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Little Hoover Commission

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About NSCLC: Our Mission

Since 1972, the National Senior Citizens Law Center has worked to promote the independence and well-being of low-income elderly and disabled Americans, especially women, people of color, and other disadvantaged minorities. Because we believe in publicly-funded safety net programs, we work to preserve and strengthen Medicaid, Medicare, Social Security and SSI. To guarantee fair treatment, we work for greater access to federal courts for citizens and for better enforcement of consumers' legal rights in safety-net programs.

NSCLC works toward an America in which elderly people and people with disabilities can live in dignity and safety, free of the worries and pain of poverty, able to afford health care to the end of their days, and able to contribute to their families and societies to the best of their abilities.

The National Senior Citizens Law Center is pleased to provide the Little Hoover Commission with an overview of the *Olmstead* decision and the related legal environment surrounding home and community-based services.

I. The Olmstead Decision and its Implementation

A. *Olmstead*: Origins and Significance

*Olmstead v. L.C.*¹ is a landmark case in which the United States Supreme Court ruled that unnecessary institutionalization of people with disabilities is a type of discrimination prohibited by the Americans with Disabilities Act (ADA). The decision has been heralded as “the *Brown v. Board of Education* for the law of disability discrimination.”²

Olmstead was brought in 1995, five years after the ADA's passage, by two women who were confined in a state psychiatric hospital in Georgia. Although everyone agreed that the women would be able to live in the community with proper supportive services, Georgia did not

have adequate community mental health programs to provide those services, and claimed that the services were not required by the ADA.

The Court declared that the unjustified institutionalization of people with disabilities was indeed a type of discrimination that violated the ADA's Title II, both because it "perpetuates unwarranted assumptions" that people with disabilities "are incapable or unworthy of participating in community life" and because "confinement in an institution severely diminishes the everyday life activities of individuals, including family relations, social contacts, work options, economic independence, educational advancement, and cultural enrichment."³

Although the original plaintiffs in *Olmstead* were institutionalized and sought to return to the community, individuals with disabilities who currently live at home or in a community-based setting are also protected by the ADA, and may file suit if the absence of alternatives puts them at risk of unnecessary institutionalization.⁴

B. *Olmstead's* Requirement of Most-Integrated Setting

Central to the *Olmstead* decision is the concept that people with disabilities should be served in the "most-integrated" setting appropriate to their needs.⁵ According to federal regulations implementing the ADA, the "most integrated setting" means "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible."⁶ The National Council on Disability, an independent federal agency, states that "the most integrated setting" is generally understood to be (1) "a place where the person exercises choice and control," (2) a "home of one's own shared with persons whom one has chosen to live with, or where one lives alone," or (3) "living in the community with everyone else like everyone else."⁷

Thus, nursing homes must not be the default for providing services to low-income frail seniors and other persons with disabilities. Because individual needs are unique, there is no single alternative setting that is required, but rather a spectrum of alternative settings. In a recent case in New York, for instance, the plaintiffs successfully brought suit to move from a large, segregated adult group home to their own apartments or homes with a flexible array of support services.⁸

The only exception to the requirement that states serve people in the most-integrated setting appropriate to their needs is if the most integrated setting would "fundamentally alter" the state's service system.⁹ Simply transferring services that are currently provided in a nursing home to a community-based setting is not considered a "fundamental alteration."¹⁰

C. Recent *Olmstead* Decisions in a Climate of Budget Cuts

States frequently cite cost as a justification to limit or eliminate funding for home and community based services. Indeed, in *Olmstead* itself the state of Georgia cited cost as a defense.

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While states may take into account “the resources available ... and the needs of others” with disabilities when allocating funding to home and community based services,¹¹ a “budget crisis does not excuse ongoing violations of federal law.”¹² In the past year, in cases rejecting California’s attempts to cut back on In-Home Supportive Services (IHSS) and Adult Day Health Care, federal courts have consistently held that California’s financial condition cannot justify violation of *Olmstead* obligations.

Oster v. Wagner (initially called *V.L. v. Wagner*) was filed in response to August 2009 cuts to In-Home Supportive Services (IHSS), which is the backbone of California’s system for serving seniors and other individuals with disabilities safely at home. It provides approximately 450,000 people with in-home¹³ help in activities of daily living like bathing, dressing, meal preparation, cleaning, medication management, and other vital tasks. Last year’s cut-backs included the elimination of domestic services for those whose “ranks” (numerical scores based on assessments) indicated that they needed either verbal cues, reminders, or some physical help to perform domestic services, as well as total elimination of all in-home services for those whose ranks produced a low average “score.”

A federal district court blocked these cuts with a preliminary injunction in October 2009, on the grounds that they were likely barred by the ADA and federal Medicaid law. The court found that the numerical ranks and scores were not accurate measures of need for personal care services, and that the cuts would disproportionately hurt certain types of people, such as elders with Alzheimer’s disease who need reminders to eat and take medication. Further, the court found that loss of in-home services would result in a downward spiral of worsening health. The court concluded that the cuts were likely violations of *Olmstead* because, for most IHSS recipients, there would be no alternative except institutionalization.

The case regarding adult care health care, *Cota v. Maxwell-Jolly*, arose in 2009 when the California Legislature made two cuts to the Medicaid adult day health care program. The first cut reduced the maximum days of service from five days to three days per week. The second cut, which became effective only in early 2010, restricted eligibility so that services would be available only to persons who had a need for physical assistance with at least two activities of daily living. This second cut most significantly affected those persons with cognitive impairments, who have the muscle strength to perform most activities of daily living but who, due to the cognitive impairments, cannot care for themselves and often cannot be left unsupervised.

In two separate rulings, a federal judge prohibited the state from implementing the three-day service maximum, and from using the new clinical eligibility criteria.¹⁴ In each case, the judge issued findings that the proposed cuts likely violated the ADA. The judge found that the standards were blunt instruments that were based almost exclusively on cost-cutting, without adequate consideration (or any consideration) of possible alternatives that would protect the ability of Medicaid beneficiaries to remain living at home.

The IHSS and ADHC cases are both now on appeal to the federal Ninth Circuit Court of Appeals. In the IHSS case, the United States Department of Justice as well as national groups like AARP have filed briefs in support of the plaintiffs.

II. State and Federal Policies on Home and Community Based Services

A. Federal Programs Established Prior to *Olmstead* Decision

The *Olmstead* decision should be seen in the context of a gradual but clear trend in long-term care away from institutional care and toward a community-based model that allows persons to choose their own living situations and to grow old in familiar and supportive places.

Under this trend, federal law has changed significantly to expand the availability of long-term care outside of institutions. The increase in long-term care options is primarily attributable to increased options within the Medicaid program.

The most common Medicaid option is a Home and Community-Based Services waiver (HCBS waiver).¹⁵ Although the statutory authorization for these waivers was not influenced by the *Olmstead* decision – the authorization was enacted pre-*Olmstead*, in 1981 -- HCBS waivers have become much more common across the country in the past decade.

Under an HCBS waiver, Medicaid reimbursement is available only for persons whose long-term care needs would qualify them for nursing home admission, and only for those services that enable them to remain at home or (in most states, including California) an assisted living facility.¹⁶ A broad package of services may be provided under the waiver, including but not limited to home health aide services, personal care services, adult day health care, home modifications, and home-delivered meals.¹⁷ Expenses of room and board are not covered.¹⁸

An HCBS waiver can be approved only if the waiver is deemed cost-neutral, i.e., if the overall Medicaid expense for waiver recipients is less than what it would be for those same persons if the waiver did not exist.¹⁹ Cost-neutrality may or may not apply to individual beneficiaries, at the option of the state. In other words, as long as the program overall is cost-neutral, the state may choose to grant eligibility to individual beneficiaries even though the approval will increase Medicaid expenses for that particular beneficiary.²⁰

A waiver may limit eligibility to particular areas of the state or, more commonly, to a set number of beneficiaries annually. This ability to limit eligibility is an attractive feature to state fiscal officers worried about a waiver's potential "woodwork effect": that if Medicaid were to fund an attractive variety of long-term care (as opposed to nursing home care only), people might come out of the woodwork (so to speak) seeking Medicaid assistance.²¹

Currently, every state offers at least one Medicaid HCBS waiver, and most states offer several.²² Overall, approximately 300 waiver programs are in operation across the country.²³ California operates several waiver programs that target different populations, including two In-Home Operations waivers for people with disabilities who meet institutional level of care requirements, in addition to the Multi-Purpose Senior Services Program waiver and waivers serving those with developmental disabilities and those with AIDS.

B. State-Plan Personal Care Services

Since 1978, federal law has authorized state Medicaid programs to make personal care services available as an entitlement under the Medicaid state plan. The statutory authority establishes that these services may be “furnished in a home or other location.”²⁴

To be eligible for Medicaid reimbursement, the services must be either “[a]uthorized for the individual by a physician in accordance with a plan of treatment or (at the option of the State) otherwise authorized for the individual in accordance with a service plan approved by the State.”²⁵ As is the case for services provided under an HCBS waiver, qualifying “personal care services” are defined in an expansive manner so the program is prepared to address the broad long-term care needs of Medicaid beneficiaries.²⁶

State-plan personal care services are provided in thirty-four states (including the District of Columbia).²⁷ California’s IHSS program began with state-only funds in 1973 and in the early 1990s, the state shifted almost all enrollees to the Medi-Cal program in order to receive federal financial participation. IHSS enrollment far exceeds enrollment in California’s waiver programs.

C. Post-Olmstead Federal Programs

1. Programs Administered by the Centers for Medicare and Medicaid Services

a. State-Plan Home and Community-Based Services

The Deficit Reduction Act of 2005 introduced a new mechanism for Medicaid coverage of home and community-based services. Referred to as the “state-plan HCBS benefit,” this new mechanism combines features of the HCBS waiver and state-plan personal care services, allowing states to offer a package of services without the need for a formal waiver or showing of cost-neutrality.^{28,29}

The state-plan HCBS benefit presents several novel twists in regard to individual eligibility. By statute, the clinical eligibility standard for the HCBS state-plan benefit must be less stringent than the clinical eligibility standard used by the state for nursing home services or for HCBS waiver services.³⁰ The Centers for Medicare & Medicaid Services (CMS) recommends that a state should choose to make its HCBS state-plan benefit standard more lenient than existing standards for long-term care eligibility.³¹

Although clinical eligibility standards for the HCBS state-plan benefit may be relatively less stringent, the financial eligibility standards are stricter. By statute, eligibility cannot be granted to any person whose income is greater than 150 percent of the federal poverty line.³² For 2010, accordingly, a state could not offer state-plan HCBS eligibility to any person with a monthly income exceeding \$1,353.75 (\$902.50 X 150%).

The state-plan HCBS benefit is still in a nascent stage. Thus far, only four states have received approval from CMS to offer the benefit: Colorado, Iowa, Nevada, and Washington.³³

California has applied to offer the benefit, but to our knowledge the application has not yet been approved. The recent federal health care reform legislation made important modifications to the option, including disallowing caps on enrollment.

b. Money Follows the Person Grants

One major barrier in implementing the *Olmstead* integration mandate is the difficulty in setting up the necessary combination of housing and services. One federal program intended to help states bridge that gap is the Money Follows the Person program (MFP), enacted as part of the Deficit Reduction Act of 2005.

Under MFP, the federal government has made grants to thirty-one selected states (including California) for five-year demonstration projects.³⁴ The goal of these projects is to enable nursing home residents to move into home or community-based settings. As the program name suggests, projects are to be designed so that Medicaid reimbursement can “follow” a nursing home resident who chooses to leave a nursing home for a home or community-based alternative. As stated in the legislation, the project should “[e]liminate barriers or mechanisms, whether in the State law, the State Medicaid plan, the State budget, or otherwise, that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary long-term services in the settings of their choice.”³⁵ CMS has allocated approximately \$1.5 billion to the thirty-one states, with the expectation (based on the states’ estimates) that approximately 34,000 persons will be transitioned out of nursing homes.³⁶

MFP followed the model of the Real Choice Systems Change Grants that CMS began awarding in 2001.³⁷ More than 300 grants have been made to states for nursing home transition programs and other programs such as “Integrating Long Term Support with Affordable Housing,” “Quality Assurance and Improvement in HCBS,” and “Respite for Adults.”

California reached only 3.9 percent of its 2007 and 2008 targets for transitioning nursing home residents under the MFP program.³⁸ While most states have encountered some difficulty in achieving targets under the program, California’s performance is one of the worst. The state can clearly do a better job in identifying and transitioning current nursing home residents to home and community based settings, especially in light of the availability of federal funds to support these efforts.

2. Programs from Administration on Aging (AoA)

a. AoA’s Core Services

For more than 30 years, the Older Americans Act (OAA) has specifically authorized funding for services to “assist older persons in avoiding institutionalization.”³⁹ Such services explicitly include case management, homemaker services, home health and client assessment services,⁴⁰ and the OAA also provides transportation and nutrition services.

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In 2006, a federal reauthorization of the OAA made the expansion of HCBS opportunities a central mission of the aging services network. Under the amended OAA, state units on aging, along with area agencies on aging, have a responsibility to help establish “comprehensive, coordinated systems at Federal, State, and local levels that enable older individuals to receive long-term care in home and community-based settings.”⁴¹

b. Aging and Disability Resource Centers

In 2003, the AoA established a partnership with CMS to fund state Aging and Disability Resource Centers (ADRCs). ADRC funding is designed to help states establish “one-stop shops” for information on LTC in order to “reduce the confusion” consumers encounter when seeking information about LTC options.⁴²

Forty-three states, including California, received three-year grants up to \$800,000 between 2003 and 2005 to initiate at least one ADRC.⁴³ To receive funding, states had to assure CMS and AoA that, by the end of the grant period, the state ADRC would be increasing public awareness of long-term care support options, providing counseling regarding options and public benefits, and making Medicaid eligibility determinations (both clinical and financial).⁴⁴ States were required to serve everyone over 60 and at least one target population of younger individuals with disabilities.⁴⁵

c. Nursing Home Diversion Modernization Grant Program

From 2007 to 2009, the AoA has invited states to apply for grants under the Nursing Home Diversion Program. Grants amounted to approximately \$500,000 for 18 months, with states obligated to provide a 25% match. As the name suggests, the state programs were meant to reduce nursing home admissions. The AoA received applications from 30 states and awarded grants to 12: Arkansas, Connecticut, Georgia, Illinois, Kentucky, Maryland, Michigan, Minnesota, New Hampshire, New Jersey, Vermont and West Virginia.⁴⁶ In evaluating provision of services under the applications, the AoA emphasized 1) the availability of “flexible service dollars,” 2) the extent to which the program would target persons at high risk of nursing home admission and/or spending down to Medicaid-eligible levels, and 3) the availability of a consumer-directed model. In evaluating “system” considerations, the AoA emphasized a state’s use of a single entry point system, infrastructure to support consumer directed approaches, and quality assurance and performance measurements.

III. Opportunities and Barriers in Home and Community Based Care

The federal policy landscape has changed significantly over the last decade, giving states more and better options for making long-term care available in people’s homes. From a consumer’s perspective, however, progress has been incremental and slow, and the word “patchwork” remains ubiquitous in any discussion of long-term care at home.

In certain limited areas, California has set the pace, most obviously in In-Home Supportive Services, the nation’s largest program of consumer-directed services. IHSS already allows consumers to hire and fire caregivers, and to direct the way that services are provided,

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subject to time and funding ceilings set by the state. As a state-plan program, IHSS has no enrollment limitations, allowing it to meet the needs of low income seniors and younger individuals with disabilities without resorting to a waiting list.

Currently, the most serious threat to *Olmstead* implementation in California is the budget situation, in particular the administration's unwise proposals to eliminate or substantially eliminate programs like IHSS. If these proposals were adopted, they would certainly be challenged, and the federal courts would most like reach the same decisions already made: cutting IHSS hurts persons with disabilities and violates the ADA. In general, also, the state has lost sight of the fact that IHSS and adult care health care are less expensive than nursing homes,⁴⁷ so that cutbacks of IHSS and adult day health care may prove to be penny wise but pound foolish.

Another threat to *Olmstead* implementation is the failure to reallocate money from institutions. Under AB 1629, nursing homes have received a significant increase in reimbursement rates in recent years. At a minimum, non-institutional services should receive increases commensurate with the increases provided to nursing homes.

Assisted living will require significant evaluation. First, it is far from clear whether assisted living is an institutional or non-institutional setting. To this point, Medicaid HCBS waivers have treated assisted living as home and community-based but, on the other hand, the MFP program has bestowed home and community-based status only to those assisted living units with a lockable front door and certain other characteristics, and CMS has announced its intent to reopen the issue in new regulations. To its credit, California uses an Assisted Living Waiver that allows waiver payment only for private-occupancy assisted living, and only when assisted living staffing of a certain quality is provided.

The Medicaid waivers in California remain relatively small and poorly publicized. In part, this deficiency is compensated for by the broad reach of IHSS. But in many cases, the availability of IHSS cannot make up for the waivers' limitations, particularly in the case of persons with greater health care needs. Waivers generally provide a broader package of services than that provided under IHSS, and the waivers' limited availability forces some Medicaid beneficiaries to move into nursing homes although care at home would be a preferable and cost-effective alternative.

Finally, we note that provision of home and community-based services is particularly important in California, where the elder population is culturally, linguistically and racially diverse. For instance, more than sixty percent of IHSS recipients aged 65 and older are from communities of color.⁴⁸ In contrast, the majority of nursing home residents are white. Home and community-based care provides increased opportunities for linguistically and culturally appropriate care, for instance by allowing family members who speak an elder's language to act as caregivers. At the same time, the current confusing array of programs is particularly hard to navigate for those whose primary language is not English.

Thank you very much for the opportunity to submit these remarks to the Little Hoover Commission on this very important topic.

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- 1 527 U.S. 581 (1999).
- 2 Ruth Colker, *The Section Five Quagmire*, 47 UCLA L. Rev. 653, 654 (2000).
- 3 527 U.S. at 600-601.
- 4 *See, e.g., Fisher v. Oklahoma Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003) (imposition of cap on prescription medications placed participants in community-based program at high risk for premature entry into nursing homes in violation of ADA).
- 5 28 C.F.R. § 35.130(d).
- 6 *Id.*
- 7 National Council on Disability, *Olmstead: Reclaiming Institutionalized Lives* at 9 (2003).
- 8 *Disability Advocates Inc. v. Paterson*, 598 F.Supp.2d 289, 320 (E.D. N.Y. 2009).
- 9 *Olmstead*, 527 U.S. at 592 (citing 28 C.F.R. § 35.130(b)(7)).
- 10 *Townsend v. Quasim*, 328 F.3d 511, 519 (9th Cir. 2003).
- 11 *Olmstead*, 527 U.S. at 607.
- 12 *V.L. v. Wagner*, 669 F.Supp.2d 1106 (N.D. Cal. 2009) (citing *Independent Living Center S. Cal. v. Maxwell-Jolly*, 572 F.3d 644, 659 (9th Cir. 2009)) (appeal filed, Jan. 4, 2010).
- 13 *Id.*
- 14 *Brantley v. Maxwell-Jolly*, 656 F.Supp.2d 1161 (N.D. Cal. 2009); *Cota v. Maxwell-Jolly*, _ F.Supp. _ 2010 WL 693256 (N.D. Cal. Feb. 24, 2010) (appeal filed, Mar. 24, 2010).
15. 42 U.S.C. § 1396n(c) (2006).
16. *Id.* §§ 1396a(a)(10)(A)(ii)(VI), 1396n(c)(1); 42 C.F.R. § 435.217 (2009).
17. 42 U.S.C. § 1396n(c)(4)(B); 42 C.F.R. § 440.180(b)(3)-(4); CTRS. FOR MEDICARE & MEDICAID SERVS., TEMPLATE FOR APPLICATION FOR A §1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER app.C (2009). Home modifications and home-delivered meals are examples of the services that are not explicitly listed in statute, but are allowed under the statutory authorization of payment for “such other services requested by the State as the Secretary may approve.”
18. *See* 42 U.S.C. § 1396n(c)(1); 42 C.F.R. § 441.310(a)(2).
19. *See* 42 U.S.C. § 1396n(c)(2)(D); 42 C.F.R. §§ 441.203(e), 441.303(f)(1).
20. *See, e.g.,* CTRS. FOR MEDICARE & MEDICAID SERVS., TEMPLATE FOR APPLICATION FOR A §1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER app.B-2 (2009).
21. 42 U.S.C. § 1396n(c)(3); 42 C.F.R. § 441.301(a)(2).
22. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., TEMPLATE FOR APPLICATION FOR A §1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER app.C (2009).
23. ENID KASSNER ET AL., AARR PUBLIC POLICY INST., A BALANCING ACT: STATE LONG-TERM CARE REFORM 3 (AARP Public Policy Institute 2008).
24. 42 U.S.C. § 1396d(a)(24)(c).
25. 42 U.S.C. § 1396d(a)(24)(A); *see* 42 C.F.R. § 440.167(a)(1).
26. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., § 4480(C); 62 Fed. Reg. 47,896, 47,898 (Sept. 11, 1997) (definition of “personal care services”).
27. ENID KASSNER ET AL., *supra* note 23, at 3.
28. *See* Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6086, 120 Stat. 102 (2006); 42 U.S.C. § 1396n(i) (2006).
29. 42 U.S.C. § 1396n(i).
30. 42 U.S.C. § 1396n(i)(1)(A), (B).
31. Medicaid Program: Home and Community-Based State Plan Services, 73 Fed. Reg. 18,684 (2008).
32. 42 U.S.C. § 1396n(i)(1).
33. GENE COFFEY, NAT’L SENIOR CITIZENS LAW CTR., THE MEDICAID LONG-TERM SERVICES AND SUPPORTS PROVISIONS IN THE SENATE’S PATIENT PROTECTION AND AFFORDABLE CARE ACT 6 (2010), http://www.nslc.org/areas/medicaid/the-medicare-long-term-services-and-supports-provisions-in-the-senate2019s-patient-protection-and-affordable-care-act/at_download/attachment.
34. *See* DEBRA LIPSON ET AL., MATHEMATICA POLICY RESEARCH, INC., MONEY FOLLOWS THE PERSON DEMONSTRATION GRANTS: SUMMARY OF STATE MFP PROGRAM APPLICATIONS 1, 3 (2007), <http://www.cms.hhs.gov/CommunityServices/Downloads/StateMFPGrantSummaries-All.pdf>.
35. Deficit Reduction Act of 2005, Pub. L. 109-171, § 6071(a)(2), 120 Stat. 102 (2006).

36. Centers for Medicare & Medicaid Services, Money Follows the Person, www.cms.hhs.gov/CommunityServices/20_MFP.asp#TopOfPage (last visited Feb. 26, 2010).
- ³⁷ See <http://www.cms.hhs.gov/RealChoice>
- 38 Denny-Brown, Noelle & Debra J. Lipson, “Early Implementation Experiences of State MFP Programs,” *Mathematica* (Nov. 2009).
- ³⁹ See *Older Americans Act Comprehensive Services Amendments of 1973*, Pub. L. No. 93-29.
- 40 42 U.S.C. §3030d(a)(5).
- 41 42 U.S.C. §3025(a)(3), (7).
- 42 Dina Elani, Greg Case, Aging and Disability Resource Centers: One Contact for Easy to Access Long-Term Care Supports, TASH Connections (September/October 2004).
- ⁴³ The ADRC Map is available on the AoA’s website at http://www.aoa.gov/prof/aging_dis/statemap.asp
- 44 Administration on Aging and Centers for Medicare & Medicaid Services, Aging and Disability Resource Center Grant Initiative 8 (April 2005).
- ⁴⁵ *Id.*
- 46 Only Minnesota, Vermont and West Virginia did not also receive Money Follows the Person grants under the DRA-authorized program. See Gene Coffey, National Senior Citizens Law Center, Money Follows the Person 101 (2008).
- ⁴⁷ See, e.g., Candace Howes, Institute for Women’s Policy Research # E512, “Costs and Benefits of In-Home Supportive Services for the Elderly and Persons with Disabilities: a California Case Study,” (May 3, 2010) (responding to the California Legislative Analyst’s Report of Jan. 21, 2010).
- ⁴⁸ Newcomer, Robert & Taewoon Kang, *Analysis of the California In-Home Supportive Services (IHSS) Plus Waiver Demonstration Program*, (July 2008).