BY TERRY M. MAGADY

Changes in In-Home Care under the PPACA

"THERE'S NO PLACE LIKE HOME" is Dorothy's refrain from the 1939 film *The Wizard of Oz*. Sixty years later, the U.S. Supreme Court concurred. In *Olmstead v. L.C.*, the Court found that under the Americans with Disabilities Act states must make reasonable accommodations to place individuals in the community rather than an institution.[1] For state Medicaid long-term care systems, including California's Medi-Cal program, fulfilling the Court's mandate, as it turns out, is a lot tougher than tapping a pair of ruby slippers together.

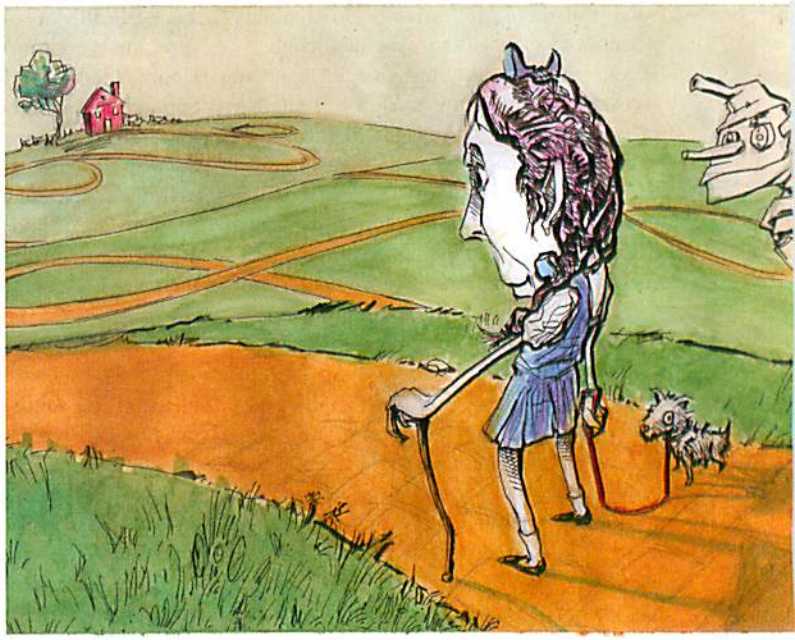
More than a decade after *Olmstead*, many people still mistakenly associate Medi-Cal only with skilled nursing facility subsidies and remain oblivious to its community-based programs. The Patient Protection and Affordable Care Act (PPACA), however, may help make home, rather than an institution, the place for people when they grew old or are disabled.[2] The PPACA expressly invokes *Olmstead*, but the act will not make it any easier for attorneys to help clients into and through the maze of California's long-term care system. First, counsel need to understand the financial requirements for Medi-Cal eligibility, which may be considered the entry point. The next challenge involves mastery of numerous acronyms representing various Medi-Cal programs that may maximize the client's eligibility, including those that have the most sought-after component of home care—the payment of caregivers.

The PPACA has a pioneering national long-term care insurance plan, called Community Living Assistance Services and Supports (CLASS). CLASS has enormous implications for home care in California, particularly relating to trusts and families helping the potentially working disabled. Other parts of the PPACA narrowly augment existing programs. Finally, alternative state plans offered by the PPACA can expand state home care systems, but only if adopted by California. Before obtaining CLASS or another program for a client's home care in California, however, Medi-Cal eligibility must be considered first.

Home Care under Medi-Cal

A person who is disabled or age 65 or older can be eligible for Medi-Cal benefits, including those helpful for remaining home, if he or she is categorically linked to Medi-Cal by eligibility to another program, such as Supplemental Security Income (SSI),[3] which has its own eligibility criteria.[4] Other entry points include specified financial requirements for a number of different Medi-Cal programs. Generally, an individual on Medi-Cal must have $2,000 or less in countable resources.[5] The Medi-Cal recipient is then only allowed to keep a specific amount of monthly income,[6] depending upon the Medi-Cal program, with the excess income paid toward a monthly share of cost, comparable to an insurance deductible.[7]

For a number of reasons, however, families of relatively substantial means can also receive Medi-Cal assistance, including home care. First, many resources may not be counted for the determination of Medi-Cal eligibility, because they are considered either exempt (e.g., a single or multifamily home[8]) or unavailable (e.g., an IRA[9]), provided certain criteria are met. Second, real property may be valued at its property tax assessed value, rather than fair market value, minus the property's encumbrances.[10] In California, the difference between these values can be substantial. Third, while each trust must be examined for certain disqualifying terms, assets held in various categories of trusts are not counted,[11] including a testamentary trust,[12] an irrevocable third-party trust if established with the property of someone other than the Medi-Cal recipient or his or her spouse,[13] and a special needs trust established with the property of a person with a disability 65 years or younger and containing a provision to pay back the state for its expenditures from what remains in the trust upon his or her death or the trust's termination.[14] Finally, there are rules to prevent the impoverishment of a spouse and, in addition, opportunities to reduce assets by gifts to others, but these matters require special direction by counsel when applied to Medi-Cal for home care.[15]



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Practitioners should understand that, generally speaking, community-based Medi-Cal does not allow special protection for spouses. However, there are exceptions for some of California's so-called home and community based (HCBS) waiver and model programs, which provide home care but may determine financial eligibility for an applicant at home as if he or she were actually in a skilled nursing facility. When there is a spouse in a skilled nursing facility, the other spouse not in a facility can retain property under the community spouse resource allowance (CSRA). The limit in 2010 is $109,560.[16] Before paying a share of cost, the spouse not institutionalized also can either retain income (up to $2,739 in 2010) as a minimum monthly needs allowance (MMMNA) or have income only in his or her own

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name disregarded.[17] A spouse's CSRA and MMMNA can then be adjusted upward through a court or administrative hearing proceeding.[18] Consequently, a married person who would be ineligible for community-based Medi-Cal and related home care without spouse protection may become eligible for home care through a HCBS waiver or model program by using spouse protection.

When expediting Medi-Cal eligibility for home care, counsel should appreciate that, unless someone is categorically eligible for Medi-Cal through SSI (which has its own gifting penalties),[19] for community-based Medi-Cal there are currently no eligibility penalties for gifts. Gifts are useful not only for accelerating eligibility but also for avoiding recovery, since the state, subject to a number of exemptions, has the right to recover its expenditures from the remaining estate of the Medi-Cal recipient upon his or her death.[20] In contrast to community-based Medi-Cal, Medi-Cal for skilled nursing facilities has a monthly ineligibility penalty for each gift,[21] and the formula for applying the penalty will become much more restrictive for planners if California adopts the federally enacted Deficit Reduction Act of 2005 (DRA).[22] For planning purposes, practitioners should also be aware that there are currently some penalty exceptions. These include a gift to a disabled child,[23] a gift of an exempt home,[24] and, at least until California implements the DRA, separate gifts on different days below the amount of the divisor used to calculate the penalty.[25]

The timing of gifts is particularly important for home care through an HCBS waiver. For example, an individual may choose not to apply for Medi-Cal until admitted to a hospital or skilled nursing facility. By that time, however, it may be difficult or impossible for the person to make gifts to expedite eligibility if there are no applicable exceptions to the penalties for skilled nursing Medi-Cal. He or she may then miss an opportunity to obtain Medi-Cal eligibility necessary for a waiver to pay for care at home. On the other hand, if prior to admission to an institution that same person had made gifts and obtained community based Medi-Cal, which has no penalties for the gifts, he or she may have been able to obtain the waiver to get home care when leaving the institution. Since an individual either may already be in a skilled nursing facility prior to moving back home or may later need to return to a facility, it is usually prudent for a practitioner to plan as if penalties will apply.

Once a person does qualify for Medi-Cal, there are varied Medi-Cal funded supports in the community, but each one, commonly known by its acronym, has its own criteria for enrollment and generally must be accessed separately. For Medi-Cal beneficiaries residing for a threshold period in a skilled nursing facility, the California Community Transitions program (CCT) funds case management, dwelling modifications, initial setup costs, and assistive technology to transition back home.[26] At Adult Day Health Care Centers (ADHCs), Medi-Cal recipients 18 years and older and at risk for institutional care receive health and social services at a weekday program out of their homes.[27] Medi-Cal's model Program of All-Inclusive Care for the Elderly (PACE) allows spouse protections[28] and has capitated financing of a package of healthcare services, including home care, in several narrow geographic areas.[29] Coordinated with Medi-Cal, the state-funded Supported Living Services can provide significant case management and in-home attendant care for adults with developmental disabilities.[30] The federally funded veteran's supplement Aid and Attendance can subsidize at-home caregivers for certain veterans or their surviving spouses.[31]

Waivers

The HCBS waiver programs provide another financial source for in-home care-giving but only for a limited number of persons.[32] Under an HCBS waiver, federal Medicaid requirements are waived so services can have an enrollment cap and need not be offered statewide.[33] The services for each HCBS waiver also must be no more costly than comparable institutional care based upon alternative formulas.[34] There are HCBS waivers for people with a developmental disability (DD waiver)[35] or with HIV or AIDS (AIDS waiver).[36] The multipurpose senior services program (MSSP), an HCBS waiver serving seniors living in certain districts who would otherwise medically qualify for institutional care, chiefly provides case management for home-based care but can offer only minimal attendant care.[37] The assisted living waiver (ALW), available in select counties, has a component that pays for assisted living services from enrolled providers for individuals residing in publicly subsidized housing.[38] In addition to meeting Medi-Cal eligibility criteria, those seeking the ALW must also consider the generally more stringent financial eligibility for federal housing subsidies, which is based upon actual or deemed income.[39] The DD waiver, MSSP, and ALW allow for spouse protections, while the AIDS waiver does not.[40]

The HCBS waiver that may provide the best opportunity for financing caregivers is the nursing facility/acute hospital waiver (NF/AH waiver), which provides care at home for Medi-Cal beneficiaries, regardless of age, who require acute, subacute, skilled, or intermediate care.[41] The NF/AH waiver offers services up to the cost of comparable institutional care for the individual[42] and allows for spouse protections.[43] A waiting list for the waiver is typical, and an applicant's medical conditions must necessitate institutional care when he or she requests placement on the list. Yet one need not be eligible for Medi-Cal in order to be on the list. Critically, however, there may not be any wait if an application for the waiver is made when one is presently in a hospital or a skilled nursing facility, since those in a hospital are given priority, and more slots are generally available for those in a skilled nursing facility.[44] Delaying until an individual goes home can result in a lost opportunity.

The program with the broadest range of potential individuals able to receive in-home care-giving is In-Home Supportive Services (IHSS). A perennial target for state budget cuts,[45] IHSS has three subsets: the Medi-Cal funded Personal Care Services Program (PCSP) and IHSS Plus Option (IPO), and the state's residual IHSS program.[46] The residual program has its own separate financial criteria comparable to SSI, including eligibility penalties for gifts.[47] The residual program is primarily for those who lack proof of citizenship and have limited residency.

PCSP and IPO have no eligibility penalties for gifts. PCSP pays for personal care, paramedical and domestic services,[48] as well as protective supervision.[49] PCSP is currently exempted from estate recovery.[50] IPO pays for PCSP services when the provider is either a spouse or a parent of a minor IHSS recipient (who would otherwise be excluded as a worker under PCSP) or the IHSS recipient is allowed advance pay or restaurant allowances (which are not provided under PCSP).[51]

Once eligible for Medi-Cal or the residual program, the person is assessed for the time necessary to complete needed IHSS tasks and allotted a number of hours each month for those tasks.[52] When protective supervision is authorized to safeguard the applicant due to behavior resulting from cognitive (rather than physical) challenges,[53] the maximum number of IHSS hours may often be allotted. The IHSS recipient can then retain workers of his or her choice at an hourly rate, which varies county by county. Depending upon the collective bargaining agreement between the workers' union and the particular county's public authority, considered the employer of record,[54] workers employed a minimum monthly number of hours can also be covered under group health and dental plans. This presents a unique opportunity for the IHSS recipient to benefit an uninsured family member serving as caregiver.

Depending upon an individual's circumstances, IHSS can sometimes only be obtained after an application for a waiver from another Medi-Cal program with more liberal financial standards than a typical community-based

Medi-Cal program. For example, a married applicant over 65 years old and otherwise medically eligible for MSSP can take advantage of MSSP's spouse protections and strategically apply first for an MSSP waiver and thereafter apply for IHSS. Similarly, a parent of a minor child with a developmental disability can strategically apply for the DD waiver, which disregards the resources and income of parents, and thereafter apply for IHSS, even with a parent as the IHSS worker. For an individual with Social Security Disability Income nullifying any allotment of IHSS hours due to a prohibitively high Medi-Cal share of cost, the person or his or her family can arrange for minimal monthly employment and strategically apply for Medi-Cal's Working Disabled Program,[55] which provides, sometimes with a premium based on income, Medi-Cal with no share of cost without counting Social Security Disability Income.[56]

CLASS

Overlaying this complicated state system is the most transformative component of the PPACA for home care in California—CLASS,[57] an unprecedented national long-term care insurance program. Scheduled to become effective in 2011, CLASS may not actually be implemented for an additional two years.[58] With amounts set by the Department of Health and Human Services (DHHS) at a level necessary ostensibly to maintain program solvency, premiums will be paid by individuals via payroll deductions. For participating employers, there will be automatic withholding, unless an employee opts out. Other methods of payment will be established for nonparticipating employers and the self-employed. Only minimum monthly premiums of $5, plus consumer price index increases, will be required for an individual whose income does not exceed the federal poverty line or who is under age 22 and actively employed while a full-time student. Critical for people with any actual or potential disabling condition, no underwriting based on preexisting conditions can be used to prevent enrollment or determine the amount of monthly premiums.[59]

For an enrollee to vest in the plan, he or she will need to pay premiums for at least 60 months.[60] For 3 calendar years of those 60 months, however, the enrollee must earn an amount ($1,120 in 2010) that is necessary to be credited with a quarter of Social Security coverage.[61] The DHSS will promulgate exceptions to these minimum earnings requirements for certain populations.[62] The premiums must be paid for at least 24 consecutive months if there is a lapse in payments for more than three months from the beginning of enrollment to the date benefits are determined.[63]

Cash benefits will then be paid for a vested enrollee who is unable to perform a minimum number of activities of daily living without substantial assistance or requires substantial supervision to protect against threats to health and safety due to substantial cognitive impairment (or has similar functional limitations as these two categories of disability).[64] The disability must be expected to last for a continuous period of more than 90 days.[65] The cash payments can be used on a broad variety of assistance determined by the individual,[66] and they will not be subject to any lifetime or aggregate limits.[67] The amount of the benefits will vary based upon measures of disability.[68] However, CLASS projects that no less than $50 per day on average will be paid.[69]

The relationship between CLASS and government benefits will be somewhat complex. On one hand, the cash payments from CLASS will not be counted for most means-tested government benefits,[70] including those in California that are the source of most home care. On the other hand, CLASS beneficiaries receiving Medicaid-financed home and community based services and supports will be allowed to retain only 50 percent of their CLASS payment, with the balance applied to the costs of those services and supports.[71] This is in contrast to Medicaid eligible residents in most institutional settings, where 95 percent of their CLASS payment will be applied to their cost of care.[72]

Most individuals will decide upon enrollment in CLASS or another program in the same manner that they decide upon a private long-term care insurance policy (e.g., based upon the product, current finances, and anticipated need). However, counsel for an individual (or his or her family or trust) with an actual or prospective disabling condition may be able to anticipate additional considerations. For example, employment may be facilitated at even a minimal level to help someone with a disability enroll in CLASS. It can help the client to maximize CLASS benefits in order to avoid arcane Medi-Cal restrictions or the recovery against the Medi-Cal recipient's estate upon death. The client or trust may benefit from the flexibility that CLASS offers regarding how available cash may be spent.[73]

This anticipation also applies to trust drafting. Practitioners should ensure that provisions are crafted to be flexible enough to allow payments that help CLASS enrollment and allow for gainful employment. The trust should allow the trustee to pay monthly insurance premiums. In addition, the trustee must be able to hire professionals who can help the beneficiary find, coordinate, and sustain some employment and, if necessary, to provide financing for an appropriate small enterprise. The terms of some trusts for disabled beneficiaries may be overly restrictive for these purposes. For example, a provision could unnecessarily prohibit actions that diminish Medi-Cal benefits. The provision would thereby preclude helping with CLASS enrollment, which may do just that. A trust may also be poorly drafted for CLASS benefits if it denies (or fails to expressly grant) the trustee the authority to invest in or loan to a business of the beneficiary, because the loan or investment could be classified as an imprudent expenditure, then subjecting the trustee to liability.

With respect to trust administration, practitioners will need to examine SSI and Social Security work incentive programs, so that benefits (not only Medi-Cal but also Medicare resulting from Social Security) can be protected, to the extent necessary, while the three-year CLASS earnings goal is met. A person receiving Social Security Disability Insurance (SSDI) benefits can still be considered disabled and keep the benefits, for example, if he or she earns less than $720 per month (with an additional maximum monthly work requirement for those self-employed) or earns in excess of that amount (or, for those self-employed, spends more hours) for nine months within a 60-month period and thereafter less than $1,000 monthly for a consecutive 36 months. Or, an SSI recipient without other income can earn $85 each month, which is not deducted from SSI benefits, and then earn an additional amount, only half of which is counted as income until the earnings equal SSI. Medi-Cal also can be maintained with earnings up to annual threshold amounts for a disabled person under Medi-Cal's Working Disabled Program or for a former SSI recipient under Section 1619(b) of the Social Security Act.[74] Particularly if a SSDI or SSI recipient comes under a CLASS exception for the Social Security quarter requirement, only the most minimal earned income may be necessary for enrollment. Termination of public benefits due to earnings should thus be relatively easy to avoid within the parameters of these work incentive programs.

In contrast to CLASS, other provisions in the PPACA result in targeted incremental changes to Medi-Cal's existing in-home programs. Most significantly for planners, commencing January 1, 2014, and continuing for five years, states will be required to include spouse protections in their waiver programs and the new optional state plans for home and community based services and supports offered in the PPACA.[75] California already has spouse protections for most of its HCBS waivers. However, California could adopt one of the PPACA's optional plans.

If this happens, the expansion of spouse protections may obviate the need to apply for a waiver before applying for other applicable programs for home care. The adoption will also increase program access for married couples who are not otherwise eligible for a waiver.

In addition, federal funding of California's CCT program will be extended another five years, and the required time in a skilled nursing facility for eligible participants will be reduced from 180 to 90 days, subtracting days covered by Medicare skilled nursing benefits.[76] This will increase the number of potential recipients of Medi-Cal-funded case management that is designed to get people from facilities to home.

Some PPACA programs will result in the expansion of the current state waivers and other in-home care, but only if a state adopts them. Two in particular may become relevant to California.[77] First, the state balancing incentive payments program will provide an enhanced federal Medicaid matching rate to states currently spending less than 50 percent of their total expenditures for long-term care on services in the home or community. The goal is to increase the states' proportion of long-term care services that are not based on institutions.[78] Whether California qualifies as such a state will depend upon the formula used for the calculation of this percentage, as well as the extent anticipated future state budget cuts diminish home care programs. To be eligible for participation, however, states must outline a plan to establish a single entry point for access into the state's system for long-term care, conflict-free case management, and uniform assessment instruments for determining eligibility for noninstitutional services and supports.[79] Implementation of such a plan could initiate changes to the multiple access points and varied assessments currently existing in California.

Second, the community first choice option will give states an enhanced federal matching rate so that the states may provide a more expansive array of community-based attendant supports and services.[80] These include deposits, one month of rent, and utilities to help transition from an institution to the community.[81] Also included are technology devices for backup systems to ensure continuity of supports and services,[82] perhaps a harbinger for the future as states, including California, look for ways to cut costs. Eligible individuals would require institutional level of care, but, unlike current HCBS waivers, there would no requirement for the services to be cost neutral compared with institutional care, and states would have to offer benefits statewide without enrollment caps.[83]

While *Olmstead* and the PPACA may not be as easy to follow as a yellow brick road, attorneys who become familiar with the complex set of government healthcare programs may at least be able to help clients go back home.

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[1] Olmstead v. L.C., 527 U.S. 581 (1999).

[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-152, tit. II, §2406(a)(2) (hereinafter PPACA).

[3] 42 C.F.R. §435.120.

[4] 42 C.F.R. §435.1323 (income limits); 42 C.F.R. §416.1205(c) (resource limits).

[5] CAL. CODE REGS. tit. 22, §50420.

[6] CAL. CODE REGS. tit. 22, §§50503, 50507.

[7] *See, e.g.*, for an individual, maximum countable income of $1,133 under the Medi-Cal Aged and Disabled program or $600 under the Medi-Cal Aged, Blind and Disabled-Medically Needy program. *See* All County Welfare Directors Letters 09-06 (Feb. 18, 2009), 09-08 (Feb. 24, 2009) *and* 09-08E (Mar. 4, 2009) (hereinafter ACWD Letters), *available at* http ://www.dhcs.ca.gov.

[8] CAL. CODE REGS. tit. 22, §50425. If California adopts the Deficit Reduction Act of 2005, the value of an exempt home will be limited to $750,000, subject to exceptions. WELF & INS. CODE §14006.15(b).

[9] CAL. CODE REGS. tit. 22, §50488 (draft). An applicant's IRA is considered exempt, as distinguished from unavailable, under Medi-Cal's working disabled program, whether or not distribution has been made. WELF & INS. CODE §14007.9(b)(2).

[10] WELF & INS. CODE §14006(c)(1).

[11] For more detailed discussion of trusts and public benefits, *see* Terry M. Magady, *Something Special*, LOS ANGELES LAWYER, Feb. 2002, at 26.

[12] Medi-Cal Eligibility Procedures Manual Letter No. 179 (May 15, 1997), at 9J-51-58.

[13] CAL. CODE REGS. tit. 22, §50489.5(a)(1).

[14] CAL. CODE REGS. tit. 22, §50489.9(a)(3).

[15] For more detailed discussion of these and other rules for Medi-Cal skilled nursing benefits, *see* Terry M. Magady, *Guiding Families through the Maze of Medi-Cal Eligibility*, LOS ANGELES LAWYER, Mar. 2001, at 19.

[16] CAL. CODE REGS. tit. 22, §50490.5 (draft).

[17] CAL. CODE REGS. tit. 22, §§50563.5, 50601, 50605(f) (draft).

[18] CAL. CODE REGS. tit. 22, §§50490.5, 50605, 50605(f), 50605.5, 50951.

[19] Social Security Administration, Program Operations Manual System, SI 01150.110, *available at* https://secure.ssa.gov/apps10/poms.nsf/aboutpoms.

[20] CAL. CODE REGS. tit. 22, §50960.2-66.

[21] CAL. CODE REGS. tit. 22, §50411.3 (draft).

[22] WELF & INS. CODE §14015.

[23] *Id.*

[24] CAL. CODE REGS. tit. 22, §50411.5(a)(4)(B) (draft).

[25] CAL. CODE REGS. tit. 22, §50411.3 (draft).

[26] *See* http://www.dhcs.ca.gov/services/ltc/Pages/CCT .aspx.

[27] WELF. & INS. CODE §§14520-88.

[28] ACWD Letter No. 97-18 (May 12, 1997).

[29] WELF. & INS. CODE §14590-97.

[30] WELF. & INS. CODE §§4689.8, 4689.8.05. While its benefits generally are not means tested, a regional center may still be able to look to "possible sources of funding for consumers." WELF. & INS. CODE §4659.

[31] 38 C.F.R. §§3.350(h), 3.351(b). Veteran's Aid and Attendance benefits have income and asset thresholds. *See* 38 C.F.R.§§3.271-73, 3.274-75.

[32] WELF. & INS. CODE §14132(t).

[33] *See* http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalWaiversList.aspx.

[34] *Id.*

[35] *See* http://www.dhcs.ca.gov/services/medical/Pages /HCBSDDMediCalWaiver.aspx.

[36] *See* http://www.dhcs.ca.gov/services/medi-cal/Pages/AIDSMedi-CalWaiver.aspx.

[37] *See* http://www.dhcs.ca.gov/services/medi-cal/Pages/MSSPMedi-CalWaiver.aspx.

[38] *See* http://www.dhcs.ca.gov/services/ltc/Pages /ALWPP.aspx.

[39] *See* 24 C.F.R. §§5.603, 5.609; U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, OCCUPANCY REQUIREMENTS OF SUBSIDIZED MULTIFAMILY HOUSING PROGRAMS, Rev-1, chs. 3-6 (HUD Handbook 4350.3).

[40] Medi-Cal Eligibility Procedures Manual Letter No. 291 (Sept. 3, 2004) at 19D-1-13 2; Medi-Cal Eligibility Procedures Manual Letter No. 307 (Dec. 10, 2009) at 19D.

[41] *See* http://www.dhcs.ca.gov/services/medi-cal/Pages/NFAHMedi-CalWaiver.aspx.

[42] *See, e.g.*, annual maximums of $29,548 for an intermediate care facility, $48,180 for a skilled nursing facility, and $180,219 for an adult subacute care facility. Nursing Facility/Acute Hospital Waiver, app. B-2-1.

[43] Medi-Cal Eligibility Procedures Manual Letter No. 291 (Sept. 3, 2004), at 19D.

[44] WELF. & INS. CODE §14132.99; Nursing Facility/Acute Hospital Waiver, app. B-3-f.

[45] *See* Department of Social Services All County Letters Nos. 09-56 (Oct. 1, 2009) *and* 09-61 (Oct. 22, 2009).

[46] WELF. & INS. CODE §12300(c).

[47] Department of Social Services All County Letters No. 00-35 (May 19, 2000).

[48] WELF. & INS. CODE §14132.95(d)(1)-(2).

[49] Department of Social Services All County Information Notice No. 1-14-05 (Mar. 21, 2005).

[50] CAL. CODE REGS. tit. 22, §50961(c).

[51] WELF. & INS. CODE §14132.952.

[52] The maximum number of monthly hours is either 283 or 195 depending upon the IHSS program and whether or not the person is severely impaired. *See* All-County Information Notice No. 1-28-06 (Apr. 11, 2006).

[53] Department of Social Services Manual of Policies and Procedures, Regs. 30-757.17.

[54] WELF. & INS. CODE §12301.6.

[55] *See* http://www.dhcs.ca.gov/services/Pages /TPLRD_WD_cont.aspx.

[56] WELF & INS. CODE §14007.9(b)(2).

[57] *See* PPACA, tit. VIII, §§3201-3204(e)(2).

[58] PPACA, tit. VIII, §3203(a)(3). The secretary of DHSS has until October 1, 2012, to designate a CLASS benefit plan.

[59] PPACA, tit. VIII, §3203(b)(3).

[60] PPACA, tit. VIII, §3202(6)(A)(i).

[61] PPACA, tit. VIII, §3202(6)(A)(ii).

[62] PPACA, tit. VIII, §3202(6)(C).

[63] PPACA, tit. VIII, §3202(6)(A)(iii).

[64] PPACA, tit. VIII, §3203(a)(1)(C).

[65] *Id.*

[66] PPACA, tit. VIII, §3205(c).

[67] PPACA, tit. VIII, §3203(a)(1)(D)(iv).

[68] PPACA, tit. VIII, §3203(a)(1)(D)(ii).

[69] PPACA, tit. VIII, §3203(a)(1)(D)(i).

[70] PPACA, tit. VIII, §3205(f).

[71] PPACA, tit. VIII, §3205(c)(1)(D)(ii).

[72] PPACA, tit. VIII, §3205(c)(1)(D)(i).

[73] *See* PPACA, tit. VIII, §3205(c)(1)(B).

[74] For further discussion of how people can work and maintain benefits, *see* http://www.ssa.gov/pubs /10095.html.

[75] PPACA, tit. II, §2404.

[76] PPACA, tit. II, §2403.

[77] Another plan option can significantly expand home care services, but it removes caps, requires statewide application, and allows eligibility for those who would not necessarily be institutionalized. PPACA, tit. II, §2402(b). Because the option results in additional cost without federal financial incentives, it is unlikely to be adopted by California.

[78] PPACA, tit. X, §10202(a)&(b).

[79] PPACA,, tit. X, §10202(c)(5).

[80] PPACA, tit. II, §2401(k)(2).

[81] PPACA, tit. II, §2401(k)(1)(B), (C), (D).

[82] *Id.*

[83] PPACA, tit. II, §2401(k)(1), (k)(3)(B).