Closing the Meal Gaps for Older Californians

Estimating Gaps in Food Assistance for Low Income Older Adults in CA & A Roadmap to Closing Them

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Executive Summary

This project included a gap analysis to estimate the scale of unmet need for food assistance among older adults, followed by a series of cross-sector, statewide stakeholder discussions to identify recommendations for closing those gaps.

Gap Analysis

This analysis compared the estimated demand for food assistance among low income older adults in California to available public and non-profit services in order to understand the scale of unmet need. Because of the significant expansions in the availability of food assistance services in response to COVID-19, some of which were targeted specifically to older adults, we estimated the scale of the gaps in food assistance "pre-COVID" and during the "COVID-era." Gaps reflect the approximate number of meals that are beyond the budgets of low income older adults, taking into consideration available food assistance services. To the degree possible, we also estimated the scale of unmet need for food programming that supports low income people who need extra assistance shopping for or preparing meals. The analysis also reviewed the distribution of overall gaps in supply by county. This analysis revealed:

Many older adults in California cannot afford to purchase all of their own meals. Nearly 2.5 million low income older adults may struggle to afford 1.24 billion meals a year in California before accounting for available services.

The scale of unmet need is very large; Program expansions during COVID made a big difference in shrinking the gap. Statewide, as many as ~842 million meals were annually beyond the budgets of low income older adults pre-COVID after accounting for available services. COVID-era expansion of food assistance programs shrank that gap to the ~370 million meal range. The two largest drivers of the reduction in meal gap from pre-COVID to COVID-era were temporary CalFresh policy changes and dramatic expansions of food bank distributions. COVID-response funding also dramatically expanded meal programs to older adults. Meals programs represent a smaller proportion of overall supply, however.

One much smaller, but critical, subset of the gap is for people who need extra assistance accessing and/or preparing food. The meals gap for low income older adults who need additional assistance (e.g. delivery, meal prep, shopping support) was approximately 32.3 million meals pre-COVID -- approximately 4% of the total gap. It was difficult to quantify the change in the supply of these types of services to older adults with incomes below the Elder Index during COVID; we know it was significant, and often temporary.

Gaps in food assistance are not evenly distributed throughout the state. While the largest gaps in terms of the *number* of meals are, naturally, in the counties with the largest populations, the counties with the largest share, or percentage, of meals that are beyond the budgets of their low income older adults are typically smaller and/or more rural.

The Roadmap for Closing Gaps

Statewide stakeholders identified the following recommendations for expanding and improving food assistance programs. Recommendations are described in greater detail in the full report.

Short-term, more urgent recommendations are flagged with a clock icon.

Recommendations to Expand and Improve Meals Programs

- Expand baseline state and federal funding of meals programs (Older Americans Act programs, etc.) based, at a minimum, on COVID-era funding levels.
- CDA and/or DHCS should consider options for leveraging restaurant-prepared meals for low income older adults in areas where the infrastructure of existing community-based meals providers has been stretched to capacity and cannot expand easily to meet community demand.
- The ACL should permanently extend COVID-era flexibilities to allow for a more fluid set of choices for meal program participants, including dine-in, "to go," grocery, and home delivery models.
- CDA should maximize program design and cross-model funding flexibilities for food programs that are funded via state funds by modeling guidance based on the flexibility that were allowed under the COVID-19 Major Disaster Declaration, rather than adhering strictly to more historically more rigid federal meals program policy.
- CDA should support AAAs to experiment with meal program service design models that move toward a more person-centered approach, including consideration of how new models maintain social connections.
- FNS should streamline paperwork and nutrition requirements for the adult portion of the Child and Adult Food Program, focusing requirements more narrowly on the needs of the target population.

Recommendations to Expand and Improve CalFresh

- Increase EBT benefits to older adults for food purchase. Options for doing this might include: a state-level guarantee of a higher minimum benefit amount for elderly and disabled households on SNAP; providing for self-attestation or other automatic trigger for the standard medical deduction for elderly and disabled households that would dramatically reduce or eliminate the need for households to provide detailed verification of expenses on a household-to-household basis; and/or maximizing the impact of medical deductions for elderly and disabled households on CalFresh through promotion, self-attestation mechanisms, and training.
- Streamline mechanisms for capturing CalFresh application signatures, including FNS extension of the COVID-era flexibility that allowed applicants to provide a signature over the phone, allowing counties to manually case notate the attestation without requiring counties to capture a recording, as well as state-level default options for telephonic

access, with appropriate resources, once that technology is fully operational in the CalSAWS single system.

- FNS and SSA should re-establish the opportunity for states to create a Combined Application Project,[1] streamlining enrollment in CalFresh for California's remaining SNAP-eligible SSI recipients.
- CDA and CDSS should engage with the design process (currently underway) for BenefitsCal, which is intended to become the primary avenue for people to apply for benefits online, to ensure that it will work well for older adults from a wide range of backgrounds (e.g. immigrant, non-English speakers, w/ various disabilities).
- CDSS should take steps to maximize the reach and ease-of-use of the simplified CalFresh paper application for older adults and people with disabilities.
- CDSS should expand outreach related to EBT online ordering to uncovered areas, including promotion of pick-up mechanisms (e.g. IHSS or other local efforts) when delivery is not available.
- With the recent implementation of the statewide Restaurant Meals Program (RMP), CDSS should work to expand access to the RMP by older adults.
- CDSS should analyze, and publish, CalFresh participation rates for older adults by county.

Recommendations to Expand and Improve Food Bank Distributions

- Increase the CSFP caseload, ensuring that the program can be offered equitably throughout the state and can be expanded to meet demand in the counties where it is currently offered.
- FNS should build more flexibility into the CSFP program delivery model, including home delivery options, and food package flexibility (e.g., cheese optional, inclusion of more culturally relevant foods).
- CDSS should encourage the inclusion of capacity-building efforts that might benefit older adults, especially in counties where gaps are relatively larger.

Other programs

- Explore ways to streamline the enrollment process for SSI, either via improvements to the overall process at the federal level (led by the Social Security Administration), and/or via expansion of effective application support services at the state (CDA) and local levels (via county or AAA leadership).
- DHCS should ensure that rates for medically supportive groceries and other food-based In-Lieu Of Service and Community Benefit interventions support the specific dietary needs, home delivery, and other program costs specific to serving older adults.

[1] See this useful report from FRAC, describing the history of CAPs and what has been learned about how to implement them effectively.

Recommendations to Expand and Improve Cross-Program Coordination & Planning

- DHCS should expand the availability of funding and reimbursement mechanisms for food assistance in the context of health care by requiring county health plans to work with community benefit providers to offer medically supportive food services that can be easily reimbursed via dedicated “in lieu of services” reimbursement rates.
- CDSS should work with county IHSS programs to ensure that they are maximizing existing program flexibilities to support clients to effectively access free and low-cost meal and grocery services.
- CDA funding to provide CalFresh application assistance via the network of older adult service providers begins in October 2022. In order to ensure that these efforts are as effective as possible, CDA should consider training focusing on medical deductions, working with county CalFresh programs to flag older adult applicants for extra assistance, target resources to counties with lowest enrollment rates, and seek additional funding to pilot a model similar to the higher education Basic Needs model.
- As outreach planning evolves for the California Food Assistance Program (CFAP) outreach planning evolves, CDA and C4A should engage closely with planning conversations to ensure that targeting includes older adults.
- CDSS should partner with CDA to pilot models that provide additional support to older CalFresh participants who need help engaging with new online EBT purchasing options.
- As a part of ongoing efforts to build out a No Wrong Door/”One Door” public information and assistance effort, CHHS should incorporate plans to integrate comprehensive referral and enrollment support to food assistance services serving older adults.
- CHHS should fund person-centered research to understand the barriers to program participation that could be addressed by changes in policy, program implementation, coordination, or otherwise. Projects should include both those with a statewide lens, as well as ones that focus on understanding the underlying barriers to participation and/or service availability in communities where gaps are especially large (geographically, as well as demographically).
- CHHS should identify, and fund facilitation of, an ongoing cross-departmental and cross-sector group for planning and monitoring progress related to food insecurity for older adults. Such a group would continuously take inventory of the problem, identify the gap in services, prioritize solutions, monitor the effectiveness of new services, and advocate for additional solutions.

Background

The dramatically increased demand among older adults for food assistance services during the COVID-19 crisis required unprecedented scaling of services and coordination between public and non-profit service providers in 2020 and 2021. In this context, it became clear that state players did not have a comprehensive picture of the overall demand for food assistance services, or how that mapped to existing service availability. The California Department of Aging (CDA), in partnership with the California Association of Area Agencies on Aging (C4A), commissioned this statewide gap analysis to quantify existing demand and the scale and distribution of service gaps. The goal of this gap analysis is to ground key players in a common understanding of the scale of the service landscape so that that CDA, C4A, the California Department of Social Services (CDSS), California Department of Public Health (CDPH) and the California Department of Health Care Services (DHCS) might align strategies to meet the nutritional needs of older adults post COVID-19.

Approach | Missing Meals Gap Analysis

This gap analysis identifies the scale of unmet need for food assistance for low income older adults in California, including the need for assistance with shopping for or preparing meals among people with functional or cognitive impairments. We estimate the annual gap in service availability by building estimates of demand, and then compare that to the availability of services (supply). All estimates are translated into meals: meals that people need but cannot afford to purchase themselves, and meals provided by public or nonprofit programs. The remainder is considered to be the "gap." It is worth noting that older adults often live in households with younger people. Our estimates reflect the meals for the older adults, not for other members of those households. Detailed methodology descriptions are included in Appendix A.

Demand Estimates

Who is low income?

To estimate the demand side, we defined "low income" older adults as those aged 60 and older, with incomes below the Elder Index. The Elder Index is a widely-used alternative measure of basic needs developed for California by the UCLA Center for Health Policy Research. It reflects actual costs of living for older adults, taking into account variation by county, household composition, and key housing circumstances. We merged the Elder Index definitions with data from the American Community Survey (ACS) to generate county-level estimates of the number of low income older adults.

Overall demand for food assistance

Overall, people are expected to need three meals per day, 365 days per year, but we know that low income older adults are often not able to afford all of those meals. We used Elder Index figures on the food costs as a share of overall budget to determine the percentage of each

person's Elder Index threshold that *should* theoretically be devoted to food costs. We assumed that older adults living in households with incomes below the Elder Index can afford a share of their meals commensurate with the relationship between their actual income and the Elder Index cost of living. The remaining meals are the demand for food assistance services. It is worth noting that older adults tend to need fewer calories as they age, but their nutrient needs are just as high or higher as for younger people.[2] This opens some debate as to whether three meals a day is always the right target for every older adult; for the purposes of this report, we handle this by assuming that the vast majority of people will need three meals per day, even if some people follow a different pattern of eating. The section below, Statewide Gaps in Food Assistance for Older Adults describes a number of important other variables that may influence the actual level of demand as compared to this estimate.

Demand among people who need additional assistance

Of course, depending on their level of independence, some older adults need food assistance provided with additional assistance. Some people require support with food shopping and/or food preparation due to disability and the availability (or not) of help in their households. This may come in the form of home-delivered meals, shopping assistance, in-home meal preparation, or meals provided at day programs. For this reason, we further estimated the demand for more supportive food assistance services, as a subset of the overall demand for food assistance. We used the American Community Survey (ACS) to identify older adults who have at least one of a variety of disabilities, and who do not have another adult in the household without those disabilities.

Estimating Supply

The annual supply of meals to low income older adults was estimated for the pre-COVID (typically 2019, depending on data availability) and COVID eras in order to demonstrate the impact of supply shifts on the scale of unmet need. Supply estimates include meals provided by the following public and non-profit food programs (see Appendix A for detailed methodology notes):

- CalFresh
- Child and Adult Care Food Program
- Food Bank distributions, including
    - Commodity Supplemental Food Program
    - Senior Farmers Market Nutrition Program
- Great Plates Delivered (COVID-era only)
- Medically Tailored Meals (via DHCS and CA Food is Medicine Coalition programs)
- Older Americans Act Meals Programs (congregate & home delivered meals), including those funded via the Families First Act and CARES Act
- Other meal programs (e.g. home-delivered meals programs *not* funded via the Older Americans Act, other county-based programs)

[2] Healthline article summarizes this nicely here.

When programs are measured in pounds distributed (e.g. food bank programs) or dollars (e.g. CalFresh), we use standard conversion rates to translate into meal estimates.

Statewide Gaps in Food Assistance for Low Income Older Adults

Nearly 2.5 million low income older adults may struggle to afford up to 1.24 billion meals a year in California.

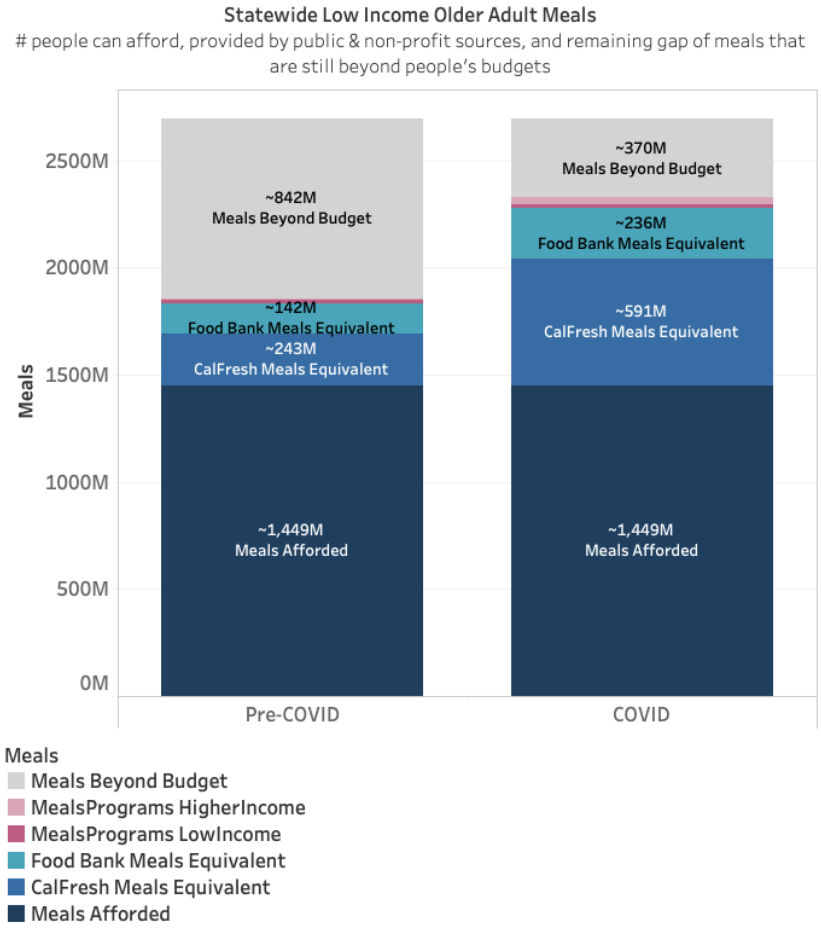
We estimate that approximately 2.46 million older adults have incomes below the Elder Index (EI) in California. After accounting for the meals that *should* reasonably be within their budgets to purchase, we estimate that approximately 1.24 billion meals are beyond their budgets. That is, *on average*, our estimates suggest that older adults with incomes below the Elder Index can reasonably afford slightly more than half of their meals.

In practice, the lower an individual's or family's income, the higher a percentage of their income we observe them actually spending on food (e.g. in national datasets like the Consumer Expenditure Survey), often higher than we estimate they “should" afford. This suggests that lower-income individuals and families in practice stretch their budgets as far as they can to afford food, which along with housing and sometimes medical care are some of the least "forego-able" expenses. We would not want to use observed spending to calculate meals afforded, however, as this would imply that such behavior is normative or expected, when in fact it is a response to a shortfall in the individual's or family's budget and may well result in difficult financial tradeoffs (e.g. credit card debt, missed medications, etc.). At the same time, it is important to know that when we describe these gaps, we do not mean that all of these meals necessarily went uneaten by low-income elders.

In some instances, people may be able to afford more food than we estimate due to lower-than-predicted other expenses (e.g. people who live in affordable housing will not, in practice, pay as much in rent as would be predicted by the EI cost estimates) or due to availability of assets or outside family financial support. Data from the Health and Retirement Survey showed that approximately 8% of low income older adults have liquid or near-liquid assets equal to at least 25% of family income. Even if we assumed that people spent down these assets on food costs, the number of meals that people could afford would only increase by approximately 100 million, leaving 1.14 billion meals out of financial reach for low income older adults.

Statewide, up to ~842 million meals were still beyond the budgets annually for low income older adults pre-COVID after accounting for available services.

Statewide, low income older adults needed more than 842 million meals beyond what was provided by public and nonprofit sources in the year prior to the onset of the COVID-19 crisis. Note that this assumes that all meals provided via Older Americans Act programs go to people with incomes below the Elder Index.[3] As this may not always be the case, the actual gap may be slightly higher.



As an exercise, we also calculated the number of meals that would be out of reach of people's budgets if we assumed that as much as 10% of total demand were excluded for any of the reasons we've described above (e.g. use of assets, lower housing costs, other supports not accounted for in our supply estimates, or lower nutritional need than three meals per day) for some portion of the population. The gap pre-COVID remains very high even when we do this - approximately 573 million meals annually. See chart in Appendix C.

COVID-era expansion of food assistance programs shrank that gap to ~370 million meals.

The expansion of a variety of types of food assistance services during COVID cut that gap to approximately 370 million meals. A recent Census Bureau report found that post-tax, real median

[3] Older Americans Act programs are not means tested, though they are targeted to populations with highest need. Enrollment data indicates whether each client self-reports income below 100% of the Federal Poverty Level. Many people do not report poverty status, and even those who do report higher incomes may still have incomes below the Elder Index. Meals to those with higher incomes are broken out in the charts here, but assumed to go to people with incomes below the Elder Index in order to have the most generous definition of the supply of meals.

household income increased more than 3 percent between 2019 and 2020 for older adults - a change that is not reflected in our demand estimates, and would result in an even smaller gap that we have not quantified here.[4]

Again, even if we assumed that as much as 10% of all meals needed for low income older adults were accounted for in some other way (e.g. lower nutritional need, assets, or other support not accounted for in our supply estimates), the gap during COVID remains, at approximately 100 million meals annually. See chart in Appendix C.

The two largest drivers of the reduction in meal gap from pre-COVID to COVID-era were temporary CalFresh policy changes and dramatic expansions of food bank distributions.

During COVID, the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps), known as CalFresh in California, had an increase in older adult participants, as well as an increase in benefits per participant due to a temporary policy change that allowed for all households to receive the maximum monthly benefit. The number of older adult participants increased by 17.6% during that time, while the total benefits going to older adults increased by 143%. That is, the massive increase in meals provided via CalFresh during COVID was almost entirely due to maximum allocations in CalFresh during the pandemic.

Meanwhile, food banks across the state increased food distribution in unprecedented ways. While it is difficult to estimate the exact number of meals provided to older adults (see methodology section for more on how we did this), there is no question that the increase was very large. Our best estimates are that meals to older adults via food bank distributions increased from ~147.6 million to 246 million meals.

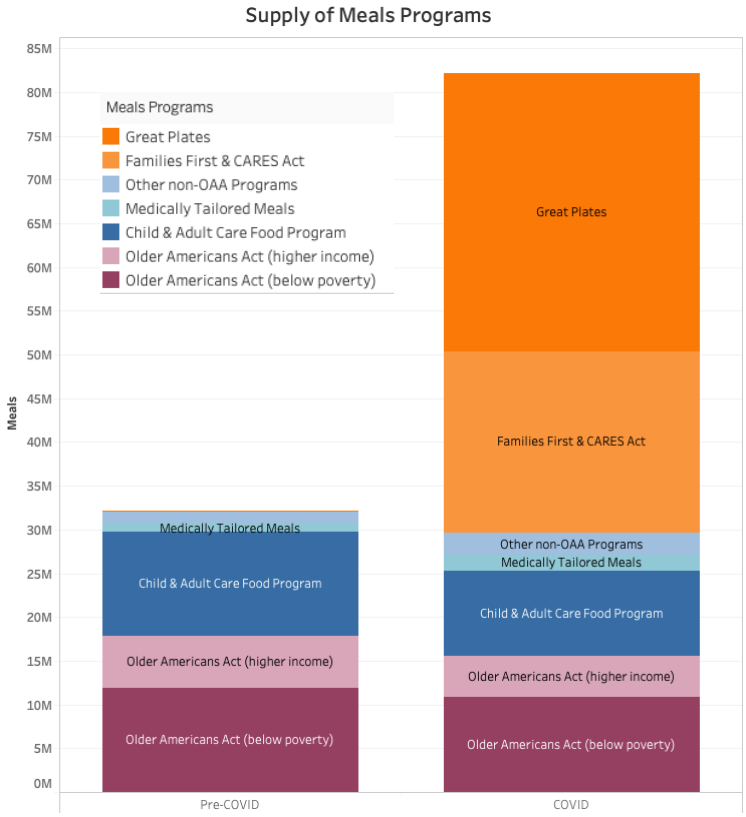
COVID-response funding also dramatically expanded meal programs to older adults.

The largest increase in meals programs during COVID came from one-time federal funding from the Families First Act, the CARES Act, and the FEMA-funded Great Plates Delivered Program. There are some natural limitations in scale built into the Older Americans Act meals programs during non-emergency times, as funding levels (not including COVID-related funding) limits the feasibility of providing more than five meals per week.

It is hard to know how much to consider Great Plates Delivered meals as addressing unmet meals needs for low income older adults, though it surely filled an important gap to ensure that

[4] See Appendix Table 4 of this report for details of how incomes for older adults shifted across the distribution of the Supplemental Poverty Measure.

older adults could shelter in place to stay safe from COVID. Policy surrounding this restaurant meals program specifically *excluded* people who were eligible for other food programs. However, since the Elder Index is often higher than the thresholds for low income food programs, we've included the Great Plates meals here under the assumption that some recipients had incomes below the Elder Index but above the other income thresholds.



Mostly, the scale of the Great Plates Delivered program is a testament to the impact of programs that can provide up to three meals per day to recipients. Older Americans Act funding levels typically preclude offering more than one meal per day. Many programs used Families First and/or CARES Act funding to provide additional meals to older adults already enrolled in Older Americans Act programs - a sound approach especially when many people were truly unable to safely access other options.

The meals gap beyond reasonable budgets for low income older adults who need additional assistance (e.g. delivery, meal prep, shopping support) was approximately 32.3 million meals pre-COVID.

Demand for meals with extra assistance

Of course, some older adults require more than just food assistance. For the purposes of this analysis, we considered the potential demand for food assistance programs for people who need assistance with food shopping and/or food preparation due to disability. This may come in the form of home-delivered meals, shopping assistance, in-home meal preparation, or meals provided at day programs. Social support is another important aspect of service design for many programs for older adults (e.g. at congregate meal programs, adult day programs, check-ins that are a part of home delivered meal program), though it is not a primary focus of this analysis. Other programs are focused almost entirely on food access, and do not typically provide additional supportive service that would make them as accessible or useful to a person with significant functional impairments. Historically, this has nearly always been the case for CalFresh and for food pantry programs, with some notable recent exceptions. Sometimes assistance

comes from informal caregivers or home care workers who help with shopping and/or meal preparation - this can sometimes bridge the gap and make food access-focused programs more helpful to people who need additional assistance.

Statewide, we estimate that 400,000 older adults with incomes below the Elder Index have disabilities that might require services that offer additional assistance with food shopping, meal preparation, and the like.[5] However, based on estimates from state reports, approximately 300,000 low income older adults in California receive assistance with shopping, meal preparation, and/or meal clean-up via the In-Home Supportive Services program. Accounting for this fact leaves ~58 million meals that these older adults are not able to easily afford before accounting for other existing services.

Supply of meals with extra assistance

On the supply side, we look at meals provided via home delivered meals programs, medically tailored meals programs, and at adult day care programs. Approximately 25.4 M of these meals were provided statewide pre-COVID. This leaves an estimated gap for these types of meals statewide of approximately 32.3 million meals. This should be treated as a ballpark estimate, given the challenges of generating population estimates for the group of people who need these services..

During COVID, it is difficult to estimate the supply of these types of meals to older adults with incomes below the Elder Index. Some programs decreased when people could not gather (e.g. adult day program meals). Other programs expanded - Great Plates Delivered, Families First Act, and CARES Act funded meals expanded dramatically, for example. But it is impossible to estimate what share of those expanded services went to older adults with ongoing needs for these types of services - many people needed assistance with food delivery due to the risk of COVID, not due to underlying limits in their independence. See the data table in Appendix B for details.

Unfortunately, we were unable to get estimates on the *scale* of use of online purchasing options that have recently become available via the CalFresh program (see details here), nor did we get estimates on food bank home delivered grocery programs. Both of these programs provide additional assistance accessing food for people who need support with acquiring groceries, but can still independently prepare meals. CalFresh online shopping options continue to expand, but are not uniformly available to all CalFresh participants statewide. Some participating retailers offer online ordering with curbside or in-store pick-up, others offer home delivery. Of course, accessing this service requires participants to have internet access and a certain level of tech savviness - neither of which are a guarantee for the population who might benefit from it most. We know from a recent survey of California food banks that 75% of respondents added or

[5] Note that the total number of low income older adults with such disabilities is much higher, but we exclude from these estimates people who live in households with other adults that do not have such disabilities and thus could feasible provide assistance.

expanded home delivery options during COVID, but it is impossible to determine how that might translate to a specific number of meals for older adults.

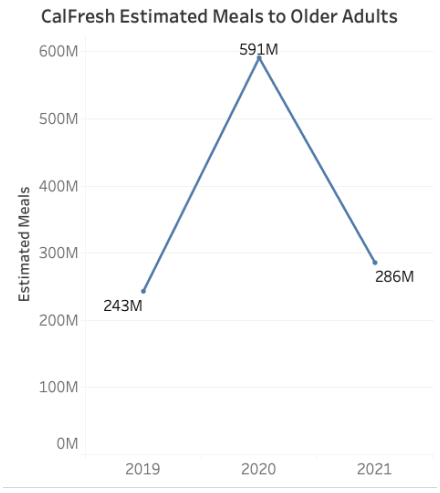
Looking ahead: The gap is likely to shift back toward pre-COVID levels, based on supply side reductions in the near term.

In the near terms, a number of policy and funding changes are likely to push the number of meals that are beyond low income older adults' budgets much closer to the pre-COVID scale.

CalFresh: benefit level changes, outreach

It is hard to overstate the impact that CalFresh maximum benefit allotments had on the supply of food assistance to older adults. When this policy reverts to individualized benefit calculations, the supply of meals will dramatically decrease. The chart on the right accounts for benefit increases that are expected based on the October 2021 adjustments to the Thrifty Food Plan, though these are nowhere near the maximum allocation level.[6]

A new, simplified CalFresh application for older adults was approved in the most recent state budget. The hope is that making the application process simpler for this population will encourage enrollment. The 2021-2022 state budget also includes $2 million in continued funding for the CalFresh Expansion-Older Adults Outreach Program that assists eligible Supplemental Security Income (SSI) and State Supplementary Payment (SSP) recipients apply for CalFresh food benefits starting in October 2022..

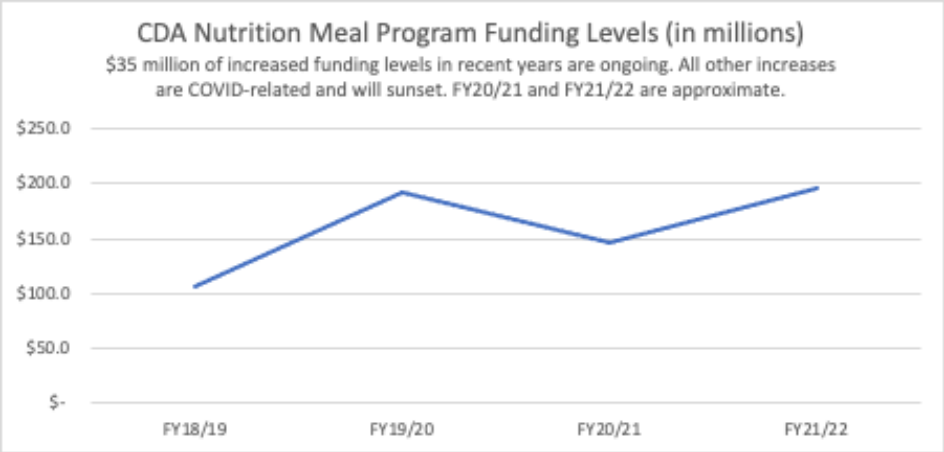


[6] Projections for 2021 here are based on May 2021 enrollment levels, increasing benefits per person from pre-COVID by 25%.

Meals: COVID-focused meals programs investments ending, some new investments

Great Plates Delivered, which significantly increased the number of meals available to older adults, has already wrapped up. Some clients transitioned to Older Americans Act-funded elderly nutrition programs, but most did not.

Meals program expansions funded via the Families First Act and CARES Act continue for now, but that funding is not ongoing; programs will need to scale down when funding runs out. On average, the annual increase in meals program funding FY 19/20 through FY 21/22 via the Department of Aging was ~$71 million, of which only half ($35 million) is currently slated to continue once COVID-specific funding expires.[7]



State support of increased Food bank distribution is short-term

It is difficult to predict whether food banks will be able to sustain the level of distribution they had in 2020/2021. Statewide, food banks increased distribution by approximately 65% from 2019 to 2020. Questions remain within the network of food banks regarding food supply, operations support, and volunteer capacity to sustain this level of distribution. The 2021 state budget did include $110 million to support the continued food bank emergency response to COVID, as well as $8 million for food banks to purchase California produce. However, these are both short term investments.

Future changes in demand are hard to predict.

It is difficult to know how the demand for food assistance will change in the coming years. On the one hand, the population of older adults is growing, especially among the "older old," who may be more likely to need assistance shopping for or preparing food. But it is impossible to predict how other resources may scale to support older adults, given the tremendous changes that are currently being proposed for the social safety net. The current "Build Back Better" framework[8]

[7] Figures provided by CDA, includes funding from: Families First Coronavirus Response Act, CARES Act, Consolidated Appropriations Act, American Rescue Plan, California expansion (state funds), OARR Senior Nutrition, Senior Nutrition..

[8] See this White House summary of elements that would impact older folks in the original version of the Build Back Better framework.

includes a variety of supports that would impact the budgets of older adults and their families. Proposals include: enhancements to long-term care; home and community based services expansions; lowering of health insurance premiums and closing Medicaid coverage gaps;[9] coverage for dental, hearing, and vision in Medicare; prescription drug reform;[10] national paid leave program;[11] and expanded Child and Dependent Care Tax Credit. There have also been proposals around meaningfully improving SSI benefits (e.g. increasing benefits, updating income and asset rules) and housing supports such as vouchers, housing trust fund support, etc. Of course, each of these are subject to change as negotiations continue at the time of writing of this report.

[9] See this CBPP brief on how this would impact older adults specifically.
[10] This New York Times article describes why this piece may not be fully realized, however.
[11] This Washington Post article describes how this may end up being just 4 weeks.

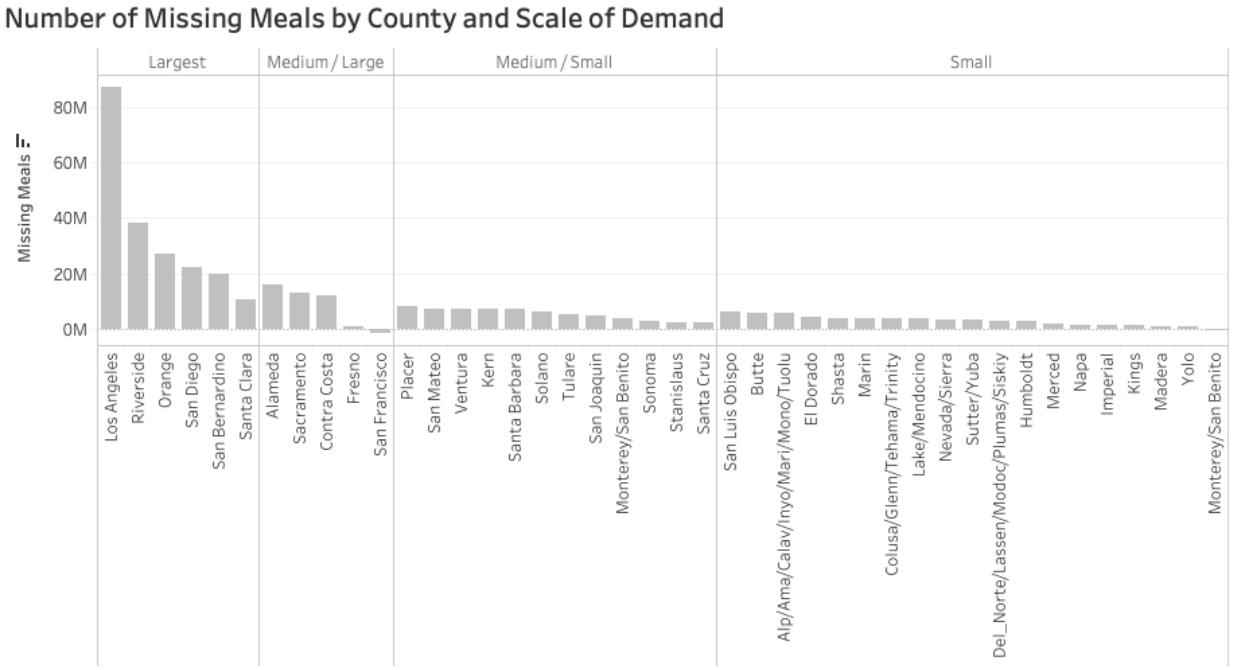
County-Level Gaps

The following county-level analysis is intended to provide a sense of how gaps in food assistance to low income older adults are distributed throughout California. All county-level estimates are for the COVID-era service level, as data was not reliably available at the county level for some food programs for pre-COVID. Note that translating available data to the county level sometimes required estimating the breakdown of services between counties when, for example, food banks or Area Agencies on Aging provided services to more than one county. Some smaller counties are grouped in order to align with the geography groupings in the American Community Survey. See Appendix A for more detail on those methods.

The largest service gaps are in the counties with the largest populations.

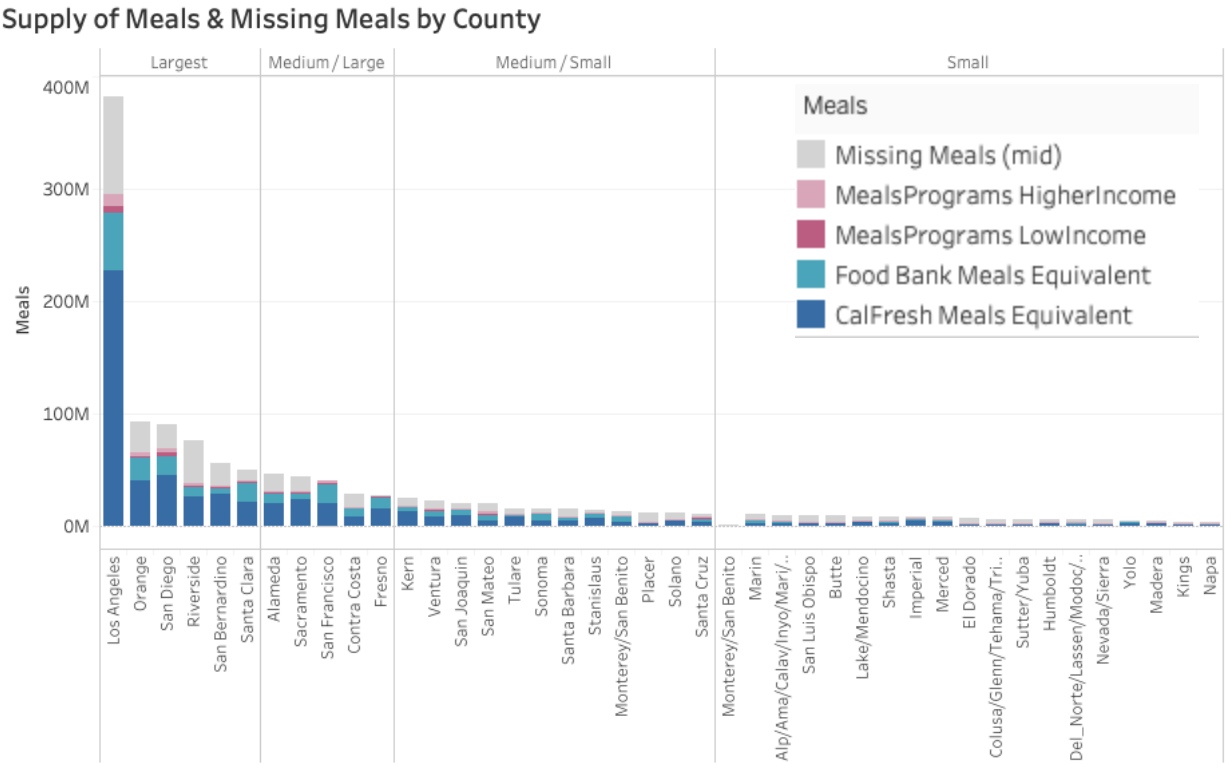
In the chart below, we sort counties based on the number of meals that are still beyond people's budgets after accounting for available services, and then group by the overall size of demand. Generally-speaking, the counties with the largest number of missing meals are simply the counties with the largest demand (e.g. many southern California counties such as Los Angeles, Riverside, Orange, San Diego, San Bernardino).

Several larger counties (Fresno, San Francisco) expanded food assistance support so much during COVID that the estimates for unmet need dropped very low relative to the size of their low income older adult populations. Both of these counties saw major increases in food bank distribution to older adults. San Francisco also stood up a fairly large Great Plates Delivered program.

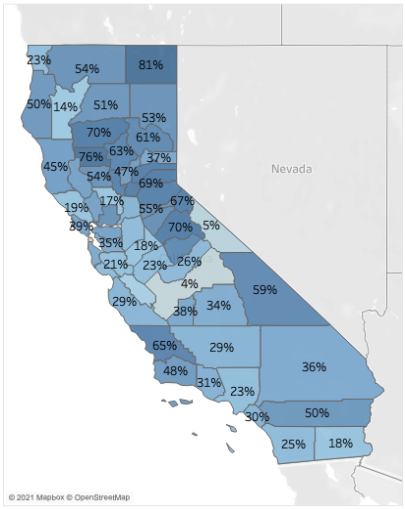


The scale of need and of demand in Los Angeles county dwarfs that of other counties.

The scale of both the supply and demand side of the story in Los Angeles is so much larger than in any other county that it bears pointing out. This is true across the majority of food assistance programs, but especially for CalFresh.



COVID Supply & Missing Meals - Elder Index, Low Income Meals

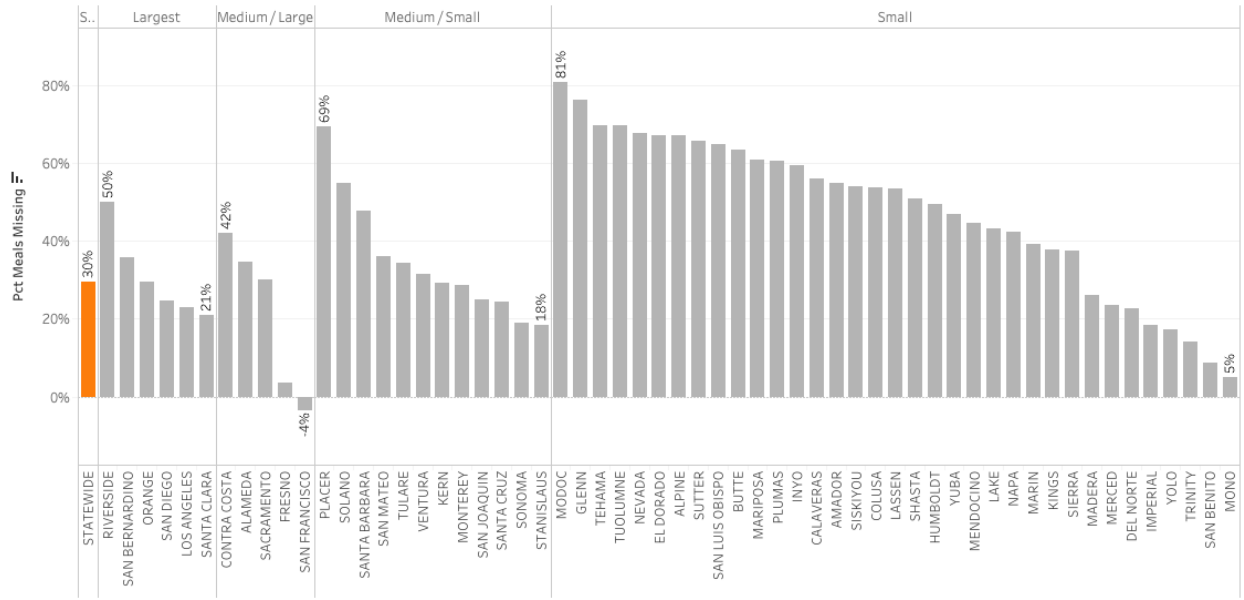


Counties with smaller populations are missing a larger percentage of the meals that people cannot afford.

When we look at the size of the gap as a percentage of the overall demand, the county-level story changes. Smaller counties are more likely to have a larger share of meals missing. This is especially true for the northern rural counties. It is out of the scope of this analysis to identify underlying causes for these differences, but future research might consider the role of various factors such as: inequality of philanthropic resources throughout the state,[12] CalFresh enrollment among older adults, uneven roll-out of federal emergency response funding (e.g. Great Plates Delivered), and other factors.

[12] A recent report from CalNonprofits highlights this issue.

% Meals Needed that are Missing by County



A Roadmap for Closing the Gaps

During September and October 2021, a statewide work group convened to review the gap analysis provided above, and jointly identified the following statewide strategies to serve as a roadmap toward closing the gaps. The group consisted of representatives from the California Department of Aging, the California Department of Social Services (CalFresh), the California Association of Area Agencies on Aging, the California Association of Food Banks, Nourish California, Meals on Wheels California.

These recommendations identify policy changes, program improvements, and ongoing planning and research work that would **expand** the availability of food assistance services as well as **improve** services and referral systems in order to better reflect the needs and preferences of California's low income older adults.

Recommendations that should be prioritized for short-term implementation are notated with a clock icon.

Policy Changes | Expanding Program Scale

The following recommendations would directly expand the availability of food assistance services.

Meals Programs

COVID-era meals program investments demonstrated a previously untapped potential for meals program expansion with the right level of investment. Increased investment in meals programs is especially important for addressing the significant gap in food assistance services for people who have difficulty preparing meals independently.

Recommendations:

1. At the federal and state levels, expand baseline funding of meals programs (e.g. Older Americans Act programming) based, at a minimum, on COVID-era funding levels. Funding increases should be phased to replace sunsetting federal COVID-focused funding, with the goal of further expansion to address remaining related gaps in the future. Such funding would allow for expanding to:
    a. Include a 2nd, or even 3rd, meal per day for those with assessed need, and
    b. Expand services to a larger number of individuals.
2. Building on models that already exist or have been piloted in California and in other states, CDA and/or DHCS should consider options for leveraging restaurant-prepared meals for low income older adults in areas where the infrastructure of existing community-based meals providers has been stretched to capacity and cannot expand easily to meet community demand. Guidance for program implementation should carefully take into account lessons learned from COVID-era implementation of the Great

Plates Delivered programs, and should be developed in partnership with AAAs and community-based meals providers to ensure that the design for program delivery and enrollment complements other local programming (e.g., regarding contracting, meal requirements, reimbursement rates, required linkages to supportive services with competence serving the target population, etc.).

CalFresh

The single-most impactful change to the supply of food assistance services to low income older adults during COVID was the temporary increase in monthly SNAP/CalFresh benefits amounts to guarantee all participants received the maximum monthly benefit. As this policy sunsets, it is imperative that policymakers consider the power of making such increases a permanent fixture of the program. Federal SNAP policy frequently refers to older adults as a part of a broader group, "elderly and disabled households." For the purposes of these recommendations, we use that terminology.

Recommendations:

3. Increase EBT benefits to older adults for food purchase. There are a variety of options for instituting across-the-board EBT allocations in this way. For example:
    a. Provide a state-level guarantee of a higher minimum benefit amount for elderly and disabled households on SNAP. A recent state law in Maryland did this, ensuring that older adults do not receive less than $30/month (nearly double the federal minimum of $16/month).
    b. Either through a state supplement or a federal waiver, provide for self-attestation or other automatic trigger for the standard medical deduction for elderly and disabled households that would dramatically reduce or eliminate the need for households to provide detailed verification of expenses on a household-to-household basis. Current standard medical deduction mechanisms remain very underutilized.
    c. CDSS should continue to work to maximize the impact of medical deductions for elderly and disabled households on CalFresh, particularly with the looming end of the Emergency Allotments. For example:
        i. Promote the opportunity to utilize this deduction to eligible CalFresh households;
        ii. Promote (to counties, to application assisters, to AAAs) opportunities to use simple mechanisms for older adults to self-attest transportation costs to medical appointments, a commonly under-reported allowable medical expense; and
        iii. Provide training and simple screening resources to application assisters for this topic.

Food Bank Distributions

The CSFP program caseload is currently capped due to limited federal funding. In California, the program is only available in 27 out of 58 counties. Even in counties that currently offer the program often experience demand that outstrips their caseloads.

Recommendations:

4. Congress should increase the CSFP caseload, ensuring that the program can be offered equitably throughout the state and can be expanded to meet demand in the counties where it is currently offered.

Cross Program Initiatives

5. DHCS should expand the availability of funding and reimbursement mechanisms for food assistance in the context of health care. Specifically:
    a. Ensure that rates for medically supportive groceries and other food-based In-Lieu Of Service and Community Benefit interventions support the specific dietary needs, home delivery, and other program costs specific to serving older adults.
    b. Develop a requirement and template for county health plans to work with community benefit providers to offer medically supportive food services that can be easily reimbursed via dedicated “in lieu of services” California Advancing and Innovating Medi-Cal (CalAIM) reimbursement rates. Templates should include training resources for health care professionals about available services, recommendations about effective ways to partner with local community-based providers that have experience offering additional supportive services, and streamlined processes for connecting community-based partners to reimbursement mechanisms; and
    c. Expand pilot funding for reimbursable medically supportive meals and/or groceries.

Policy Changes | Increasing Flexibility in Program Delivery

A variety of existing state and federal meals program design features stand in the way of providing services that meet the diverse set of preferences and needs of California’s low income adults. In some cases, current policies create inefficiencies in service delivery, and/or barriers to participation either by older adults themselves or by provider agencies.

Meals Programs

The siloed nature of Older Americans Act meals program funding, and its highly prescriptive program delivery requirements, prevent local service networks from providing services that flex to participant needs. Restrictive program delivery options have also historically prevented community providers from exploring more efficient models. Program flexibilities that were extended during the COVID-19 public health crisis created an opportunity for experimentation

that should be embraced permanently into the future. In many cases, meal program providers discovered during the public health emergency that participants responded very positively to the more flexible program models, in many cases leading to a higher number of people utilizing services and an increase in the number of meals distributed. In order to increase the reach of these programs, they need to truly "work" for the community they aim to serve - increased funding isn't enough, the program models should allow for efficient mechanisms to provide food assistance in the ways that people really want.

Recommendations:

6. The ACL should permanently extend COVID-era flexibilities to allow for a more fluid set of choices for meal program participants, including dine-in, "to go," grocery, and home delivery models. In particular:
    a. The "to go" model should become a permanent option of the congregate meal program. Although to-go meals are allowed under the home-delivered meal program for people who are social distancing, this does not address the long term need to allow congregate clients choice in where they eat a meal and in what social activities they participate in. For example, some older adults may participate in social activities at a dining site and then choose to take their meal to-go; others may want to dine-in several days a week but take meals to-go on other days.
    b. The ACL should extend flexibility to move funding across nutrition models, as it makes sense for participant needs and preferences.
    c. The ACL should further extend policy flexibility to allow for Title III-C funding to be used for grocery models (e.g. food bank-provided groceries, either picked up by participants or offered for home delivery). While it is possible to fund these types of activities using Title III-B funds, it is not possible to measure the impact of those efforts with III-B reporting mechanisms.
7. CDA should maximize program design and cross-model funding flexibilities for food programs that are funded via state funds by modeling guidance based on the flexibility that were allowed under the COVID-19 Major Disaster Declaration, rather than adhering strictly to more historically more rigid federal meals program policy. This might include more flexibility in:
    a. Meals program delivery models (dine-in, to go, home delivery, grocery/food pantry, meal kits, etc);
    b. Cross-program funding movement; and
    c. Definitions of nutrition requirements, depending on the mechanism of food assistance.

Furthermore, the Child and Adult Food Program operates under an entirely separate set of paperwork and nutrition requirements for the adult program portion. These cumbersome rules create a barrier to participation among many agencies, reducing the flow of federal funding for these types of meals. Given that programs that do succeed in enrolling in CACFP often provide

two meals a day to a very vulnerable population, maximizing enrollment in that model is another important way to increase availability of federal funding to older adults.

8. FNS should streamline paperwork and nutrition requirements for the adult portion of the Child and Adult Food Program, focusing requirements more narrowly on the needs of the target population. One option for streamlining nutrition requirements would be to align CACFP requirements with those for Older Americans Act programs or those for other services that target medically needy older adults.

CalFresh

The application process for CalFresh is notoriously cumbersome. It is not unusual for applicants to be denied benefits when they are unable to complete all of the required steps, rather than for lack of eligibility. A variety of policy flexibilities would streamline that process, increasing access for older adults.

Recommendations:

9. Streamline mechanisms for capturing application signatures, specifically:
    a. FNS should extend the COVID-era flexibility that allowed applicants to provide a signature over the phone, allowing counties to manually case notate the attestation without requiring counties to capture a recording. The method of documenting signatures via a caseworker note is one used in Medi-Cal and was temporarily extended to CalFresh during COVID and should be made permanent.
    b. All counties should ensure that end to end telephonic access, including capturing electronic signatures over the phone, are the default implementation option with appropriate resources, once that technology is fully operational in the CalSAWS single system.[13]
10. FNS and SSA should re-establish the opportunity for states to create a Combined Application Project,[14] streamlining enrollment in CalFresh for California's remaining SNAP-eligible SSI recipients.

[13] Note that Section 78 (a) of Assembly Bill (AB) 135 (Chapter 85, Statutes of 2021, would guarantee that, "to the extent permitted under federal law, an individual shall have the option to complete an application or recertification interview and provide the required client signature by telephone." It would also authorize the CalSAWS consortium "to develop, deploy, and maintain a telephonic signature solution to enhance the ability for county human services customers and staff to complete transactions by telephone. The bill, until the CalSAWS consortium has implemented an integrated telephonic signature solution, would authorize an applicant for public social services or public assistance to make an oral attestation regarding their qualification for services or assistance if they are unable to provide a physical signature or if the county is unable to accept an electronic signature."

[14] See this useful report from FRAC, describing the history of CAPs and what has been learned about how to implement them effectively.

Food Bank Distributions

CSFP's current program design is rigid - food box contents are strictly prescribed, and do not take into consideration client preferences. Furthermore, boxes must be picked up, either in person or by a proxy. This prevents access by isolated older adults who may find it difficult to pick up a heavy box of food but who are still able to prepare meals independently. During the initial months of COVID response, FNS allowed for a variety of program design flexibilities for CSFP, including a delivery option; maintaining and expanding those flexibilities would increase access to the program, reduce food waste, and position it as a more effective supplementary grocery program.

Recommendations:

11. FNS should build more flexibility into the CSFP program delivery model, including:
    a. home delivery options, and
    b. food package flexibility (e.g., cheese optional, inclusion of more culturally relevant foods).

Cross-Program Policy Changes

The In-Home Supportive Services program is an important mechanism for supporting older adults who need assistance making full usage of a diverse set of food assistance programs. However, lack of policy guidance results in under-utilization of this support.

12. CDSS should work with county IHSS programs to ensure that they are maximizing existing program flexibilities to support clients to effectively access free and low-cost meal and grocery services. Effective expansion of these flexibilities may require expanded state funding to support additional hours. It is worth noting that, in households where a spouse or live-in family member is the IHSS provider, expansion of these authorized hours also increases household income. CDSS should provide clarification, promotion of, and/or technical support regarding the following areas:
    a. Home delivered meal programs, while an alternative service for meal preparation, do not provide three meals per day and sometimes include frozen meals. This allows for meal preparation hours for:
        i. Heating of frozen meals; and/or
        ii. Preparation of remaining meals not provided by the home delivered meal program.
    b. Authorization of additional food shopping hours when clients are enrolled in grocery-based food assistance services (e.g. pick up from food pantries, online EBT ordering) that might require additional time.[15]

[15] Note that San Francisco county currently authorizes hours this way after determining, in partnership with CDSS, that current policy allowed it.

Policy Changes | Reducing Demand

The Master Plan for Aging includes several recommendations that would indirectly reduce demand for food assistance by increasing incomes and/or reducing expenses for low income older adults. For example, it includes concrete recommendations for:

- Increasing SSI/SSP and Cash Assistance Program for Immigrants benefit levels up to meet the Elder Economic Index and Federal Poverty Level;
- Expanding the availability of a variety of types of affordable housing; and
- Streamlining and modernizing enrollment processes for Medicare Savings Programs, which would reduce medical expenses.

In addition to these, this workgroup recommends:

13. Exploring ways to streamline the enrollment process for SSI, either via improvements to the overall process at the federal level (led by the Social Security Administration), and/or via expansion of effective application support services at the state (CDA) and local levels (via county or AAA leadership).

Program Improvements

These recommendations would improve service delivery without the need for policy change.

Meals Programs

While it is certainly the case that the historically rigid funding and service delivery requirements for Older Americans Act meals programs play an important role in preventing local service networks from maximizing the flexibility of service delivery designs to participant needs, more innovation is still possible within the confines of existing policy. Furthermore, new state funding of meals expansion provides the opportunity to experiment with more diverse program offerings.

Recommendations:

14. CDA should support AAAs to experiment with meal program service design models that move toward a more person-centered approach, including consideration of how new models maintain social connections. Examples of innovation program model that AAAs may pursue include:
    - Improvements in culturally relevant services, such as expansion of the availability of culturally appropriate meals, assessing and addressing language accessibility by non-English speakers
    - Different meal offerings for traditional congregate or home-delivered meals (e.g. models that allow more meal choices (e.g. restaurant-style menu), breakfast or supper offerings)
    - Food assistance models that work well for people who can cook at least some meals at home (e.g. meal kits w/ instructions, connections to food pantries, home delivered grocery programming, grocery shopping and/or pick-up assistance).

- Innovations related to the *location* of services (e.g. partnerships with other community food programs like youth/school programs, virtual lunchrooms, meal provision at low income senior housing or single-room occupancy hotels).

CDA support for these types of efforts would likely need to include:

a. funding for targeted needs assessment and planning work, start-up costs for pilot programming efforts, and outreach;
b. technical assistance; and
c. facilitation of peer-to-peer support (e.g. convening, sharing of resources across PSAs

CalFresh

Older adults sometimes struggle with CalFresh application and recertification experiences, as well as with the options for using benefits effectively once enrolled. Major changes are afoot in these areas for the program as a whole, however, which presents great opportunity to consider the design and supports that should be included to ensure that the program works as well as possible for older adults.

Recommendations:

15. CDA and CDSS should engage with the design process (currently underway) for BenefitsCal, which is intended to become the primary avenue for people to apply for benefits online, to ensure that it will work well for older adults from a wide range of backgrounds (e.g. immigrant, non-English speakers, w/ various disabilities). It is worth noting that testing with even a small number of different types of users may reveal the need for important changes. Specifically:
    a. CDA should coordinate user testing (working with AAAs to identify diverse older adult participants) via the portal's demo site, and then share feedback to CalSAWS.
    b. CDSS should strongly encourage CalSAWS to conduct user testing focused on a diverse set of older adults, and request a summary of results of that testing including related design improvements.
16. CDSS should maximize the reach and ease-of-use of the simplified CalFresh paper application for older adults and people with disabilities by:
    a. Leveraging best practices from other states;
    b. Engaging in an iterative, user-centered design process with clear metrics for success (e.g. easy to fill out, easy to submit, easy to process by counties to ensure quick receipt of EBT cards, etc.) when creating the application;
    c. Providing training and technical assistance to counties to use the form upon launch; and
    d. Promoting the form to clients through direct communication channels, inter-departmental partnerships and outreach networks.

17. CDSS should expand outreach related to EBT online ordering to uncovered areas, including promotion of pick-up mechanisms (e.g. IHSS or other local efforts) when delivery is not available.
18. With the recent implementation of the statewide Restaurant Meals Program (RMP), CDSS work to expand access to the RMP by older adults by:
    a. Conducting targeted outreach to restaurant vendors, especially in counties that are not yet participating;
    b. Work with counties to ensure older adults are aware they may be eligible to participate in the RMP; and
    c. In counties where the RMP is already established, conduct outreach to restaurant vendors to expand the variety and nutritional quality of partnering restaurants and/or meal providers.
19. CDSS should analyze, and publish, CalFresh participation rates for older adults by county. Current publicly available data includes the number of older adults participating, but does not provide context for the demographics of those participants (e.g. language, race/ethnicity, SSI status, etc.), or how participation numbers compare to the likely eligible population.

Food Bank Distributions

CDSS is in the process of allocating recently-authorized food bank capacity grants. This creates an opportunity to leverage that funding to incentivize increases in free grocery programming that benefits older adults.

Recommendation:

20. CDSS should encourage the inclusion of capacity-building efforts that might benefit older adults, especially in counties where gaps are relatively larger. Specifically, CDSS and CDA should work to connect food bank leadership with local AAA leadership to identify locally-tailored approaches in counties with significant food assistance gaps among older adults.

Cross-Program Collaborations

Improved cross-departmental and cross-programmatic outreach, referral systems, and service delivery is essential for ensuring that food assistance services are offered in a truly person-centered manner.

Recommendations:

21. CDA funding to provide CalFresh application assistance via the network of older adult service providers begins in October 2022. In order to ensure that these efforts are as effective as possible, CDA should consider:

a. Providing training for application assisters regarding medical deductions (note - these training resources would be beneficial throughout the application assistance network, not just at AAAs);
b. Working with county CalFresh programs to flag older adult applications who would benefit from additional application assistance and refer them to older adult-focused assisters in their community; and
c. Targeting application assistance and outreach resources to those counties and sub-populations with the lowest older adult enrollment rates.
d. Seeking expanded funding to support piloting a model similar to the higher education Basic Needs model,[16] which includes full-time basic needs coordinators at serving institutions to support not just CalFresh but all appropriate benefits (in this case, e.g. ensuring the client is assisted with IHSS, SSI, or other benefits including complementary food assistance);

22. As outreach planning evolves for the California Food Assistance Program (CFAP) outreach planning evolves, CDA and C4A should engage closely with planning conversations to ensure that targeting includes older adults.
23. CDSS should partner with CDA to pilot models that provide additional support to older CalFresh participants who need help engaging with new online EBT purchasing options. For example, some potential pilots might include ideas such as:
    a. Development of outreach/educational materials related to online EBT shopping, tailored to an older adult audience;
    b. Fund hands-on/telephonic support for client education;
    c. Volunteer support for EBT online shopping and/or pick-up;
    d. Encourage county IHSS programs to authorize additional IHSS hours for online EBT shopping and/or pick-up;
    e. Linkages to low cost internet (there may be an opportunity to leverage broadband expansion funds, for example).
24. As a part of ongoing efforts to build out a No Wrong Door/"One Door" public information and assistance effort, CHHS should incorporate plans to integrate comprehensive referral and enrollment support to food assistance services. For example:
    a. Leverage data sharing to increase cross enrollments (State Health Information Guidance may be a useful tool for this).
    b. Implement screening and referral protocols that ensure that people are connected to the full complement of food assistance services that might make sense for them (e.g. meals programs, food pantry programs, CalFresh, shopping/food preparation assistance via IHSS or other local programs).
    c. Identify touchpoints (enrollment, reassessment, etc.) in related services when referring older adults to comprehensive food assistance screening and enrollment would make sense. Examples of services where this may be relevant include: Medi-Cal, In-Home Supportive Services, hospitals or rehab facilities (e.g. at

[16] See a description of this model here.

discharge), Community-Based Adult Services/Adult Day Health; and low income housing (e.g. at application/waitlisting).

Planning & Research

While the recommendations listed above represent important steps toward expanding and improving the food assistance landscape in California for low income older adults, it is clear that there is more work to be done to better build a more person-centered system. Continuous improvement in that regard will require an ongoing cross-sector focus on the issue.

Recommendations:

25. CHHS should fund person-centered research to understand the barriers to program participation that could be addressed by changes in policy, program implementation, coordination, or otherwise. Projects should include both those with a statewide lens, as well as ones that focus on understanding the underlying barriers to participation and/or service availability in communities where gaps are especially large (geographically, as well as demographically).
26. CHHS should identify, and fund facilitation of, an ongoing cross-departmental and cross-sector group for planning and monitoring progress related to food insecurity for older adults. Such a group would continuously take inventory of the problem, identify the gap in services, prioritize solutions, monitor the effectiveness of new services, and advocate for additional solutions.

Appendix A: Methodology

Estimating demand

To estimate the demand side, we utilized data from the American Community Survey (ACS). To arrive at the number of meals needed by lower-income seniors (age 60+), we first must specify a level under which seniors qualify as “low income” and determine that population's overall number of meals needed. Overall, people are expected to need three meals per day, 365 days per year. They are able to afford some, but not all of these meals on their own, which we estimate using the methods described below.

To define the lower-income population, we use the Elder Index (EI), a widely-used alternative measure of basic needs developed for California by the UCLA Center for Health Policy Research. The EI was developed by the UCLA Center for Health Policy Research's Health Disparities in 2009; they analyzed the actual cost of living in California's 58 counties based on local market rates for items such as housing, food, health care, transportation and other basic necessities. The EI thus represents a standard against which we can measure elders' incomes in California to determine if they can afford all of their essential needs.[17]

The EI is defined based on county, family type (e.g., single elder, elder couple, with or without children, etc.), and housing type (e.g., renter, owner, owner with a mortgage). We merged these standards to our ACS data in 2019. Because the latest EI data available through the UCLA website is for 2015, we increased levels for inflation to 2019 dollars after merging to the ACS.

With this data in hand, the next step of the demand side analysis was to determine how much each older adult in the dataset can afford for food costs. The EI contains not only a total dollar value for overall need, but subcomponent dollar values such as needs for housing costs, medical costs, food, etc. We used this data to determine the percentage of each person's EI threshold that *should* be devoted to food costs. For example, an older couple might have a total EI threshold value of $50,000. If the food portion of that threshold were $5,000 this would represent 10% of the EI budget. If the elder couple had exactly $50,000, they would have enough income to exactly meet their food needs of $5,000. But consider another hypothetical couple with $25,000. To determine how much this couple could afford, we assumed that they too should be able to devote 10% of their budget to food, just like the couple whose income allows them to achieve the EI standard. This means that the second couple can devote $2,500 to food. Because we know from the EI that $5,000 is necessary, this leaves another $2,500 in unmet need (or demand) that must be fulfilled from other sources, such as government or community food assistance. We use this logic to arrive at the total dollar amount of "shortfall" of all older adults in the county below the EI standard. We then converted these dollars to meals, using the implied meal costs under the EI standard. We also account for households that may reasonably be using assets rather than

[17] Find more information about the Elder Index here, at the UCLA Center for Health Policy Research.

income to cover food costs. Data from the Health and Retirement Survey showed that approximately 8.3% of low income older adults have liquid or near-liquid assets that are more than 25% of family income, so we adjust down the total demand accordingly.

Of course, depending on their level of independence, some older adults need services that are more than just food. Some people require additional assistance with food shopping and/or food preparation due to disability and the availability (or not) of help in their households. For this reason, we further estimated the demand for more supportive food assistance services, as a subset of the overall demand for food assistance. To do this, we again use the ACS, but here consider the health difficulties of the elders in each county who fall below the EI standard. We define those who may need their meals delivered as those who answer yes to at least one of the following three questions on the ACS:

1. Because of a physical, mental, or emotional condition, does this person have difficulty doing errands alone such as visiting a doctor's office or shopping;
2. Is this person blind or does he/she have serious difficulty seeing even when wearing glasses? or
3. Does this person have serious difficulty walking or climbing stairs?

For those that respond yes to at least one of these questions, we first looked to see whether there is another adult in the household who does not have one of these three difficulties. Older adults who have another adult in the household without any difficulties were assumed to be able to rely on this person or persons to provide help. Thus, we were able to estimate the number of older adults who have one of these difficulties AND who have no other adult who they co-reside by county, generating the estimate of meals that in the shortfall for which additional support would be required (e.g. delivery, shopping assistance, in-home meal preparation).

Estimating Supply

CalFresh

The California Department of Social Services provided several monthly datasets of total CalFresh issuances, by county, to households of different sizes and older adult composition.[18] Unfortunately, data on case-level issuances from the electronic benefits transfer (EBT) system did not match to all active households found in the MEDS system. We calculated estimates for matched and unmatched cases, as follows:

- *Matched households:* For each household type in each county, we calculated the total issuances that went to older adults based on the percentage of participants they represent for that household type. Then we summed those figures across all household

[18] Household compositions based on # total recipients in the household, # older adults age 60+ in the household, and # older adults age 60+ and on SSI in the household.

types up for each county. This allowed us to account for the variation in average benefit amount by household size and composition.

- *Unmatched households:* We assumed that, in a given county, older adults get unmatched issuances proportional to their share of the unmatched recipients. We then adjusted that amount slightly, on a county level, to reflect the fact that older adults typically represent a larger share of the caseload than they do estimated issuances. (For example, in one county, older adults represented 14% of the recipients, but only 13% of estimated issuances - we scaled unmatched issuances accordingly according to each county's actual data in that month). For 2019, we further adjusted down the issuances that went to unmatched SSI recipients (benefit levels for most SSI cases where issuances matched were ~90%+ of the level of other non-SSI senior households, so we applied a .9 adjuster to the share of unmatched folks). We didn't bother with the SSI adjustment for the COVID-era estimates since all households had maximum benefit allocations during that time.

For pre-COVID, we used the December 2019 data. It reflects a lot of the SSI eligibility expansion enrollment, so annualizing it gives a good sense of how much CalFresh was really heading out to older adults before the pandemic hit. For COVID-era, we averaged the May 2020 and December 2020 figures.

CalFresh meal equivalents are calculated according to the estimated cost per meal for food secure low-income households, by county, according to the Elder Index meal cost methodology.

Child and Adult Care Food Program (CACFP)

The Child and Adult Food Care Program (CACFP) is a state and federally funded Child Nutrition Program (CNP) designed to provide nutritious meals and snacks served to infants, children, and adults. The Adult Day Care component is available to public or private nonprofit organizations or certain for-profit organizations that provide healthy meals that meet the meal pattern standards in a nonresidential day care facility to functionally impaired adults or adults who are 60 years of age or older. Examples of providers include adult day care centers, support day care centers, adult day health centers, and approved Alzheimer centers. There are functional eligibility requirements, but not income eligibility requirements. The California Department of Education's Nutrition Services Division provided a dataset[19] summarizing Child and Adult Care Food Program (CACFP) meals for adult day programs by program and county for FFY1819 and FFY1920. More recent data was not available at the time of the data request. We summarized the meals data (including breakfast, lunch, and supper, but not snacks) by county and treated FFY1819 as pre-COVID and FFY1920 as COVID-era.

[19] The data was retrieved June 14, 2021 representing a point in time, and as such, retrieval on a different day may have different results.

Food Bank Distributions

Food distributed by food bank programs are typically reported in pounds. We have converted pounds to meals using Feeding America's current estimates of 1.2 pounds per meal.[20]

There are three relevant datasets for food bank distributions:

Overall food bank distribution poundage

Food banks have reported the total number of pounds distributed to CDSS/CalVolunteers on a weekly basis since March 2020. CalVolunteers provided a dataset that includes overall pounds distributed weekly from mid-March 2020 through June 2021. Because reporting is sometimes inconsistent for some food banks, we estimate annual COVID-era food bank distribution for each food bank by first calculating an average of weekly food distributed (excluding missing reports) since March 2020, then multiplying by 52 weeks.

In order to estimate the share of overall food bank distributions that went to older adults, we employed several methods. We reached out to several food banks who have more detailed participant enrollment tracking systems to get a sense of how distributions to older adults might track with the share of the local population in poverty that are older adults. For these food banks, we used these actual reported figures. For the rest, we used this data, along with other outside sources, to create an estimation method.

We reviewed national surveys about food pantry utilization and food insecurity. According to the California Health Interview Survey, statewide 17% of people who report they are food secure are age 60+; this was very close to the share of older adults statewide with incomes below 185% FPL. This was in line with a national Feeding America survey in 2014 that found that 16.6% of food bank clients were seniors age 60+. We chose 17% as a statewide lower-bound estimate. Each county's lower bound was then scaled according to their actual percentage of seniors below 185% FPL compared to state rates. Given that many food banks who provided actual distribution data for older adults reported a notable increase in the share of their food going to older adults during COVID, often in the 30%+ range, we considered 30% to be an upper bound. We averaged the local floor with the 30% upper bound for each to get an estimate for each food bank and county.

Unless provided an actual breakdown directly from the food bank, we made county-level estimates based on the share of the population of older adults with incomes below the federal poverty level in each county that a food bank served.[21]

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[20] "How Feeding America turns $1 into at least 10 Meals," retrieved September 1, 2021.

[21] Based on Table B17020: Poverty Status in the Past 12 Months by Age, 5-year American Community Survey (2015-2019) to maximize sample size. Tables retrieved from the U.S. Census Bureau at data.census.gov on August 30, 2021.

Commodity Supplemental Food Program (CSFP) poundage

CDSS provided a dataset with the total annual number of CSFP food boxes allocated to each participating food bank, pre-COVID (2019) and during-COVID (2020, 2021), with an average box weight (30 pounds). Food banks that serve multiple counties provided break-outs of the share that go to each county. All of these food boxes go to low income older adults. Figures in this analysis assume 100% distribution of all boxes. CSFP food box pounds were assumed to be included in the overall food bank distribution pounds (and thus not double-counted), unless they were distributed in a county that was outside the typical service area of the distributing food bank.

Senior Farmers Market Nutrition Program poundage

The California Association of Food Banks provided the total pounds of food distributed, by food bank and by county, for this program in 2020 and in 2021. All this food goes to older adults. We do not have figures for pre-COVID for this program. While we have these figures, they were considered to have been included in the overall food bank distribution pounds, above.

Great Plates Delivered

CalOES provided[22] the total number of meals provided by the Great Plates program (a FEMA-funded meals program targeting older adults sheltering in place during COVID and not participating in other meal programs) by city or county of service from May 2020 through July 9th, 2021. We mapped these to the appropriate counties and generated an annual estimate based on the 14 months of service figures. Given the eligibility criteria of this program, we do not consider these meals to go to older adults with incomes below the federal poverty level, though it is possible that recipients had incomes below the Elder Index. In San Francisco, approximately 30% of Great Plates Delivered clients transitioned to the traditional meals programs when the program spun down.

Medically Tailored Meals

We received two datasets on Medically Tailored Meals. The target population for these meals is low-income people with chronic or severe illness:

- California Department of Health Care Services provided monthly enrollment figures for medically tailored meals for older adults provided by vendors by county from July 2019 to June 2020. Clients receive three meals per day. For pre-COVID estimates, calculated annual estimates based on the average service level from July 2019 to February 2020. For COVID era, we used March 2020 to June 2020 average service levels to calculate an annualized estimate.
- The California Food is Medicine Coalition provided a dataset with medically tailored meals distributed to older adults (60+) in 2019 (pre-COVID) and in 2020 (used for COVID-era) by

[22] Provided to Ventura County Area Agency on Aging via a public records request.

coalition providers. Two providers distribute in more than one county, and have not provided estimates of how they break down between counties.

Older Americans Act Meals

Upon CDA's request, RTZ Associates provided a dataset that included Older Americans Act meals (congregate meals, and home delivered meals) for FY1819, FY1920, and one on the way for FY2021, by Area Agency on Aging (AAA). They also have income information - below 100% FPL, above 100% FPL, Decline to State/Unknown. Data was aggregated by AAA and client zip code, where available. We mapped zip codes to counties, and excluded any meals provided to out-of-state zip codes.

There are 33 AAAs in California, some of which provide services in multiple counties. When zip codes weren't available, we did the following:

- When the AAA only provided services in a single county, we assumed that the county of service is the AAA county.
- When the AAA served more than one county, we first checked to see if most meals in the AAA had zip code information available. If so, we allocated the remaining meals according to the ones that do have zip code data in that fiscal year. When AAAs were missing most zip codes, we requested county-level estimates from those AAA directors. If those AAAs did not provide estimates, we allocated remaining meals according to the distribution of older adults with incomes below the federal poverty level between the service counties.[23]

Other Meals

Meals on Wheels California and the California State Association of Counties (CSAC) both fielded a survey to their members to request information about the number of meals provided through other food programs beyond those listed above before and during the COVID-19 era. Those meals were included in the supply counts, mapped to the appropriate counties of service.

[23] We erred on the side of using the data that had the right age cut-off (age 60+, as opposed to 65+) and we assumed distributions between counties would skew toward the populations with the highest need (<100% FPL). American Community Survey 5-year estimates, Table B17020: Poverty Status in the Past 12 Months by Age. Retrieved from the U.S. Census Bureau at data.census.gov on August 30, 2021

Appendix B: Demand for and Supply of Meals for People who Need Additional Assistance

	Pre-COVID
Meals needed for people who need extra assistance (non-IHSS, below EI)	57.6 M
OAA HDM HigherIncome Meals	3.9 M
OAA HDM LowIncomeMeals	7.3 M
HDM nonOAA Higher Income Meals	193 K
HDM nonOAA LowIncome Meals	1.2 M
Child & Adult Care Food Program	11.9 M
Medically Tailored Meals	1 M
Supply of meals for people who need assistance	25.4 M
Remaining gap, counting all meals	32.3 M
Remaining gap, counting only lowest income meals	36.3 M
Major changes in supply of meals for people who need extra assistance during COVID	
Great Plates	31.8 M
FF & CARES	20.6 M
Non Older Americans Act - added	1.2 M
Medically Tailored Meals	855 K
CACFP	-2.2 M
Total	52.3 M
Total, excluding Great Plates	20.5 M

Appendix C: Estimate of Meals Beyond Budget Assuming 10% Budget Buffer