between 2010 and 2022, the number of Californians aged 65 and older increased by approximately 44%, and that number will only continue to soar over the next twenty years. More specifically, the Governor's Budget estimates IHSS caseload will further increase by 10% in FY 2025-26 and 8% in FY 2026-27—in fact, since the release of the Governor's Budget, the rate of growth has already exceeded these projections based on actual caseloads as of January 2026. As California's aging population grows, it should be expected that the demand for IHSS will also increase.

County Administration of IHSS is Chronically Underfunded. County IHSS administration has been chronically underfunded for several years. By the Administration's own assessment, the program is underfunded by at least $246 million total funds ($125 million General Fund). This shortfall has resulted in extreme caseloads, 400–600 clients per social worker in some counties, creating delays in reassessment timeliness, contributing to staff turnover, and worsening access to care. Nearly half of all counties have been unable to increase staffing over the last two fiscal years because their administrative funding allocation is insufficient to support additional positions. Underfunding of social workers—the gateway to IHSS services—leads to greater likelihood of reduced compliance with federal and state mandates for timely intakes and reassessments and limits counties' capacity to keep pace with rising demand for services.

Removal of State's Share of Cost for Growth in IHSS Hours Ignores Program Cost Drivers and Undermines Program Access. The Governor's Budget proposes eliminating the state's share of cost associated with growth in IHSS hours provided to consumers (a $233.6 million General Fund shift to counties), beginning in FY 2027-28. The Administration justifies the proposed cost shift by noting that functional index (FI) scores, which measure an individual's relative need for in-home assistance, have remained relatively stable as authorized hours have increased. This suggests counties may not be conducting assessments accurately or consistently. However, counties utilize state-mandated tools to assess for services, and the California Department of Social Services (CDSS) maintains significant oversight of county assessments through the legislatively-mandated comprehensive Quality Assurance (QA)

[2] California Health Care Foundation, *Policy at a Glance,* https://www.chcf.org/wpcontent/uploads/2025/04/MediCalSeniors_PolicyAtAGlance.pdf, April 2025.

[3] California Legislative Analyst's Office (LAO), *The 2025-2026 Budget for IHSS*, https://lao.ca.gov/Publications/Report/5009#:~:text=Cost%20Per%20Hour%20Continues%20to,hour%20in%20January%201%2C%202025, March 2025.

process. To our knowledge, such accuracy concerns have never been raised through existing QA or State oversight settings and have only recently emerged for the first time in the context of proposed State General Fund savings. Shifting these costs onto counties does not address assessment accuracy but instead places IHSS recipients' health at risk and counties under further financial strain, the latter of which directly impacts health and social service safety net programs more broadly.

Cost drivers, including California's continued and significant growth of its aging population, are impacting the IHSS program. There are more older adults in the program and they are living longer. As older adults live longer, they require increasing service hours, needs-based fluctuations that fall well within established FI scores. Rising hours also reflect increases in the number of people with cognitive impairments, such as dementia and Alzheimer's disease, who require protective supervision. Protective supervision provides additional supervision for individuals with cognitive impairments who need constant monitoring to prevent injury or danger. Protective supervision cases receive the maximum number of authorized hours, but FI rankings do not account for the need for protective supervision. As a result, an individual with a low FI rank can still be approved for what may seem like an unusually high number of hours if they qualify for protective supervision. These and other root causes for cost drivers in the IHSS program should be analyzed and discussed with counties, policy makers, and stakeholders, rather than assuming counties are inaccurately assessing services and thereby shifting these growing costs on to counties, if effectuated will have dire impacts on providers and consumers alike. For further discussion on these factors and cost drivers, please see CWDA's analysis in Attachment A.

State Validates County Assessment Accuracy and Demographic Cost Drivers. Recent correspondence from the California Department of Health Care Services (DHCS) to the Centers for Medicare & Medicaid Services (CMS)—in response to the Dr. Mehmet Oz, Federal Administrator for CMS, communication calling upon certain states including California to justify their increasing Medicaid expenditures including in the IHSS Program—directly affirms that increased IHSS hours are not the result of inaccurate county assessments, but rather the predictable outcome of demographic shifts and rising needs among program recipients. In its February 17, 2026, response to CMS, ***the State clearly affirms that IHSS expenditure growth is the "predictable and intended result" of long-standing federal and state rebalancing policy encouraging home- and community-based services.*** The State further confirms that caseload growth, aging of the population, and higher service requirements are driving higher authorized hours, not county error, noting that ***"higher approved service hours correspond to increased acuity and functional need"*** and that the California State Auditor has identified no systemic issues with IHSS expenditure growth[4]. This explicit recognition by the State reinforces CWDA's

[4] California State Auditor. (2021). In-Home Supportive Services Program. Report 2020-109

position: IHSS hours growth is consistent with demographic reality, and the needs of an aging population, and should not be mischaracterized as evidence of county error.

Cost-Shift Proposal Will Aggravate Existing Pressures on Social Safety Net Programs Funded by 1991 Realignment Revenues. As IHSS is a realigned program under 1991 Realignment, removing the State's cost-share in hours growth would effectively place a higher burden on 1991 Realignment funding that counties rely upon to support caseload and cost growth in the IHSS Program, locally-negotiated IHSS wages and benefit increases that are collectively bargained, as well as other health and human services programs realigned to counties and delivered by county agencies serving the most vulnerable Californians, including but not limited to foster care/child welfare programs, CalWORKs, CalFresh administration, behavioral/mental health, and public health.

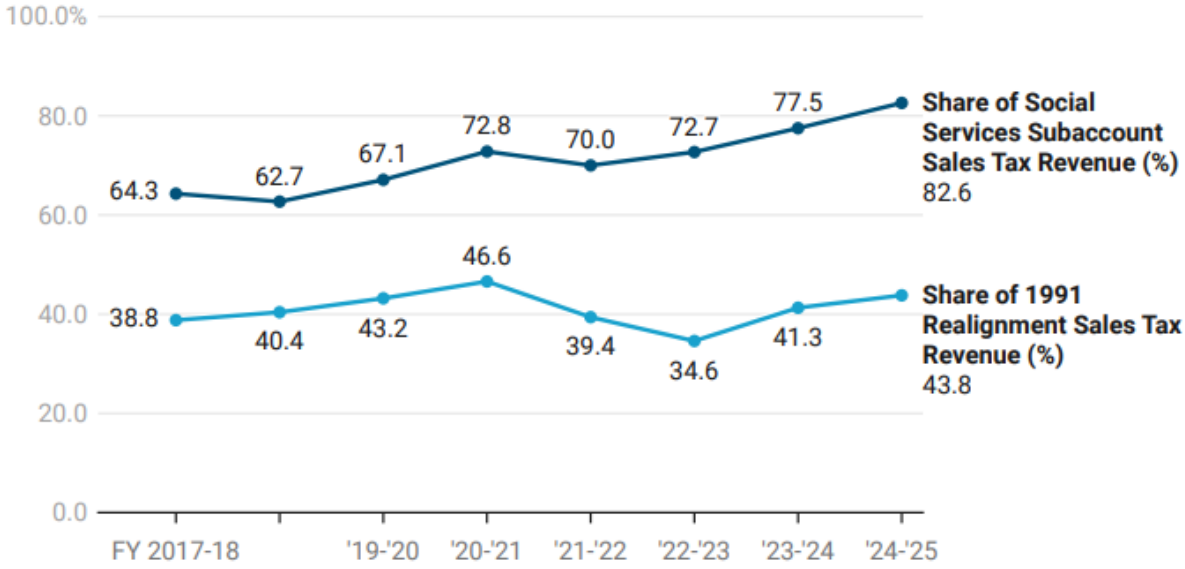
In fact, for FY 2024-25, counties' share of IHSS services costs (known as the IHSS Maintenance-of-Effort, or MOE)—despite being most recently re-based in 2019—already absorbs a considerable amount of dedicated realignment revenues for social services programs, with the FY 2024-25 IHSS MOE accounting for approximately 81% of social services realignment funding (Social Services Base, inclusive of sales tax and VLF) for that year. This leaves little funding available for other realigned human services programs, such as CalFresh administration, which is experiencing significant policy changes and cost pressures as a result of H.R. 1 that will impact vulnerable clients. Moreover, for the past two years, realignment revenues (specifically 1991 Realignment sales tax revenues) which allow counties to meet growth in costs for realigned programs such as IHSS have not grown and have failed to reach the existing base level of funding. There is currently $234.4 million in unpaid growth funding across FYs 2023-24 and 2024-25 alone for human services programs, severely jeopardizing counties' ability to meet currently growing costs of the IHSS program. Given this trend, many counties will be facing significant funding gaps as they work to sustain increased local costs—including cost shifts and efforts to mitigate harm as a result of H.R. 1.

This is further evidenced by the UC Berkeley Labor Center report[5] to CDSS (December 2024) related to statewide collective bargaining, which highlights the growth in IHSS costs are taking an increasing share of the overall 1991 Realignment revenues, and "because growth in the MOE has outpaced growth in sales tax revenues, counties today have a smaller share of Realignment funding available to pay for other realigned social services, health, and mental health programs than in the period prior to the pandemic." See below chart from the UC Berkeley Labor Center report which demonstrates how counties' share of IHSS costs account for a growing portion of

[5] Rhee, Nari, et al. *Analysis of the Potential Impacts of Statewide or Regional Collective Bargaining for In-Home Supportive Services Providers*. UC Berkeley Labor Center, 2024.

available 1991 realignment revenues for health and human services programs. The proposal will magnify these challenges, making it more difficult for counties to cover the costs for safety net programs through 1991 Realignment, as was intended when 1991 Realignment was established. Some counties may be forced to rely on other county fund sources that support county infrastructure (i.e. transportation, parks), which will result in reduced services and infrastructure investments, such as senior transportation services to county residents, including older adults and persons with disabilities. Other counties may be forced to make cuts to their social safety net program operations.

Figure 6.2. County MOE Share of 1991 Realignment Sales Tax Revenues and Social Services Subaccount Revenues, FY 2017-18 to FY 2024-25 (est.)



Note: Blue Sky Consulting Group analysis of data from the California Department of Finance and IHSS program cost data obtained from the California Department of Social Services.

Note: The aforementioned 81% figure includes social services and VLF base funding for social services programs, VLF funding comprises a small share of total available funding for social services programs under 1991 realignment (approx. $216 million of $2.7 billion). The above chart highlights the IHSS MOE as a portion of sales tax revenues.

Lastly, we note this proposal is at odds with the existing IHSS cost-sharing framework and agreement as established in 2019 (Chapter 27, Statutes of 2019). The 2019 IHSS MOE was implemented in accordance with recommendations from the Department of Finance's Senate

Bill 90: 1991 Realignment Report.[6] As outlined by the Department of Finance, the main goal of the IHSS MOE reform was to ensure that county IHSS expenses remain within the limits of available social services Realignment funding, preventing counties from having to redirect resources from other health and human services programs.

Proposed Cost Shift and Associated Trailer Bill Language Poses Risks to IHSS Stability and Caregiver Workforce. The proposed cost shift and its associated trailer bill language (TBL) create both a perverse incentive for counties to reduce hours for services legitimately needed to keep highly vulnerable Californians safely in their homes, as well as produce a chilling effect on county collective bargaining efforts with IHSS provider representatives. At worst, the proposed trailer bill language would create a "race to the bottom" as the caseload average would be reset annually, thereby incentivizing counties to always be below that average. As the TBL is currently drafted, 50 percent of counties would always be below that statewide average and therefore subject to the cost shift. This structure would also punish counties with particularly vulnerable demographics such as a higher proportion of an older population, as their IHSS consumers may have a higher-than-average hours need.

Counties serve as the employer of record for bargaining purposes, and their ability to negotiate competitive wages and benefits is tied to stable and adequate program funding. When the State withdraws support, such as through reductions in hours-per-case funding or unfunded administrative cost burdens, counties are left with fewer resources to meet provider demands. As counties face heightened fiscal pressure, they are less able to negotiate fair, livable wages with providers, this weakens the caregiving workforce at a moment when IHSS is already experiencing shortages and rising demand.

Proposed Solution: Reject the Governor's Proposed Removal of the State's Share of Cost for Growth in Hours and Associated TBL

CWDA urges the Legislature to reject the $233.6 million reduction and its associated TBL included in the Governor's Budget. Rejecting this proposal will prevent counties from making difficult decisions that may lead to dangerous service gaps, destabilization of the caregiving workforce, and increased hospitalization and institutionalization among older adults and people with disabilities. Moreover, this proposal exacerbates county fiscal pressures by shifting additional safety net costs all at a time when county resources are critical to mitigate the most severe impacts of H.R. 1.

Impact of CFCO Fiscal Penalties Enacted in the 2025 Budget Act. Counties are already under immense strain due to the IHSS Community First Choice Option (CFCO) penalties enacted in

[6] https://www.counties.org/wp-content/uploads/2025/04/senate_bill_90-1991_realignment_report.pdf

the 2025 Budget Act. CWDA respectfully urges the Legislature to enact trailer bill language in the 2026 Budget Act that maintains the current 50 percent State, 50 percent county cost-sharing arrangement between the State and counties for IHSS CFCO penalties. 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.

Under federal CFCO rules, California must maintain 100% compliance with timely IHSS reassessments to retain an enhanced 56% federal funding match (6% above the standard federal match). If compliance falls short, the State faces financial penalties by forfeiting the enhanced match. Historically, the State paid these penalties. However, beginning July 1, 2025, counties were required to cover half, and beginning July 1, 2026, counties will be responsible for the full cost based on current law.

CFCO Penalties are Exacerbating Application Backlogs and County Understaffing Issues. The State estimated this cost shift due to CFCO penalties to be $40.5 million in FY 2025-26 (representing 50% of the full estimated penalty cost, for a full cost of $81 million), growing to $92.1 million in FY 2026-27. As of December 2025, counties have been assessed approximately $7.7 million in penalties. Based on the actual penalties incurred and estimates of future penalty assessments, CWDA estimates the FY 2026-27 total cost to be much lower than expected. To maintain the 50% State/50% county cost split, CWDA estimates the total General Fund impact to be approximately $16 million in FY 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. IHSS social workers process applications and annually review and adjust needs. Counties report that IHSS applications are taking longer to respond to, and other IHSS recipients who may have growing needs for additional services are receiving a delayed response from overburdened social work staff. Since the CFCO penalties were enacted, roughly one in six counties have seen a decline of more than 10% in the share of applications processed within the required 90-day timeframe. The latest data from CDSS shows that the number of late applications processed has grown from over 1,600 applications in July 2025 to over 4,600 applications as of December 2025. This trend cannot be explained as a short-term backlog that will be resolved once counties catch up on CFCO reassessments, as the sustained and accelerating growth in late applications reflects a workforce capacity problem driven by chronic IHSS social worker understaffing that reallocating staff to CFCO compliance has only intensified.

The State is responsible for funding the administrative costs of social workers who perform assessments and reassessments. Yet and as noted above, while the State has affirmed that counties are underfunded for IHSS administration, the Budget has not included funding for counties at adequate levels according to the State's own analysis. Because of this

underfunding, counties must preserve whatever funding they can for administration. Further impacting funding is the fact that caseloads have been increasing faster than administrative funding. In the 2019-20 fiscal year counties received a total of $300.6 million for IHSS program administration; in 2025-26 counties received $431.1 million for administration, or a roughly 43.4 percent increase. For comparison, during that same period, IHSS caseload increased by 56.4 percent, from about 518,000 to 810,000.

These delays are having real impacts of unintentional harm on clients. See below a few examples of the real-world impacts penalties are having on current IHSS recipients and applicants.

Consider "Dan", an 80-year-old living alone. Dan experienced a significant change in condition requiring increased hours and requested a change-in-condition assessment. However, because CFCO cases are being prioritized his assessment was significantly delayed. During the waiting period for an assessment, Dan's needs are going unaddressed.

A son submitted an IHSS application on behalf of their aged father in October. Due to the prioritization of CFCO cases, the county advised an assessment would not occur for 2–3 more months. The applicant has 11 different medical diagnoses, and his family has been advised by his physician to not leave him alone. The delay places him at risk of injury and may jeopardize his ability to safely remain at home.

Increasing penalties without addressing the above issues worsens existing administrative strain and delays access to care for consumers. Counties are already struggling to absorb costs imposed in the 2025 Budget Act. The absorption of 100% of the CFCO penalties, which is set to take effect July 1, 2026, will only exacerbate these undesired tradeoffs, negatively impacting the ability for older adults and persons with disabilities, including young children served through regional centers, from accessing IHSS services and threatening IHSS provider capacity. IHSS applicants will wait longer to receive services, annual reassessments will be delayed, and those who rely on IHSS services could face serious threats to their safety and stability.

Proposed Solution: Adopt TBL to Maintain the Current CFCO Penalty Cost-Sharing Arrangement and Other Clarifying Changes

In addition to maintaining the 50/50 split in CFCO penalties to address fiscal and client concerns, CWDA has identified both technical and programmatic concerns related to CFCO penalties that we are proposing to address through proposed TBL. The CWDA TBL (Attachment B) would address the following:

- Maintain the current 50/50 state-county cost-sharing arrangement for CFCO penalties,

  Preserving the existing cost-sharing arrangement is essential to safeguard counties from shouldering the full fiscal impact of CFCO penalties at a time when demand for IHSS is growing and county staffing capacity remains severely constrained. County social

workers are already struggling to complete reassessments and respond to new applications within required timeframes due to chronic underfunding and caseload pressures. Shifting 100% of the penalty to counties would intensify these pressures, divert resources away from processing intakes, and risk reduced access to timely IHSS assessments for older adults and people with disabilities. Maintaining a shared cost arrangement avoids destabilizing an already fragile system and is essential to protect program access and relieve additional pressure on county systems struggling to meet growing demand.

- Make county penalty payments contingent on CDSS providing specific information to counties to allow for county-level financial reconciliation and documentation,

  We appreciate efforts the State has made to provide counties back-up documentation for counties to be able to verify the penalties, and understand runway was needed to develop processes and pull together the relevant data sources to assist counties in their validation of the penalty amounts. However, counties often identify discrepancies between their own calculations and the penalty amounts invoiced by the state, but the underlying reasons for these discrepancies were challenging for counties to identify the source of due to insufficient or lagging case-level or process-level information, some of which took months for the State to provide. This lack of clarity undermines counties' ability to plan, budget and ensure the accuracy of assessments. Without sufficient information counties are unable to reconcile penalty amounts with overdue cases, which creates auditing risks and will result in penalty payment delays. The proposed TBL would condition county penalty payments on CDSS providing the necessary documentation, ensuring accountability and transparency, improving data quality, and enabling counties to properly verify and manage their financial obligations.

- Exempt cases that move counties or return from leave from penalty calculations for 30 days after notifying the county of the status change,

  Counties are currently being penalized for factors entirely outside their control—most notably when IHSS recipients transfer between counties or return from hospitalization, out-of-home care, or leave status. In these scenarios, reassessment due dates can fall soon after the individual's return, causing the case to become overdue almost instantaneously. Counties are then penalized even though they have no practical opportunity to schedule or complete the reassessment in time. Establishing a 30-day exemption period in these circumstances is a reasonable and necessary fix. It protects counties from unfair penalties, aligns the system with real-world operational constraints, and ensures penalties reflect genuine delays rather than unavoidable real-world transitions.

- And add technical fix to prevent full pass-through of any federal match losses that are

unrelated to late county reassessments and the IHSS CFCO penalties at hand.

CWDA believes the original statute to effectuate the CFCO penalties was unintentionally broad, and under a scenario where the State loses the enhanced CFCO match for reasons beyond county-specific overdue reassessments (for example, in the event of a federal rule change), it could suggest pass-through of the full liability of loss of federal funds onto counties. This was never the intent of the original proposal and clean up language is needed to clarify that the penalty is only specific to overdue CFCO reassessments. Without statutory clarification, counties risk being held financially responsible for federal funding losses that have no connection to late reassessments or county performance. The TBL would add technical corrections to ensure that counties are only responsible for penalties directly tied to documented county-level delays. This safeguard preserves the integrity of the cost-sharing framework and prevents inappropriate cost-shifting to counties.

Below we comment on the Administration's other IHSS budget proposals:

- **Eliminating the IHSS Backup Provider System (BUPS) (a $3.5 million General Fund reduction).** BUPS prevents gaps in care when a regular IHSS provider is unavailable by matching IHSS recipients with short-term providers. According to the California Association of Public Authorities (CAPA), in FY 2024-25 over 4,100 requests were submitted to BUPS, and almost 2,500 were fulfilled. Note that CAPA could not gather data from all 58 counties, and as of this date CDSS has not provided CWDA with the requested data for all 58 counties, but we believe it is likely that the number of requests received and fulfilled is higher. Eliminating BUPS would leave recipients with no safety net, creating service gaps for consumers who rely on backup providers in emergency situations. Consumers with the most complex needs, especially those relying on backup providers, will face increased health risks and potential institutionalization. We also note that the BUPS was already reduced in the FY 2024-25 Budget by $3 million General Fund to true up to utilization of the program.
- **Auto-terminating IHSS recipients when Medi-Cal is discontinued (an $86 million General Fund reduction).** The Governor's budget proposes to automate the termination of IHSS to align with the termination of Medi-Cal eligibility. Currently, when a Medi-Cal case is discontinued, the IHSS recipient falls into the IHSS Residual program and payments to their provider can continue until the county takes action to reinstate Medi-Cal. Once the individual comes back into Medi-Cal, the IHSS social worker will rescind the discontinuance and reinstate the recipient in IHSS. The near immediate removal from IHSS, as proposed, will cause a lapse in pay to IHSS providers, until Medi-Cal is restored, which will cause hardship for both recipients and their care providers. County IHSS social workers, in many counties, will engage recipients to encourage them to come into Medi-Cal compliance, rather than immediately terminate their benefits.

While framed as a cost containment measure, the "savings" would come from denying services to low-income older adults and people with disabilities. Auto-termination will disrupt care continuity and create payment lapses for providers. These reductions come at the expense of low-income disabled Californians and older adults who rely on IHSS as their lifeline. Although CDSS has indicated to CWDA and counties that current programming in the Case Management Information and Payrolling System (CMIPS) will largely automate restoration, the current automation does not completely mitigate our concerns on impacts to clients and consumers and will create further workload issues for county social workers.

- Trailer Bill Language: Strengthen Oversight of For-Profit Advocacy Organizations. CWDA supports the Governor's proposed trailer language providing oversight and guardrails to protect vulnerable IHSS recipients from exploitation by unregulated, for-profit entities. The language provides strong recipient protections and better oversight and accountability for-profit advocacy organizations. We request an amendment to subdivision (k) relating to determinations that lead to the suspension of for-profit organizations' ability to act as an authorized representative. We specifically request that "or county" be stricken from that section as we believe it is more appropriate for the department to make this determination.

Conclusion. IHSS is the foundation that allows hundreds of thousands of Californians to live with dignity, stability, and independence in their own homes. The proposed reductions and full shift of CFCO penalties to counties would result in the removal of vital support from older adults and persons with disabilities who rely on IHSS for their most basic daily needs, disrupt trusted care relationships, and increase the physical, emotional, and safety risks facing older adults and people with disabilities. Cost shifts to counties are untenable and puts inappropriate and unsustainable fiscal pressure on counties in their ability to meet other health and social service program mandates through 1991 Realignment. Ultimately, these proposals would destabilize the home and community-based services system California has worked to strengthen.

CWDA urges the Legislature to **reject the proposed IHSS reductions, maintain the 50/50 CFCO penalty cost-sharing**, and **adopt the requested statutory clarifications** to ensure accountability and continued access to essential in-home care services.

Sincerely,

Carlos Marquez III, Executive Director | CWDA

Cc: Chris Woods, Office of the Senate President Pro Tempore
Mareva Brown, Office of the Senate President Pro Tempore
Jason Sisney, Office of the Speaker of the Assembly
Kelsy Castillo, Office of the Speaker of the Assembly
Elizabeth Freeman, Senate Budget and Fiscal Review Subcommittee No. 3
Nicole Vazquez, Assembly Committee on Budget Subcommittee No. 2
Kirk Feely, Fiscal Director, Senate Republican Fiscal
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Megan DeSousa, Senate Republican Fiscal Office
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Paula Villescaz, Office of the Governor
Kim Johnson, Health and Human Services Agency
Corrin Buchanan, Health and Human Services Agency
Jennifer Troia, California Department of Social Services
Kris Cook, Human Services, Department of Finance

Attachment A

IHSS Primer – How Counties Assess for IHSS Service Hours and Potential Factors in Service Hour Growth over Time

Key Points:

- Rising IHSS hours reflect demographic changes in the older adult population, and more children and adults with cognitive impairments that need protective supervision. As older adults live longer, they require increasing services.
- Counties use state-mandated and validated tools to determine IHSS hours and are overseen by a rigorous CDSS quality assurance process.
- Historical trends show hour growth aligns with policy changes and population needs, rather than changes to the IHSS Maintenance-of-Effort (MOE).

How do IHSS Social Workers assess need for assistance?

Functional Index (FI) rankings and Hourly Task Guidelines (HTGs) are the two main tools social workers use to determine the level of assistance needed (FI rank) and number of hours authorized (HTGs). FI rankings identify whether assistance is needed and to what degree; HTGs translate that into how much time should be authorized.

Both FI ranks and HTGs are state-mandated tools. The California Department of Social Services (CDSS) maintains significant oversight of county use of the tools through a rigorous quality assurance process.

FI ranks range from 1 to 6 and reflect an individual's functional ability & safety in each service category. A rank 1 means the person is independent and needs no assistance, while a rank 6 indicates the person requires paramedical services (such as injections) prescribed by a licensed healthcare professional. FI rankings measure the relative need for in-home assistance.

HTGs are time ranges that correspond to FI ranks and provide timing guidelines for how long each task should take. Each FI rank has its own time range, translating functional need into the actual number of hours or minutes a caregiver is expected to spend on that task. For example, for meal preparation, the HTG range changes depending on the assigned FI rank.

FI Rank[7]	Example Description	HTG (hours/week)
1	Independent	No time authorized
2	Able to perform tasks but needs verbal assistance	3:01–7:00
3	Can perform tasks with some physical assistance	3:30–7:00
4	Can perform tasks with significant assistance	5:15–7:00
5	Cannot perform tasks with or without assistance	7:00 hours/week (fixed maximum)
6	Used only if the individual needs assistance with paramedical tasks (such as injecting medications)	Time determined by a licensed health care professional as directed on the SOC 321 Form.

How the HTGs were developed:

The HTGs were developed by CDSS in 2005 in coordination with CWDA, counties, IHSS recipients, IHSS providers, advocates, and provider unions. The legislation (SB 1104, Chapter 229, Statutes of 2004) also required the development of the quality assurance program mentioned above, which oversees use of the HTGs. The HTGs were designed "to provide counties with a standard tool for consistently and accurately assessing service needs and authorizing service hours." After development, the HTGs were tested and validated by researchers at Sacramento State University.

Factors Impacting Average FI Rank and Authorized Hours:

CDSS indicates that the FI ranking has stayed the same, yet authorized hours are increasing. However, CDSS data from CMIPS is needed to determine what is driving these numbers.

For example, potential drivers:

- **Exploding Senior Population.** Between 2010 and 2022, the population of Californians 65 and older increased by 44% (usafacts.org). By 2040, that population will increase by 59 percent (Public Policy Institute of California). As older adults age, one can expect their needs for assistance will gradually grow over time, but not enough to put them into a different ranking. As noted above, an individual can have needs adjusted upwards but may stay in the same ranking. Counties report adjustments of one to two hours a year for an older adult is typical, even as the functional ranking remains the same, to

[7] FI Rank 6 is unique and does not follow HTG limits because paramedical tasks are ordered by a doctor, and the medically required time must be authorized.

accommodate an aging population with growing needs for in-home assistance over time.

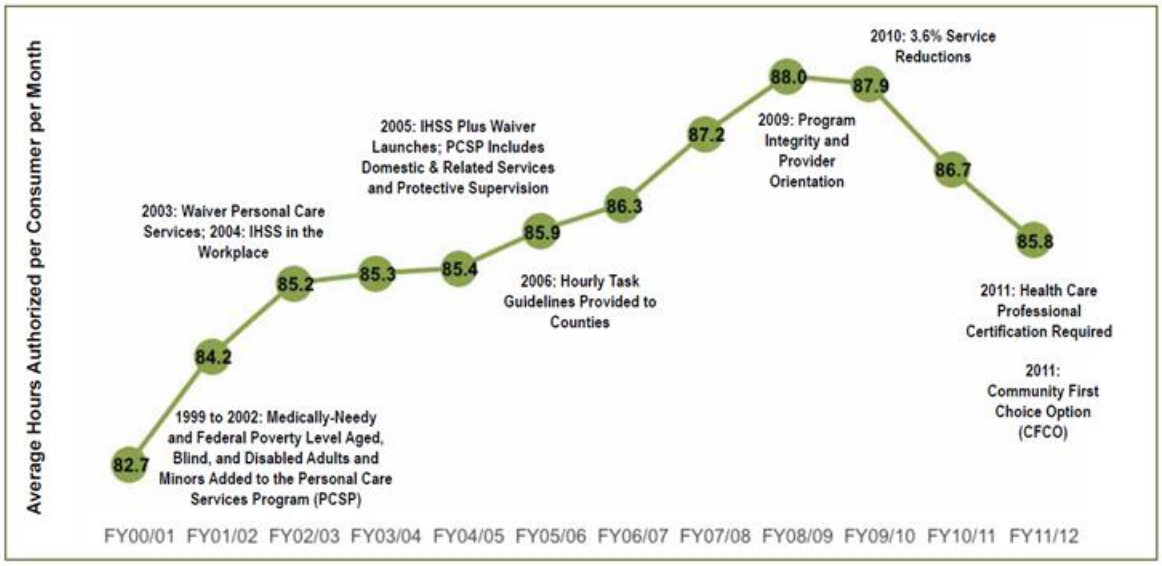
- **Doubling Minor Cases Since 2017.** In November 2025, minors' cases (0-17 years of age) were approximately 11.5% of the caseload; compared to about 6.5% of the caseload in November 2017. While CDSS did not regularly publish data on minors' cases prior to 2017, one report noted that in 2005, minors' cases represented just 4% of all IHSS cases (Newcomer et. al, 2008). Child cases can have different impacts on the average ranking scores.
    - Age-appropriate guidelines affect hours for minors by limiting assistance to needs that exceed what is typical for their age. A child may have a rank 3 in a service category but won't receive hours for tasks normally expected at their developmental stage. As they grow, if they require more help than their peers, their hours may increase even if their functional rank stays the same.
    - One potential impact that can drive average assessed hours up comes from the increase overall in children diagnosed for autism/spectrum disorders, as those children are eligible for regional center services. Because regional centers are considered a "payer of last resort", children and their families will seek out and may qualify for Protective Supervision (PS) through the IHSS Program (see additional detail next bullet).
- **Increase in Protective Supervision, a service with maximum hours.** Protective Supervision (PS) requires ongoing monitoring by the provider resulting in the highest number of authorized hours (195 hours/month if not severely impaired, or 283 hours/month if severely impaired[8]). PS is evaluated separately from FI ranks and is based on the person's mental functioning, while FI ranks measure physical ability. A person with PS but low FI ranks can be approved for what may seem like a high number of authorized hours even though they have low FI rankings.
    - *For example, an 11-year-old diagnosed with autism and severe cognitive and behavioral safety awareness deficits is physically independent (e.g., can dress themselves and eat independently with some verbal prompting), so they receive a low FI ranking for those categories. However, they frequently wander from home and cannot assess danger or follow safety instructions consistently. This is the type of behavior that would justify PS.*
- The average number of overall cases that receive PS grew from 7.4% in May 2017 (earliest CMIPS II data counties received from CDSS) to 11% of cases in November 2025.
- Between 2020 and 2025 there was an approximately 22% increase in older adults living with Alzheimer's in California. A UCSF report estimated that the number of Californians living with dementia/Alzheimer's will increase by 127% between 2019 and 2040 (Ross et al, 2021). Individuals with dementia/Alzheimer's are more likely to need PS.
- The increased incidence of Californians with intellectual/developmental disabilities can

[8] An IHSS recipient is considered *severely impaired* for the purposes of protective supervision if they require 20 or more hours per week of combined personal care, meal prep/cleanup when feeding is required, and paramedical services.

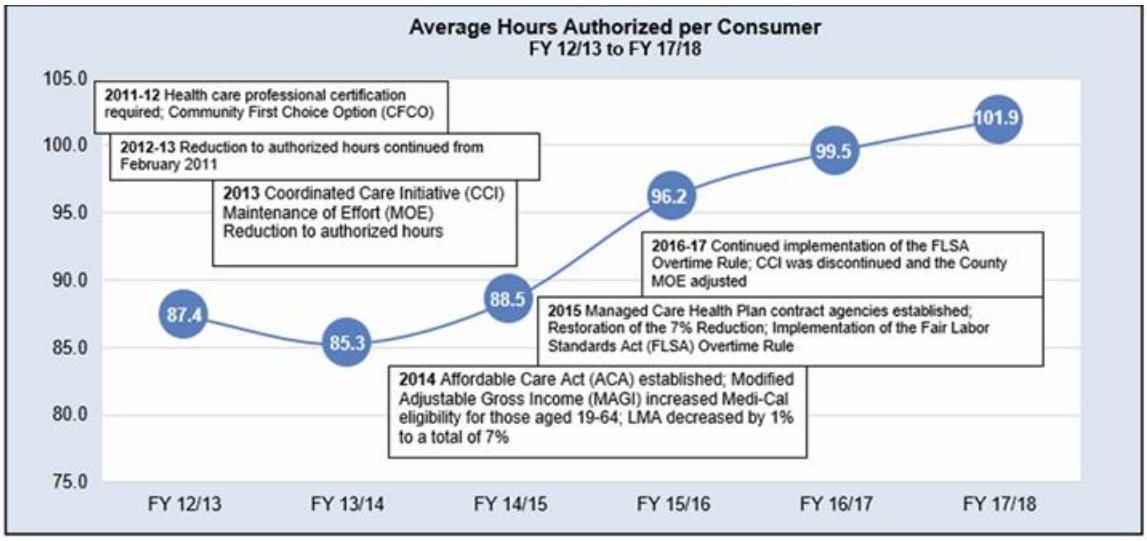
also impact the rise in PS in the IHSS program. Based on data from the California Department of Developmental Services, the number of individuals with intellectual/developmental disabilities served by the department grew by approximately 45% between 2010 and 2020 (DDS Fact Book, Fiscal Year 2019-2020).

Growth in Authorized Hours is Consistent with Demographic and Policy Changes – Not in alignment with the MOE

Based on the historical trend data (see graphs on next two pages), it is evident that average hours were rising during and after introduction of the HTGs. Hours increased consistently almost every year until 2010 when a service reduction in hours was implemented due to a state law change in response to the Great Recession. Hours began to increase again in 2015 when prior service reductions began to be restored. Hours were also consistently increasing before the IHSS MOE inflation factor was reduced from 7% to 4% in 2019-20. Changes in authorized hours closely align with demographic shifts and policy changes.



Source: In-Home Supportive Services Consumer Characteristics Report, September 2015



Source: [In-Home Supportive Services Consumer Characteristics Report, April 2019]

Fiscal Year	Average Authorized Hours
2005-06	85.9
2006-07	86.3
2007-08	87.2
2008-09	88.0
2009-10	87.9
2010-11	86.7
2011-12	85.8
2012-13	87.4
2013-14	85.3
2014-15	88.5
2015-16	96.2
2016-17	99.5
2017-18	101.9
2018-19	110.6
2019-20	113.9
2020-21	116.7
2021-22	119.1
2022-23	121.2
2023-24	122.7
2024-25	124.6
2025-26	125.1
2026-27	127.0

Timeline of Average Hour Increases

2000–2009: Hours rise before and during HTG rollout.

2010-2014: Hours dip only when state-mandated reductions to authorized hours are imposed (not related to MOE).

2014–present: Hours consistently increase prior to the reduction of the IHSS MOE inflation factor to 4% in 2019 and during dramatic demographic changes mentioned.

Attachment B: Proposed CFCO TBL

Amend the Welfare and Institutions (W& I) Code Section 12306.16 (d)(7) to read:

(7) *(A)* Beginning July 1, 2026, if the state ceases to receive enhanced federal financial participation for the provision of services pursuant to Section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)) due to noncompliance of timely case reassessment for the Community First Choice Option program, the *state and county shall each pay 50 percent of the amount of lost* ~~county shall pay, separate from the rebased County IHSS MOE payment, a 100-percent share of the~~ enhanced federal financial participation that would have been received pursuant to Section 1915(k) of the federal Social Security Act (42 U.S.C. Sec. 1396n(k)) for the months in which the state did not receive the enhanced federal financial participation. ~~For the 2025–26 fiscal year, the state and county shall each pay 50 percent of the amount of lost enhanced federal financial participation described in this paragraph.~~ *Counties shall only be held responsible for their share of the enhanced federal financial participation due to case-specific penalty assessments associated with noncompliance of timely reassessment for their individual county.* The department shall develop guidance, in consultation with the County Welfare Directors Association of California, to implement this paragraph.

(B) Any case that has changed addresses to an address that is outside of their prior county, and any cases that have returned from leave status, shall be exempted from a penalty assessment for 30 days from the date of notification to the county and shall not be included in the penalty determination. The department shall develop guidance, in consultation with the County Welfare Directors Association of California, to implement this paragraph.

(C) County payment for its share of the lost enhanced federal financial participation due to federal fiscal penalties, pursuant to paragraph (A), shall be contingent upon the department providing the county with timely and sufficient data necessary to reconcile overdue reassessments. Data shall include, recipient case number and status for each affected reassessment, social worker assigned to that case, hours paid per case used to calculate the penalty, the methodology used to calculate the penalty, the date and time the data used to calculate the penalty was pulled, the penalty amount attributed to each case, and the total penalty cost for each case attributed to the county. The department shall provide quarterly data to the County Welfare Directors Association that includes the total amount of fiscal penalties paid to the federal Centers for Medicare and Medicaid and total amounts charged to counties for federal penalties for reconciliation.