

**Connecticut Medicaid:  
A Primer**

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## **Medicaid Overview**

Medicaid has provided a health care safety net to millions of Americans since its enactment under Title XIX of the Social Security Act in 1965. In 2007, Medicaid provided health care coverage for almost 60 million Americans.<sup>1</sup> With the recent passage of the national health reform law, the Patient Protection and Affordable Care Act (PPACA), Medicaid will continue to play a significant role in the expansion of health insurance coverage to many Americans. In its current form, Medicaid provides health care coverage for many low-income children and families who do not have access to employer-sponsored insurance, individuals with disabilities who lack private coverage or for whom adequate coverage is not available, and low-income seniors dually eligible for both Medicare and Medicaid.<sup>1</sup> In addition, Medicaid is the largest payer of long-term care services, and finances more than 40 percent of overall nursing home and long-term care spending, including both institutional care and home and community-based services.<sup>1</sup>

Medicaid is jointly financed by the state and federal government as an entitlement program. States receive federal matching dollars at a rate based on state per capita income, with poorer states receiving more federal money. In contrast, the Children's Health Insurance Program (CHIP) is a block grant program, so coverage can be denied for eligible children when the funding runs out.<sup>1</sup> States receive higher federal matching rates for CHIP than for Medicaid. Participation in Medicaid and CHIP is voluntary, but all states, the District of Columbia, and the territories participate. Federal law requires certain basic guidelines and eligibility standards, but states have broad authority to design eligibility, benefits, delivery system, and payment mechanisms within federal rules.<sup>1</sup>

## **Eligible Populations in Connecticut**

In 2007, 530,300 Connecticut residents were enrolled in Medicaid. This equals approximately 15 percent of the Connecticut population, slightly lower than the national Medicaid coverage rate at 19 percent.<sup>2</sup> More recent estimates suggest that in April 2010, more than 620,000 individuals were enrolled in some form of Medicaid program in Connecticut.<sup>3</sup> The rate of uninsured in Connecticut in 2007 was 9.4 percent, compared to 15.4 percent in the U.S.<sup>4</sup> Eligibility for Connecticut Medicaid varies based on individual characteristics. See Table 1 for a basic overview of income eligibility by population and program.

**Table 1. Eligibility Levels by Population, Income Limit, and Program**

<b>Population</b>	<b>Income Limits Program</b>	<b>Income Limits Program</b>
Children (<19)	0 to 185% FPL <i>HUSKY A (Medicaid)</i>	186 to 300% FPL plus <i>HUSKY B (CHIP)</i>
Families	0 to 185% FPL <i>HUSKY A (Medicaid)</i>	0 to 300% SSI plus <i>Charter Oak Health Plan (state-funded)</i>
Pregnant Women	0 to 250% FPL <i>HUSKY A (Medicaid)</i>	0 to 300% SSI plus <i>Charter Oak Health Plan (state-funded)</i>
Low-Income Adults	0 to 56% FPL (68% in Region A) <i>Medicaid for Low-Income Adults</i>	0 to 300% SSI plus <i>Charter Oak Health Plan (state-funded)</i>
Seniors (65 +)	56% FPL (68% in Region A) <i>Community Medicaid</i>	0 to 300% SSI plus <i>If eligible for HCBS waiver</i>
With Disability	56% FPL (68% in Region A) <i>Community Medicaid</i>	0 to 300% SSI plus <i>If spend down or eligible for HCBS waiver</i>

**Children & Parents**

Healthcare for Uninsured Kids and Youth (HUSKY) is the primary means of coverage for low-income children, parents, other caregivers, and pregnant women in Connecticut. HUSKY is composed of two programs: **HUSKY A (Medicaid)** and **HUSKY B (CHIP)**. HUSKY A provides Medicaid coverage for children (up to age 19), adults, and other caregivers up to 185 percent of the federal poverty level (FPL). HUSKY A also provides coverage for pregnant women up to 250 percent FPL. There are no copayments or premiums required for HUSKY A. HUSKY B provides coverage to children only above 185 percent FPL. All children are eligible for HUSKY B, regardless of income.<sup>5</sup> There is no asset test required for eligibility for either HUSKY A or B.<sup>6</sup> Premiums for HUSKY B are based on a sliding scale divided into three income bands:

- Band 1: Over 185 up to and including 235 percent FPL
- Band 2: Over 235 up to and including 300 percent FPL
- Band 3: Over 300 percent FPL<sup>5</sup>

Upon enrolling in HUSKY A or HUSKY B, beneficiaries choose between three managed care organizations (MCOs) including Aetna Better Health, AmeriChoice by United Healthcare, and Community Health Network.<sup>7</sup> Connecticut began mandatory enrollment for these populations in Medicaid managed care in 1995.<sup>8</sup> In addition, enrollment in HUSKY Primary Care, a primary care case management (PCCM) program, is available for HUSKY A members who live in Hartford, New Haven, Waterbury, or Windham. The primary difference between these options is that care is coordinated by the primary care physician (PCP) and the MCO in the MCO option, while in the PCCM option, the member enrolls directly with a PCP and care coordination is conducted exclusively by the PCP.<sup>7</sup>

Copayments and premiums differ between HUSKY A and HUSKY B, but the benefit packages are mostly the same.<sup>5</sup> Covered benefits include: outpatient physician visits, preventive care, immunizations, eye exams, hearing exams, nurse midwives, podiatrists, chiropractors, naturopaths, preventive family planning services, inpatient physician, emergency care, and family planning.<sup>9</sup>

Behavioral health, dental, and pharmacy services are carved out of MCO packages. Mental health and substance abuse services are provided through the **Connecticut Behavioral Health Partnership (CT BHP)**. CT BHP is a partnership between the Department of Children and Families (DCF) and the Department of Social Services (DSS) to provide behavioral health services to HUSKY enrolled children and families as well as children involved with DCF through a contract with Value Options, Inc.<sup>10</sup> Services provided for children through this partnership include: routine outpatient, medication management, extended day program, intensive outpatient program, partial hospital program, crisis stabilization resources, home-based services, home health agency services, mobile crisis, inpatient hospitalization, sub-acute residential, and peer and family peer specialist services.<sup>10</sup> Adult services include routine outpatient, medication management, intensive outpatient program, partial hospital program, home health agency services, inpatient hospitalization, and peer and family peer specialist services.<sup>10</sup> HUSKY A and B members do not pay for any mental health or substance abuse services.<sup>10</sup>

Dental services are provided by the **Connecticut Dental Health Partnership**. Dental benefits include: preventive and diagnostic services, emergency services, restorative services, oral surgery, and orthodontia.

All HUSKY members receive the same pharmacy benefits. The use of generic prescription drugs is required when available. However, permission may be granted for coverage for certain brand name drugs. HUSKY A members require no copayments for prescription medication.<sup>11</sup>

As of July 1, 2010, HUSKY B copayments increased to equal those of cost sharing by state employee health plans.<sup>12</sup> However, most preventive services still require no copayment.<sup>12</sup> If beneficiaries qualify under Band 1 or Band 2, total annual out-of-pocket costs, including copayments, coinsurance, and premiums, cannot exceed 5 percent of a family's gross income.<sup>12</sup> **HUSKY Plus Physical** provides additional services for children enrolled in HUSKY B who meet the criteria for Children and Youth with Special Health Care Needs (CYSHCN). No additional copayments, deductibles, or premiums are required for these supplemental benefits. Benefits are only available to HUSKY B members in Band 1 and Band 2. These services are already covered under the traditional HUSKY A benefit package.<sup>13</sup>

As of June 2010, there were 378,571 individuals enrolled in HUSKY A (249,156 children up to age 19, and 129,415 adults),<sup>14</sup> and 15,476 children enrolled in HUSKY B.<sup>15</sup>

### ***Low-Income Childless Adults***

Connecticut was recently granted approval by the federal government under new federal authority of PPACA to expand Medicaid coverage to low-income childless adults by transferring its **State-Administered General Assistance (SAGA)** medical program to Medicaid. Eligibility for **Medicaid for Low-Income Adults** includes Connecticut residents, ages 19 to 64 who do not receive Supplemental Security Income (SSI) or Medicare, and who are not pregnant.<sup>16</sup> Income eligibility for single adults and married couples is 56 percent FPL, except in Region A of the state (primarily southwestern CT) where eligibility is 68 percent FPL. There are no asset requirements. Individuals at higher incomes may qualify after spending down—paying out of pocket for medical services to meet income eligibility.<sup>16</sup> Since this program is now authorized through the Medicaid program, administration shifted from the Community Health Network of Connecticut to the DSS.<sup>16</sup> Connecticut is the first to expand coverage to low-income

adults under PPACA.<sup>17</sup> The new Medicaid coverage will provide Medicaid benefits to approximately 45,000 single individuals previously enrolled in SAGA.<sup>18</sup>

The services covered under this new Medicaid expansion include: Inpatient and outpatient hospital services, physician services, laboratory services, prescription drugs, mental health services, immunizations, and emergency services.<sup>17</sup> Members will access these services through the Connecticut Medical Assistance Program (CTMAP), the state's fee-for-service Medicaid provider network.<sup>16</sup> SAGA was funded only by the state, so the ability to draw federal dollars to the state through the federal Medicaid match is beneficial to the state. The state estimates the net savings to be at least \$53 million between the effect date of the change, April 1, 2010, and July 2011.<sup>18</sup>

**Charter Oak Health Plan** is a state program that provides limited health coverage to uninsured adults, ages 19 to 64, of all incomes. There are approximately 15,000 people enrolled. As of June 1, 2010, a monthly premium of \$307 is required for new enrollees in Charter Oak Health Plan, regardless of income. Deductibles and coinsurance still vary based on income. Prior to this, premiums were based on income level and the remaining premiums were subsidized by the state. Members who were enrolled prior to June 1, 2010 continue to have premiums based on income and partially subsidized premiums.<sup>19</sup> An array of services is provided, including primary care and specialist office visits, preventive care, emergency room visits, prescription medications, durable medical equipment (DME), behavioral health services, outpatient rehabilitation, maternity pre and post natal care, inpatient rehabilitation, skilled nursing, inpatient hospital visits, and outpatient surgical. Copayments and coinsurance vary by service. The Charter Oak Health Plan has an annual benefit maximum of \$100,000 and a lifetime maximum of \$1 million.<sup>20</sup> Coverage is provided by the same three MCOs that offer coverage through Medicaid.<sup>20</sup>

### *Seniors and People with Disabilities*

Seniors and people with disabilities may access Medicaid Assistance for the Aged, Blind, and Disabled (MAABD) through many pathways including Community Medicaid, spenddown, Home and Community-Based Waivers, and Medicaid for the Employed Disabled. In addition, the **Medicare Savings Program (MSP)** provides premium and copayment support to certain participants who are dually eligible for both Medicare and Medicaid.

Individuals eligible for **Community Medicaid below the Medically Needy Income Limit (MNIL)** fall into one of three categories: individuals, age 65 and over; individuals with a disability, between the ages 18 to 65; and individuals who are blind.<sup>21</sup> Asset limits for this population are \$1,600 for a single individual and \$2,400 for a married couple. Certain assets, such as a home and an automobile used for transportation to and from work or medical appointments, are excluded from these limits.<sup>21</sup> Income limits vary based on region of the state and whether or not the individual lives in an institution. In Region A, the monthly income limit (after specified deductions) is 68 percent FPL, (\$610.61 for a single person and \$777.92 for a married couple). In Regions B and C, the income limit is 56 percent FPL (\$506.22 for a single person and \$672.10 for a married couple). Single persons who reside in an institution have a monthly income limit of \$2,022.00.<sup>21</sup> Individuals who do not meet the income limits, but still need health care coverage may "spend down" to become eligible for Medicaid through the **Medically Needy** option.<sup>8</sup> To spend down, individuals may deduct medical bills from income above the medically needy income limit to meet eligibility requirements.<sup>21</sup> Copayments are only required of individuals who reside in institutions.<sup>21</sup> The benefits covered under this program include: outpatient medical services, prescriptions, hospital services, and nursing home care.<sup>21</sup>

Seniors and persons with a disability age 18 and older are also eligible for **ConnPACE**, a state-funded service that assists eligible members with the cost of their prescription drugs. In addition, ConnPACE

may provide monthly premium assistance with certain Medicare Part D premiums. Income limits for ConnPACE are \$25,100 for a single individual and \$33,800 for a married couple. To be eligible for ConnPACE an individual must not be enrolled in Medicaid. As of June 2009, there were 29,665 seniors and 4,392 persons with disabilities enrolled in ConnPACE.<sup>22</sup>

Home and community-based services (HCBS) waivers allow states to expand coverage to people with higher incomes who have unique health care needs, including seniors, persons with physical disabilities, HIV/AIDS, mental retardation and developmental disabilities (MR/DD), traumatic brain injury, and children with specific health conditions. These HCBS waivers are authorized under section 1915(c) of the Social Security Act.<sup>23</sup> The income limit for all HCBS waivers in Connecticut is 300 percent of SSI.<sup>8</sup> In dollar terms, to be eligible, individuals must make no more than \$2,022 per month and have assets no more than \$1,600 for an individual (not including a home or vehicle needed for transportation to employment or medical services). Connecticut has several HCBS waivers.

The **Connecticut Home Care Program for Elders (CHCPE)** helps frail seniors avoid placement in a nursing facility and remain in their home by providing an array of services and supports including medical services, care management services, adult day health services, companion services, home delivered meals, homemaker services, assisted living services, personal care attendant services, and in some cases chore assistance. In 2009, there were 14,937 participants enrolled in CHCPE.

The **Acquired Brain Injury (ABI) waiver** is for individuals, ages 18 to 64, who have an acquired brain injury, meet the level of care requirement defined by the state, and are able to participate in developing a plan of care to live in the community. The level of care requirement means that without the waiver, you would need to receive care in a nursing facility, a long-term care intermediate facility, or a chronic disease hospital. This waiver is person-centered, meaning that the participant is at the center of care planning and is the employer of all the service providers. 19 services are available through this waiver, including: personal care assistance, homemaker services, chore services, case-management, respite care, vehicle modification services, pre-vocational services, supported employment, environmental accessibility adaptations, transportation, specialized medical equipment and supplies, personal emergency response systems, companion services, transitional living services, cognitive/behavioral programs, home delivered meals, community living support systems, independent living skill training, and substance abuse programs.<sup>24</sup> In 2009, 365 participants were enrolled in the ABI waiver.

The **Personal Care Assistance Waiver** provides personal care, assistive technology, and personal emergency response system (PERS) for individuals with physical disabilities, ages 18-64.<sup>25</sup> Through this waiver, the individual is an employer, and is able to hire, train, and fire his/her own personal care attendants.<sup>26</sup> 725 participants were enrolled in 2009.

The Department of Developmental Services (DDS) operates two HCBS waivers. The **Connecticut Comprehensive Supports Waiver** provides services to individuals who have a developmental disability and are 18 years or older, or have mental retardation and are three years or older,<sup>25</sup> and live in a community living arrangement, a community training home, or assisted living.<sup>27</sup> Services offered include adult day health, community training homes/community living arrangements, group day supports, live-in caregiver, respite, supported employment, independent support brokers, adult companion, assisted living, clinical behavioral support, environmental modification, health care coordination, individual goods and services, individualized day supports, individualized home supports, interpreter, nutrition, personal emergency response system (PERS), personal support, specialized medical equipment and supplies, transportation, vehicle modifications.<sup>25</sup> As of 2009, there were 4,546 participants enrolled in the Comprehensive Supports waiver.<sup>8</sup>

The **Individual and Family Support (IFS) Waiver** provides services and supports to individuals who do not need 24-hour care and live in their own home. Services provided through this waiver include: home and community supports such as personal assistance, adult companion, supported living, individual habilitation, personal emergency response systems, and respite; day/vocational supports such as group day, individualized day, and supported employment; ancillary supports including consultative therapies, specialized medical equipment and supplies, and non-medical transportation; and additional support services such as home and vehicle modifications, interpreter services, family training, and family and individual consultation and support.<sup>27</sup> In 2009, 3,591 participants were enrolled.<sup>8</sup>

The **Working for Integration Support and Empowerment (WISE) program** is a mental health waiver that helps individuals with serious mental illness avoid placement in a nursing home and helps transition individuals living in a nursing home back to the community.<sup>28</sup> This waiver provides community support, supported employment, assertive community treatment, home accessibility adaptations, non-medical transportation, peer supports, recovery assistant, short term crisis stabilization, specialized medical equipment, and transitional case management for individuals with mental illness ages 22 and older.<sup>25</sup> Enrollment in this waiver began in April 2009.<sup>8</sup>

The **Katie Beckett Waiver** allows individuals with severe disabilities to be cared for at home, and qualify based only on the individual's income and assets. To be eligible, individuals must be severely disabled and of any age, although this waiver is predominantly used by children. The individual must be eligible for care in an ICF/MR facility. This program has a long waiting list.<sup>28</sup> 187 participants were enrolled in this waiver in 2009.<sup>8</sup>

The **Medicaid for the Employed Disabled (MED)** program allows Connecticut residents with a disability to earn income through employment without losing medical coverage. To be eligible, an individual can earn no more than \$75,000 per year. Premiums are based on a sliding scale. Covered services are the same as those provided under Medicaid for persons who are aged, blind, or disabled. A person can have assets worth \$10,000 for an individual or \$15,000 for a couple and still qualify. A car for transportation to work or medical appointments, a home, and a retirement savings account are not counted as assets.<sup>29</sup>

## **Ineligible Populations**

Individuals living in Institutions for the Treatment of Mental Disease (IMDs), or Corrections facilities are not eligible for Medicaid. Non-citizens with less than five years of residency are not eligible for Medicaid coverage, but Connecticut provides 100 percent state-funded coverage for this group.<sup>8</sup> Until recently, low-income childless adults were not covered by Medicaid, but the recent national health reform law changed that exclusion.<sup>1</sup>

## **Mandatory and Optional Services**

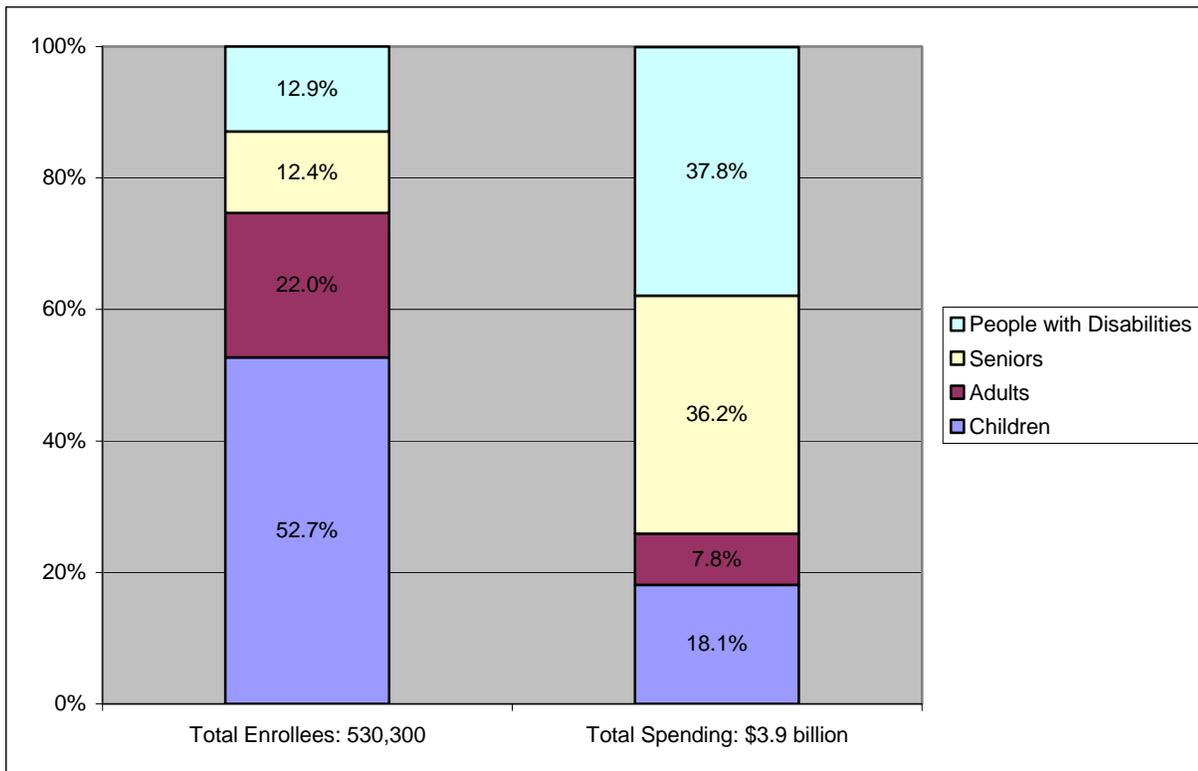
Overall, Medicaid provides a broad array of health and long-term care services. Certain services are mandatory according to federal regulation. Mandatory services include: physicians' services; hospital services (inpatient and outpatient); laboratory and x-ray services; early and periodic screening, diagnostic, and treatment (EPSDT) services for individuals under 21; federally-qualified health center and rural health clinic services; family planning services and supplies; pediatric and family nurse practitioner services; nurse midwife services; nursing facility services for individuals 21 and older; home health care for persons eligible for nursing facility services; and transportation services.<sup>1</sup> In addition, states often choose to cover optional services that provide additional supports for the diverse needs of the Medicaid population. Such optional services include: prescription drugs; clinic services; care furnished by other licensed practitioners; dental services and dentures; prosthetic devices, eyeglasses, and durable medical

equipment; rehabilitation and other therapies; case management; nursing facility services for individuals under age 21; intermediate care facility for individuals with mental retardation (ICF/MR) services; home-and community-based services (by waiver); inpatient psychiatric services for individuals under age 21; respiratory care services for ventilator-dependent individuals; personal care services; and hospice services.<sup>1</sup> As described above, Connecticut provides an array of these mandatory and optional services through its diverse Medicaid, CHIP, and state-only programs.

### Funding, Expenditures, and Reimbursement

Connecticut’s Federal Matching Assistance Percentage (FMAP) is 50 percent for Medicaid. In other words, every dollar Connecticut spends on Medicaid, draws down a dollar from the federal government.<sup>30</sup> CHIP draws a slightly higher match rate at 65 percent. Total Medicaid spending by Connecticut and the federal government totaled 3.9 billion in FY 2007. Expenditures are unevenly distributed between beneficiaries. Although children make up more than half of Medicaid enrollees in Connecticut, they account for only 18 percent of total expenditures. In contrast, seniors and people with disabilities together make up approximately one quarter of enrollees, and account for nearly three-fourths of total Medicaid spending (Figure 1).

**Figure 1. Connecticut Medicaid Enrollment and Spending, FY2007.**

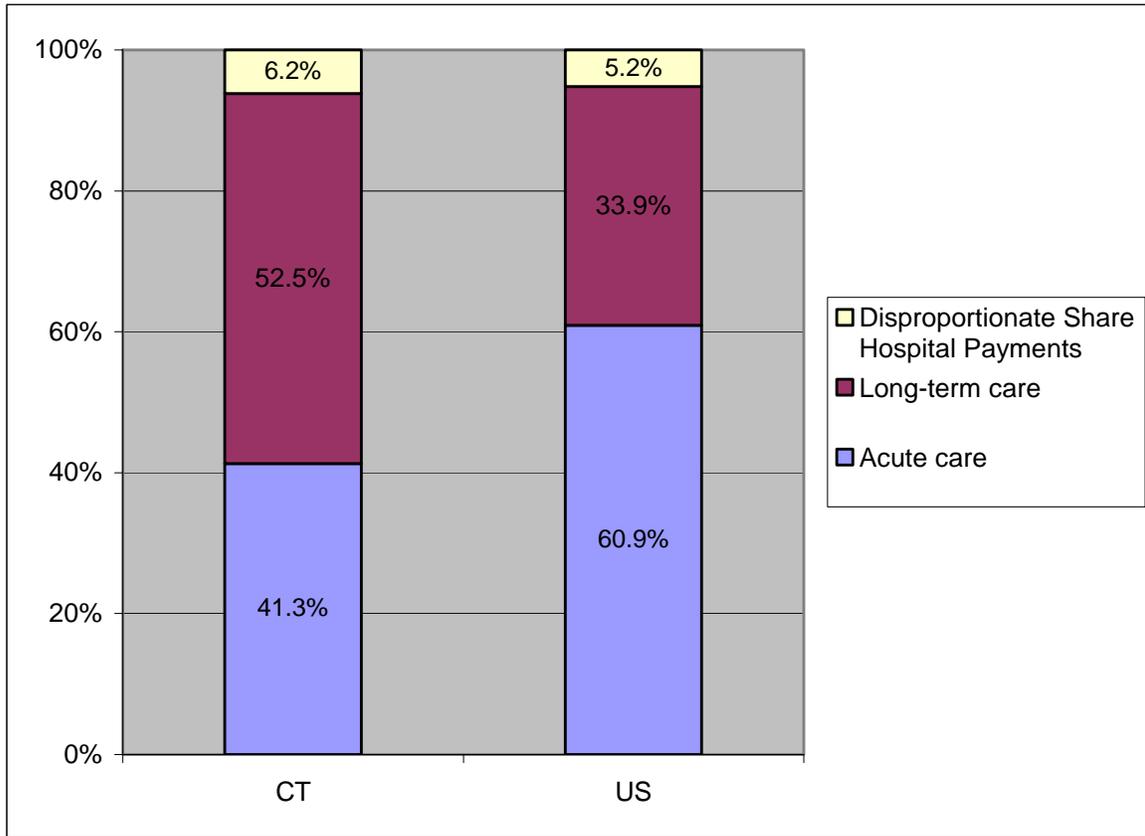


Sources: Statehealthfacts. Connecticut: Medicaid enrollment. 2009; <http://www.statehealthfacts.org/profileind.jsp?sub=52&rgn=8&cat=4>. Accessed July 6, 2010.  
 Statehealthfacts. Connecticut: Medicaid spending. 2009; <http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=8&cmprgn=1>. Accessed July 6, 2010.  
 Notes: Total spending includes both state and federal spending on Connecticut Medicaid in FY2007.

Since Medicaid is the primary payer of long-term care services, it makes up a large portion of overall expenditures. In Connecticut, spending on long-term care accounts for a larger percentage of total Medicaid expenditures relative to the rest of the country, with nearly 53 percent in Connecticut, compared to less than 34 percent in the U.S. overall (Figure 2). Furthermore, in 2008, 52.1 percent of long-term care

Medicaid expenditures in Connecticut were attributed to nursing facility care, compared to 43.2 percent in the U.S.

**Figure 2. Distribution of Medicaid Spending by Service, Connecticut and the U.S.,**



**FY2008.**

Source: Statehealthfacts. Connecticut: Medicaid spending. 2009; <http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=8&cmprgn=1>. Accessed July 6, 2010.

Traditionally, Medicaid offers lower reimbursement to providers for the provision of health care services. In Connecticut, the overall Medicaid-to-Medicare fee index in 2008 was 0.99, considerably higher than the national rate of 0.72.<sup>31</sup> However, this higher fee ratio is primarily due to higher rates for obstetric care in Connecticut (Table 2).

**Table 2. Medicaid-to-Medicare Fee Index, Connecticut and the U.S., FY2008.**

	CT	US
All services	0.99	0.72
Primary care	0.78	0.66
Obstetric care	1.74	0.93
Other services	0.59	0.72

**Conclusion**

Connecticut offers a wide variety of services to diverse participants through Medicaid, CHIP, and state-only initiatives. Its recent expansion of Medicaid to low-income adults through PPACA will bring additional federal funds to the state and provide better coverage to many low-income adults in Connecticut.

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