

Medi-Cal Bold Idea — *In-Home Supportive Services Integration into Managed Care*

by Chapman Consulting

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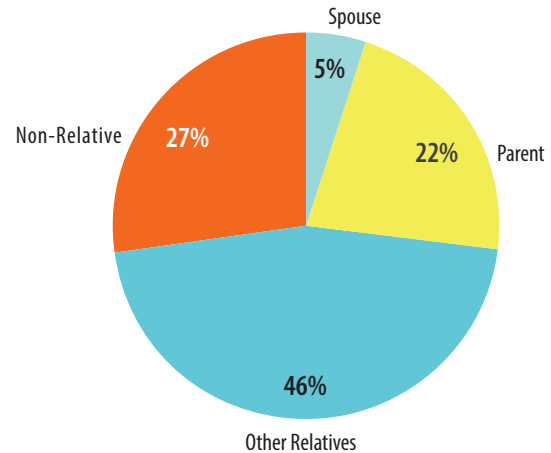
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Executive Summary

California In-Home Supportive Services (IHSS) is a primarily self-directed Medi-Cal program that operates outside of California's State Medicaid Agency, the Department of Health Care Services (DHCS). The California Department of Social Services (CDSS), County Social Service Agencies, and county Public Authorities administer IHSS, with the state and counties splitting the nonfederal costs to run the program. This fragmented system results in varying processes between counties, inconsistent provider training, and limited oversight. Consequently, recipients may struggle to get IHSS services, face delays and gaps in services, and have difficulty finding a provider — increasing the risk of an avoidable skilled nursing facility placement or hospital admission.

The IHSS program serves over 800,000 recipients statewide and employs more than 700,000 providers (or caregivers), over 70% of which are recipient family members (see Figure 1). Counties handle overall program administration, including assessments, eligibility decisions, and ongoing case management, while county Public Authorities employ and furnish IHSS providers. Medi-Cal managed care plans (MCPs) assume financial risk for institutional long-term care services (such as stays in a nursing facility) but cannot leverage all the Medi-Cal services — including IHSS — to prevent institutional care. Meanwhile, California's aging population is growing rapidly, especially in rural areas where services to support older adults and those with disabilities, like home and community-based services, are already scarce.¹ Furthermore, the split financing for IHSS between the counties and the state chronically underfunds counties and does not have a mechanism to stabilize revenues during economic downturns.

Figure 1. IHSS Providers by Type, January 2026



Source: "In-Home Supportive Services (IHSS) Program Data," California Department of Social Services, January 2026.

Integrating IHSS into the Medi-Cal MCP benefit, both financially and administratively, would address operational and policy challenges and align financial incentives. Under this model, MCPs would assume responsibility for assessments, eligibility decisions, service approval, care coordination, and helping recipients find providers. This structure would preserve core recipient self-direction rights, while allowing MCPs flexibility to provide personal care services via an agency model. This reform would improve access, equity, and consistency by standardizing processes, reducing geographic disparities, and leveraging MCP infrastructure to integrate IHSS with members' broader health and long-term care needs.

The Problem: What Needs to Change and Why

In-Home Supportive Services (IHSS) is one of Medi-Cal's most critical programs for long-term services and supports. By providing personal care services as an alternative to nursing facility placement, it enables hundreds of thousands of Californians to stay safely in their homes. The program is projected to serve approximately 875,000 people in fiscal year 2026-27.²

However, IHSS faces major challenges with funding, coordination with other Medi-Cal benefits, equity for members with complex needs, standardized provider training, and limited accountability and oversight.

By preventing unnecessary nursing facility placement, IHSS saves the state between \$22,000 and \$153,000 per person annually.³ As Medi-Cal faces increased fiscal pressure, optimizing the IHSS cost-reduction strategy becomes even more critical, especially as nursing facilities in California face capacity constraints.⁴

IHSS is also the nation’s largest Medicaid self-direction program. However, the independent-living principles of self-direction do not work equally well for everyone. Members with cognitive impairments, including those with Alzheimer’s or other dementias, and people with limited English proficiency may struggle to find and maintain caregivers. Additionally, rural residents and people emerging from homelessness often lack access to stable caregivers and face difficulty in starting or maintaining IHSS services. For members who need IHSS and especially for populations with complex needs, stronger integration with Medi-Cal services is essential.⁵

Integrating IHSS into the Medi-Cal managed care plan (MCP) benefit would strengthen workforce development by aligning providers with MCP care team models and by improving accountability through managed care performance frameworks. This could lead to more timely service delivery, better connections between long-term care and medical care, and better outcomes for members who rely on these supports which would all help avoid costly and unnecessary admissions to nursing facilities or hospitals.

How IHSS Started and Evolved

IHSS began in 1973 as a state social service program administered by the California Department of Social Services (CDSS) for older adults, people who are blind, and people with disabilities.⁶ IHSS combined an Attendant Care Program established in the 1950s and a Homemaker Chore Program established in the 1970s,

and was funded via state General Fund, county share of cost, and limited federal funding.⁷

IHSS became a Medi-Cal benefit in 1991, allowing the state to draw federal matching funds. That same year, the state shifted IHSS administration to counties through realignment.⁸ The state raised sales tax by 0.5% and increased vehicle license fees, then gave these revenues to counties to operate specified programs, including IHSS. This approach reduced state General Fund support for IHSS and shifted fiscal responsibility to the counties. In 2012–13, the historical percentage-based county share-of-cost model (where counties covered 30% to 35% of nonfederal share of cost for IHSS services and administration) was replaced with an IHSS county maintenance of effort (MOE). This MOE was further adjusted in July 2019 when the California Department of Finance determined that the 1991 realignment could no longer support the county costs of IHSS.⁹ The MOE reflects a set amount of nonfederal IHSS costs and may be adjusted annually by growth factors and a portion of locally negotiated wage increases. Table 1 provides overall IHSS spending by payer.

Table 1. IHSS Spending by Payer, Fiscal Year 2024–25

IHSS SPENDING FY 2024-25		
Federal share	\$13.4 billion	55%
State share	\$8.7 billion	36%
County share	\$2.1 billion	9%
Total	\$24.2 billion	100%

Source: *In-Home Supportive Services Statewide Collective Bargaining Report to the Legislature* (PDF), California Department of Social Services, April 2025.

Shifting IHSS administration to the counties offered increased program flexibility based on local needs and was intended to create incentives for counties to innovate within IHSS delivery. Better member outcomes and service efficiencies were also meant to benefit counties and the state financially. However, in practice, the realignment structure has major funding challenges.

Sales tax revenues can decline during recessions, giving counties less money. Counties are not reimbursed for actual program costs. Also, although there are annual adjustments to the IHSS MOE and some flexibility among county funding streams, overall IHSS program growth has outstripped county revenues, and counties have limited ability to control costs. When revenue falls short, there is no gap-filling financial mechanism built into realignment, and additional changes to realignment programs over the years have not come with corresponding funding adjustments. The 1991 realignment no longer works as originally intended, and the financing model has prevented counties from adequately funding the IHSS program to meet the critical needs of this population.¹⁰

Today's Fragmented System

Currently, all 58 counties conduct IHSS eligibility assessments and approvals. County Public Authorities (which exist in 56 of the 58 counties) manage provider registries, handle collective bargaining with the unions that represent IHSS providers, and conduct provider and recipient training.¹¹ Along with the care recipient, the Public Authorities also serve as the employer of record for IHSS providers. CDSS maintains a centralized payroll system for providers, and the California Department of Health Care Services (DHCS) pays for program costs.

Meanwhile, MCPs coordinate medical care and some behavioral health and community-based services for many of the same IHSS recipients. This split structure creates parallel oversight systems for a member's care, limits data sharing, and weakens accountability across the full Continuum of Care. And although MCPs are accountable for members' overall health outcomes and bear financial risk for nursing facility and hospital care, they have no authority over IHSS, one of the primary services that can prevent unnecessary institutionalization.

Additionally, Contract Mode IHSS, a delivery model in which an agency hires and manages IHSS providers on

behalf of the recipient, is currently available to only a very small subset of IHSS recipients — around 1,100 people — in San Francisco County.¹² So, even though this model works best for recipients who struggle to self-direct their care, including those with cognitive impairments, it is not widely available. Increased access to this option under MCP integration could significantly improve access to personal care for populations that cannot, or prefer not to, self-direct their care. It may also allow flexibility of IHSS service provision for members when their providers are temporarily unavailable (e.g., when providers are out sick or take vacation).

Real Consequences for People

This fragmentation and the limited funding have real consequences. A 2021 California State Auditor report found that tens of thousands of IHSS recipients did not receive services in a given month despite being authorized, resulting in millions of hours of unmet need.¹³ Delays in assessments and approvals, difficulty finding and keeping IHSS providers, and inconsistent county processes all contributed to gaps, instability, and inequities.¹⁴

Inadequate IHSS data structure and analytics are also a limiting factor. MCPs are increasingly expected to implement population health management efforts by using data, analytics, and proactive care coordination to identify and address needs across an enrolled population. In contrast, IHSS administration lacks a population-level approach and remains reactive and fragmented.¹⁵ Without structured population management tools and integration across primary care, behavioral health, and other long-term services, there is little opportunity to anticipate needs, to coordinate services, or to intervene early to prevent health deterioration, avoidable hospitalizations, and avoidable institutional care.¹⁶

These challenges disproportionately affect those with the greatest needs, including Medi-Cal members with complex medical, behavioral health, and functional needs; older adults aging into disability; people with cognitive impairments or limited English proficiency;

recipients without dependable natural caregivers; and rural residents, where home and community service gaps are the widest. Medi-Cal recipients emerging from homelessness face particular difficulty. After they have been housed, they still often lack stable caregivers and may struggle to hire, train, or manage a provider under the traditional participant-directed model. This issue puts both service continuity and housing stability at risk.¹⁷

The current structure also strains counties and the IHSS workforce. Counties face rising caseloads, budgets that do not grow with demand, significant administrative burdens, workforce shortages, and limited tools to match caregiving supply with need. Poor coordination and approval delays contribute to unstable hours and income for providers, hurting provider retention and recipient continuity of care.

Why This Matters Now

Medi-Cal enrollment among older adults is rising, overall long-term care demand is projected to grow, and IHSS enrollment is increasing across age groups.¹⁸ At the same time, the program represents a large and growing share of state and county spending amid heightened Medicaid fiscal insecurity due to the federal 2025 H.R. 1 Act and other impending restrictions that limit the states' ability to raise funds (e.g., new limitations on provider taxes).¹⁹ Recent California budget proposals to limit the state's role in financing future growth in IHSS hours signal concern about cost trajectory, and increased fiscal pressure forces counties to make difficult decisions with respect to IHSS service provision.²⁰

IHSS is a cornerstone of California's long-term care system, but its historical administrative structure is poorly aligned with today's integrated care goals, population needs, and financing realities. Without structural reform, the state will likely see widening inequities; persistent unmet need; IHSS workforce instability; and increased risk of vulnerable Californians cycling into more costly nursing facilities and hospitals, many of which already face space constraints.

The Bold Idea

The bold idea is to fully integrate IHSS, both financially and administratively, into the MCP benefit. Integration into Medi-Cal managed care and increased access to agency-provided personal care services for IHSS recipients would create a stronger Continuum of Care for older adults and people with disabilities who need help with daily activities. It would also reduce fragmentation, streamline services, improve care access, and realize cost savings over time through improved benefit coordination.

Required Legislative and Budget Changes

This transformation would require the California legislature to take action to change how IHSS is administered and funded. Multiple Welfare and Institutions Code sections would need adjustment to reflect IHSS administration under DHCS and its contracted MCPs. The legislature would also need to rework the 1991 realignment funding that counties currently receive to administer IHSS. Also, any redirection of the revenue from vehicle license fees may require a ballot initiative, because Proposition 47, passed in 1986, mandated that these revenues be provided to local governments.²¹ The counties' portion of IHSS realignment dollars could be redirected to a new state fund specifically for IHSS administration, in order to maintain existing funding levels.²² DHCS would then calculate and increase MCP capitation payments appropriately to cover the costs of administering IHSS. DHCS would need to align rates carefully across programs (including institutional long-term care) to incentivize home and community-based services (HCBS).

Self-Direction Approaches in Other States

Self-directed Medicaid programs exist in all 50 states and in Washington, DC (in addition to Medicaid state plans and HCBS waivers that may provide personal care services via agency models), and enrollment has grown significantly since 2013.²³ Furthermore, the

administration of self-directed programs through managed care organizations is not unique in Medicaid. What is unique is the scale of California's IHSS program. With a projected total caseload of 875,344 in fiscal year 2026–27 (with a subset of 1,100 in Contract Mode), IHSS is far larger than any other self-directed program in the country.²⁴ New York, with the second-largest program, had 142,407 recipients self-directing their care in 2023.²⁵

The June 2025 Medicaid and CHIP Payment and Access Commission (MACPAC) report to Congress describes the commonalities of self-direction models across states.²⁶ Under most Medicaid waiver authorities, care recipients cannot receive direct cash payments. Instead, a financial management service (FMS) agency acts as a fiscal go-between for the state Medicaid program or managed care organization, the recipient, and the personal care provider.

In California, county Public Authorities serve as a kind of FMS.²⁷ Along with the IHSS recipient, they are the employer of record for providers and negotiate with unions on wages and benefits. Public Authorities also conduct provider background checks, help match recipients with providers, provide training, and incorporate feedback from IHSS Advisory Committees.

Incorporating Lessons from California's Earlier Integration Effort

California can learn from its prior effort to partially integrate IHSS. As part of the Coordinated Care Initiative (CCI) in 2014, in seven participating counties, DHCS financially integrated IHSS into managed care by adjusting capitation rates for MCPs and integrated Medicare-Medicaid Plans (MMPs) and created a "pass-through" payment to counties for IHSS administration. The state also implemented an IHSS MOE statewide, requiring counties to maintain their 2011–12 IHSS spending levels, with an annual growth factor of 3.5% plus locally negotiated wage increases.²⁸

MCPs and MMPs were required to coordinate with counties for IHSS administration and delivery. IHSS social workers participated in interdisciplinary care

teams for members. The state also created the California In-Home Supportive Services Statewide Authority (Statewide Authority) to serve as the employer of record for providers in the seven counties and established a 13-member advisory committee to provide ongoing advice to DHCS and CDSS.²⁹

Although this model shifted IHSS financing to MCPs and moved the employer-of-record role to the Statewide Authority, counties still administered IHSS.

Why IHSS Integration Under CCI Ended

The legislation creating CCI included a "poison pill" provision. It gave the California Department of Finance authority to discontinue IHSS and managed care integration without legislative approval if the integration did not generate General Fund savings. Though some reasons for IHSS cost increases over this period were unrelated to the managed care and IHSS integration, the Department of Finance ended the IHSS carve-in with the 2017–18 budget and shifted \$600 million in IHSS costs back to counties.³⁰

What Worked

Despite challenges with early implementation and early cost increases to the state's General Fund, the limited CCI IHSS integration led to considerable improvements in care coordination for plan members receiving IHSS services.³¹ Authorization time frames improved. Recipients received increased service hours. Coordination between IHSS and MCP staff through integrated care teams was a noted success across several state and federal evaluations. One plan even worked to colocate IHSS and MCP staff to improve coordination and mutual learning.³²

Evaluations of CCI found that both plans and HCBS providers successfully advocated for additional IHSS hours for recipients who needed them, and together these plans and providers identified additional unmet member needs. Importantly, MMPs were contractually required to incorporate IHSS social workers into integrated care teams, and these contract provisions were paired with increased state and federal oversight. A similar approach could be replicated under a more

robust IHSS integration to help ensure that recipients receive coordinated services.

How It Would Work in Practice

MCPs would assume responsibility for conducting IHSS assessments, determining eligibility, authorizing service hours, credentialing IHSS providers, delivering provider and recipient training, and helping to match those providers to recipients who have not identified their own. MCPs would continue to offer self-directed IHSS — preserving recipients’ key rights to select, hire, and fire their providers — but would have additional flexibility to expand agency-provided IHSS, which may work better for members who have difficulties in managing their own care.

Oversight of IHSS would transition entirely to DHCS, eliminating the fragmented regulatory and financial oversight approach that currently exists. IHSS would be subject to the same oversight, quality monitoring, and accountability frameworks as other MCP benefits. County administration would discontinue, and county Public Authorities would be replaced either by MCP FMS entities or by a Statewide Authority — similar to the 2014 approach. Improved data sharing between MCPs, providers, and the state would improve visibility into recipient needs and improve outcomes. It would also enable MCPs and the state to find efficiencies and to eliminate service duplication. Table 2 outlines the current state of IHSS administration, and Tables 3 and 4 provide what administration may look like under managed care integration.

Table 2. Current State of IHSS Administration

MEDI-CAL OVERSIGHT AGENCY: DEPARTMENT OF HEALTH CARE SERVICES		
ADMINISTERING STATE AGENCY		
California Department of Social Services Maintains IHSS Provider Payroll System		California Department of Health Care Services
County Public Authority Responsibilities	County Social Service Agency Responsibilities	Medi-Cal MCP Responsibilities
▶ IHSS provider employer of record ▶ IHSS provider credentialing ▶ Matching of recipients with providers ▶ Training for IHSS recipients and providers	▶ IHSS assessments ▶ IHSS service authorizations	▶ Medi-Cal hospital and provider services ▶ Institutional long-term care ▶ Certain MCP-administered waiver services: Community-Based Adult Services (CBAS) ▶ California Advancing and Innovating Medi-Cal (CalAIM) services: Enhanced Care Management (ECM) and Community Supports

Source: Claire Ramsey, *In-Home Supportive Services (IHSS): A Guide for Advocates* (PDF), Justice in Aging and Disability Rights California, June 2019.
Note: MCP is managed care plan.

Table 3. IHSS Integration with Managed Care by Using an FMS Model

MEDI-CAL OVERSIGHT AND ADMINISTERING AGENCY: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES	
MEDI-CAL MANAGED CARE PLAN	
Medi-Cal MCP Responsibilities	Medi-Cal MCP FMS Responsibilities for IHSS Self-Direction
▶ Medi-Cal hospital and provider services ▶ Institutional long-term care ▶ Certain MCP-administered waiver services (e.g., CBAS) ▶ CalAIM services: ECM and Community Supports ▶ IHSS assessments ▶ IHSS service authorizations ▶ Delivery of personal care services via agency model (i.e., Contract Mode)	▶ IHSS provider employer of record ▶ IHSS provider credentialing ▶ Matching of recipients with providers ▶ Training for IHSS recipients and providers

Source: Authors' analysis, 2026.

Note: MCP is managed care plan, FMS is financial management services, CBAS is community-based adult services, CalAIM is California Advancing and Innovating Medi-Cal, ECM is Enhanced Care Management, IHSS is In-Home Supportive Services.

Table 4. IHSS Integration with Managed Care by Using a Statewide Authority Model

MEDI-CAL OVERSIGHT AND ADMINISTERING AGENCY: CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES	
Medi-Cal MCP Responsibilities	Statewide Authority Responsibilities for IHSS Self-Direction
▶ Medi-Cal hospital and provider services ▶ Institutional long-term care ▶ Certain MCP-administered waiver services (e.g., CBAS) ▶ CalAIM services: ECM and Community Supports ▶ IHSS assessments ▶ IHSS service authorizations ▶ Delivery of personal care services via agency model (i.e., Contract Mode)	▶ IHSS provider employer of record ▶ IHSS provider credentialing ▶ Matching of recipients with providers ▶ Training for IHSS recipients and providers

Source: Authors' analysis, 2026.

Note: MCP is managed care plan, CBAS is community-based adult services; CalAIM is California Advancing and Innovating Medi-Cal; ECM is Enhanced Care Management; IHSS is In-Home Supportive Services.

Building Consensus and Planning the Transition

CDSS, DHCS, counties, and MCPs must leverage lessons learned from CCI and other HCBS and Medi-Cal transitions when designing, implementing, and building consensus around IHSS administration through MCPs. Given the history of IHSS as a social service program rather than a Medi-Cal program and the continued strong advocacy support for the current program model, this transition would need a robust stakeholder approach.

A transition and design advisory group would need to encompass multiple state agencies; not only DHCS and CDSS, but also the Department of Managed Health Care as a plan oversight entity and the California Department of Aging as a key administrator of state programs that intersect with those that serve IHSS recipients. Advisers would also have to include commercial and local MCP sponsors, county social service agencies, county IHSS Public Authorities, IHSS providers and their union representation, and IHSS members.

An operational transition of this magnitude would be lengthy by necessity and may need a regional approach based on MCP service area. The stakeholder advisory groups could provide input on transition processes and develop measurable benchmarks for MCP readiness to administer IHSS. Given the complexity of the financing, the program, and the risk to IHSS recipients during transition, DHCS may consider tying IHSS integration to a new competitive procurement of MCPs.

Financing and Affordability

This IHSS and managed care integration proposal would eliminate the county share (i.e., 1991 realignment funding for IHSS) of nonfederal costs and shift them to DHCS for IHSS administration within Medi-Cal managed care. County Public Authorities are already funded through the state's General Fund, not through the same realignment dollars that support IHSS administration.

These General Fund dollars could be shifted to a new Statewide Authority to serve as the IHSS provider employer of record. Or they could be used to adjust MCP capitation rates to enable MCP plans to set up their own FMS entities to serve as the employer of IHSS providers, in addition to the necessary capitation rate adjustment to MCPs for IHSS administration. The Statewide Authority has been attempted before, but the FMS approach could allow local flexibility in negotiated IHSS provider benefits — an approach valued by participants of the CDSS collective bargaining workgroup.³³ Overall, an appropriate rate structure must incentivize MCPs to coordinate across Medi-Cal HCBS services to reduce both medical and long-term care placement costs among their members.

Potential Cost Savings

Integration of IHSS into managed care may realize savings for the state and MCPs in several ways. Given the MCP service areas, the state could achieve savings through simplification of IHSS program administration as county-by-county administration was eliminated

and as MCPs found alignment in case management for members across programs.

Because MCPs are responsible for nursing facility care, incentives would align plans to provide lower-cost, community-based care by coordinating the Medi-Cal benefits that support older adults and people with disabilities. Coordination of IHSS, Community Supports, ECM, and other supportive waiver programs would reduce long-stay nursing facility admissions. As a quality control, through rate setting, DHCS would have to incentivize strategically across programs and provide sufficient oversight of MCPs to ensure that members received robust and coordinated services across benefits and that they received care in the most appropriate setting.

To handle the transition and administration of IHSS, MCPs would need to build capacity. DHCS could consider an approach like the Housing and Homelessness Incentive Program (HHIP) and Incentive Payment Program (IPP), which provided funds to incentivize MCPs to build capacity to deliver Community Supports and ECM under CalAIM. HHIP and IPP provided funding based on key MCP performance measures related to member engagement, service delivery, sustainable technology, workforce, provider networks, and health equity. HHIP required MCPs to coordinate to submit one homelessness plan per county — a framework that should be replicated for the IHSS transition to ease county burden of coordinating across multiple MCPs. While this approach may require greater up-front costs, the trade-off of improved plan capacity, a smoother transition for IHSS recipients, and reduction in avoidable medical and nursing facility costs would yield cost savings in the longer term.

For Medi-Cal members also in Dual Eligible Special Needs Plans operating with exclusively aligned enrollment, the potential for cost savings is even greater. Plans can coordinate Medicare and Medi-Cal benefits to reduce avoidable emergency department visits and hospital stays, as well as institutional care.³⁴

Impacts on Recipients, Counties, and Providers

A phased-in approach would support recipients by giving counties and MCPs time to build capacity to thoughtfully transition IHSS providers and support staff to the Statewide Authority or to the MCP FMS entities, ideally retaining IHSS providers' locally negotiated benefits. DHCS could mandate extended continuity-of-care periods for IHSS authorized hours and services while MCPs build capacity to reassess members who are receiving IHSS services and to identify any unmet needs. MCPs would subsequently coordinate care for the members across the Medi-Cal plan benefits like medical services and HCBS, including ECM and Community Supports. To increase accountability and the transparency of the transition, DHCS could require reporting and provide public data with respect to the managed care integration.

Managed care integration would reduce overall funds to counties but also remove the counties' currently underfunded responsibility for IHSS administration. Realignment revenues would continue to flow to counties for other realignment programs. Union negotiations for IHSS providers would shift to either the MCP's FMS or the Statewide Authority.

Risks, Trade-Offs, and Unintended Consequences

Numerous risks are associated with integrating IHSS into managed care. Although self-direction programs exist in managed care in other states, this integration may be perceived as a loss of patient and provider rights, with MCPs and their delegated provider organizations adding an extra layer of complexity — and potential new variability — to the program. As noted earlier, self-direction programs do not always work well for certain populations, but disability and independent-living advocacy organizations have generally resisted adjustments to the model and have doubts about MCPs managing IHSS. Furthermore, recent stakeholder work by CDSS

regarding a shift to a regional or Statewide Authority for IHSS administration indicates that local control continues to be highly valued among IHSS stakeholders.

In contrast, there may be increased political interest from the governor's office, the legislature, and health plans to transition IHSS to managed care, given the potential for cost savings amid the heightened budget uncertainty resulting from the 2025 H.R. 1 Act and other state budget pressures. The state may also be feeling pressure from the federal government in regard to IHSS spending. A January 2026 letter to DHCS from the US Centers for Medicare & Medicaid Services (CMS) about Medi-Cal program integrity concerns specifically called out IHSS spending and program-specific oversight. CMS asked the state to clarify the root causes for the IHSS increase in spending from \$8.2 billion in 2015–16 to \$28.5 billion for 2025–26.³⁵ CMS also asked DHCS to provide additional information with respect to program oversight.

Operational Risks

Operationally, without strong continuity-of-care provisions for IHSS recipients and a robust transition plan that honors previously negotiated benefits for IHSS providers, there would be great risk of disruption to both recipients and providers. These carefully negotiated benefits include health care, childcare, and transportation cost reimbursement for IHSS providers, who are often themselves older adults with low incomes. Without these established benefits, many of the providers might not be able to provide care, increasing the risk of a large number of IHSS recipients going into avoidable institutional care. And without strong guidelines about authorized service provision, there is a risk that MCPs might reduce care hours or negatively affect IHSS access.

Current MCPs are a mix of national commercial players and local nonprofit plans, with varying levels of operational sophistication to deliver HCBS. Their readiness to absorb both the financial risk and the responsibility for IHSS program administration would vary. Furthermore, Medi-Cal managed care models vary by county,

and — in Southern California in particular — MCPs are highly delegated both to other managed care plans and to large provider groups, which could add complexity to IHSS administration even under a single MCP.

Under managed care integration, variation in IHSS administration by county could be replaced by MCP model variability if strong oversight and guardrails from DHCS were not put into place. In implementing managed care integration of IHSS, the legislature and DHCS might want to be prescriptive about whether IHSS administration could be delegated to downstream plans or large provider organizations.

Consensus and Advocacy Concerns

Even with a robust and lengthy stakeholder design process, there is a risk that consensus would not be built for IHSS and managed care integration. In fall 2025, due to concerns among a broad group of advocates, DHCS halted planning efforts to integrate four home and community-based waiver programs in 2028. This situation provides a window into the opposition that IHSS integration might face.

Advocates cited several concerns about integrating those four waiver programs, including MCP failures to provide robust Community or Home Transition Services through Community Supports. Another concern was that MCPs had failed to close gaps in or to expand the Community-Based Adult Services (adult day health) program since it was transitioned to managed care in 2012.³⁶

Many of the suggestions that advocates provided to the state regarding the four waiver programs could be applied to IHSS and managed care integration, including implementation of data collection and oversight, monitoring, and enforcement tools to track service quality and timely, equitable access. While a workgroup (or multiple workgroups) on the topic of managed care integration would endeavor to create consensus among all stakeholders, it is possible that full consensus would never be reached. In that case, the state would need to

make a decision that would benefit the most IHSS recipients and long-term program sustainability.

Conclusion: Why This Idea, Why Now

There is evidence that the IHSS status quo is not working equitably for all populations and is not sustainable because of continued underfunding, inefficiencies in program administration, and limited county and state oversight of service delivery. California's rapidly aging population amplifies the state's need to address programmatic inequities, to align incentives, and to control Medi-Cal costs overall.

If bold reform is not implemented, the projected increase in the IHSS-eligible population will overwhelm the existing infrastructure, resulting in a broken system, including for the most vulnerable members. Fewer eligible individuals will receive IHSS services, and those enrolled may continue to have unmet needs. Those who are ultimately unable to access IHSS services will receive costly care through avoidable hospitalizations and long-term stays in nursing facilities, further taxing a hospital and facility infrastructure that is ill-equipped to support the increase.

The time to act is now. By fully integrating IHSS into Medi-Cal managed care, California can build a more equitable, efficient, and sustainable long-term care system that truly serves all who need it.

Endnotes

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