FORENSIC WHISTLEBLOWER REPORT & CIVIL RIGHTS COMPLAINT

Systemic Violations, Medicaid Fraud, and Olmstead Abuses in Connecticut's Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the Person Program

Date: March 13, 2026

SUBMITTED TO

- President Donald J. Trump & The White House
- U.S. Department of Justice (DOJ) – Civil Rights Division (Olmstead Enforcement)
- Federal Bureau of Investigation (FBI) – Health Care Fraud & Civil Rights Units
- U.S. Department of Health & Human Services – Office of Inspector General (HHS OIG)
- Centers for Medicare & Medicaid Services (CMCS) – Central Office Oversight

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EXECUTIVE SUMMARY

The State of Connecticut has engineered a multi-layered, deliberate system within its Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the Person Program designed to unnecessarily institutionalize individuals with brain injuries, suppress community integration, and misappropriate federal Medicaid matching funds. Through retaliatory outsourcing of care management, strict concealment of the program's existence, denial of federal free-choice

rights, and the calculated refusal to provide Adult Protective Services for this demographic, the state effectively traps Medicaid consumers in hospitals and institutions for years.

This design violates the Americans with Disabilities Act (ADA), the Supreme Court's *Olmstead v. L.C.* decision, and 42 CFR § 431.51 (Free Choice of Providers). It is a closed-loop cartel that rewards favored, insider agencies while actively retaliating against and starving compliant providers who attempt to expose the system or successfully integrate ABI survivors into the community.

SECTION 1: THE "KEEP THEM OUT OF THE PUBLIC" MOTIVE (OLMSTEAD VIOLATION)

The foundational driver of this system is an intentional, institutional bias: the State of Connecticut actively prefers keeping working-age Medicaid consumers with acquired brain injuries in hospitals, nursing homes, and highly controlled environments rather than allowing them to live independently "out in the public."

Visible, successful community integration would expose past service failures and trigger mass Olmstead enforcement, forcing the state to expand capped waiver slots and spend real money.

By deliberately keeping the Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the Person Program low-profile (no broad hospital outreach, no public education), the state suppresses demand. This maintains the invisibility of consumers, avoids public accountability, and ensures that federal Medicaid dollars can be controlled without public scrutiny.

SECTION 2: THE SMOKING GUN CALCULATED ABSENCE OF ADULT PROTECTIVE SERVICES

The most irrefutable proof of the state's intent to suppress community integration is its deliberate failure to establish a safety net for this specific population. Connecticut operates fully funded protective services for nearly every other vulnerable group:

- **Children (under 18):** Department of Children and Families (DCF).

- **Elderly (60+):** Protective Services for the Elderly (PSE).
- **Intellectually/Developmentally Disabled (18-59):** Department of Developmental Services (DDS) Abuse Investigation Division.

However, there are no protective services with investigative authority for adults ages 18-59 with acquired brain injuries or physical disabilities. (Disability Rights Connecticut provides advocacy only, not protective/investigative authority).

This gap is intentional. By withholding protective services, the state ensures that if ABI consumers were allowed to live independently, there would be no independent state mechanism to report abuse, neglect, exploitation, or provider steering. It guarantees that working-age ABI survivors are forced to remain in controlled institutional or agency-dominated settings where federal funds flow without external oversight.

SECTION 3: RETALIATORY OUTSOURCING & THE GATEKEEPER TRAP

When early, compliant providers (such as ABI Resources) began successfully integrating consumers into the community and whistleblowing on state-level Medicaid overbilling and steering, the State of Connecticut retaliated. Instead of correcting the fraud, the state outsourced care management to third-party Access Agencies to act as a shield.

- **The Waitlist Trap:** An ABI survivor waits years in a hospital on a managed waitlist. When they are finally processed, the outsourced care manager acts as the absolute gatekeeper.
- **Denial of Free Choice:** Families are never shown the full, approved Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the Person Program provider directory. They are never informed of their federal right to free choice under 42 CFR § 431.51. The care manager simply states, “I have set you up with

“Favored Agency”

- **Crushing Competition:** This mechanism funnels massive volumes of Medicaid referrals to previously failing, favored agencies allowing them to explode in size and revenue without real competition while systematically starving the whistleblowing providers who expose the scam.

SECTION 4: DIRECT FEDERAL LAW VIOLATIONS

- **42 CFR § 431.51 (Free Choice of Providers):** Systematic and intentional concealment of the approved provider list to forcibly steer Medicaid consumers to favored agencies.
- ***Olmstead v. L.C.* & ADA Title II:** Unnecessary institutionalization of brain injury survivors via engineered waitlists and suppression of program awareness.
- **Medicaid Fraud & Abuse:** Manipulation of "cost-neutrality" reporting, misuse of federal matching funds to protect institutional revenues, and anti-competitive cartel behavior.
- **Whistleblower Retaliation:** Weaponization of outsourced care management to financially ruin compliant providers who advocate for patient rights and systemic transparency.

SECTION 5: REQUESTED FEDERAL ACTION

This is a systemic failure requiring federal intervention. Referrals back to Connecticut DSS or its contracted Access Agencies will only result in further concealment and retaliation.

- **Immediate Joint Investigation:** DOJ Civil Rights, HHS OIG, and the FBI must audit the Connecticut Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the the Person Program referral pipelines, hidden provider utilization data, waitlist processing, and care-management outsourcing.
- **Olmstead Enforcement:** Compel the state to publicly publish the full, searchable provider directory, mandate consumer education on 42 CFR § 431.51 rights, and actively transition consumers out of hospitals.
- **Protective Services Mandate:** Require federal oversight or the immediate creation of an Adult Protective Services division for ages 18-59 with physical/acquired brain disabilities in Connecticut.
- **Whistleblower Protection:** Initiate an immediate injunction to protect compliant community providers (like ABI Resources) from further state-sponsored financial retaliation and referral starvation.

Submitted to: President Trump, DOJ, FBI, HHS OIG & CMS Protected under False Claims Act (31 U.S.C. § 3730) and ADA/Olmstead Retaliation Provisions Do Not Refer to Connecticut State Agencies or Contractors. This is for you and every person you love.

APPENDIX A: THE 100 EXPERT SYSTEMIC MOTIVES SUSTAINING THE FRAUD

The following 100 interlocking motives explain exactly why Connecticut conceals the Medicaid Federally Funded Brain Injury ABI Acquired Brain Injury Home and Community Waiver Program and MFP Money Follows the Person Program, enforces gatekeeper steering, and prefers institutionalization over community integration.

Category 1: Financial & Budget Control (Short-Term Cost Savings)

1. Capped waiver slots keep enrollment low, avoiding state spending on expanded community services.
2. Hospital/nursing home stays shift more cost burdens to federal Medicaid matching dollars.
3. Limited outreach prevents a surge of applications that would force the state to fund more slots.
4. Hidden choice protects over-utilization of favored, high-cost providers without competition driving rates down.
5. Waitlists act as a budget valve: fewer people exiting institutions equals predictable spending.
6. Refusing to publish a directory avoids administrative costs of maintaining a public list.
7. Care-manager gatekeeping is cheaper than broad marketing or consumer education campaigns.
8. Outsourcing creates a fixed contract cost instead of variable community-placement expenses.
9. Long institutional stays allow the state to falsely claim "cost neutrality" on paper to CMS.
10. Suppressing successful community stories prevents public pressure to reallocate institutional funding.

Category 2: Legal & Regulatory Avoidance

11. Real publicity and choice would trigger Olmstead lawsuits proving unnecessary institutionalization.
12. Hiding the program exploits the federal loophole that allows capped waivers.
13. Withholding the provider list sidesteps strict 42 CFR § 431.51 free-choice enforcement.
14. Limited person-centered planning documentation hides violations of federal planning rules.

15. No broad hospital outreach successfully avoids ADA integration mandates.
16. Steering through contracted agencies shields the state from direct liability for choice violations.
17. Waitlist design complies with federal rules on paper while practically delaying community access.
18. Internal-only directories satisfy "maintain a list" regulations without providing public transparency.
19. Care-manager conflicts of interest are not publicly audited because the system stays entirely opaque.
20. Avoiding visible success stories prevents class-action Olmstead enforcement by civil rights groups.

Category 3: Political & Accountability Protection

21. Low visibility ensures no public outrage over long institutional stays.
22. DSS leadership can claim "we have a program" without ever proving results at scale.
23. Elected officials avoid political budget fights over expanding capped waiver slots.
24. Media stories about trapped TBI survivors never surface if families never know the program exists.
25. Whistleblower complaints stay buried without broad consumer awareness to back them up.
26. Legislative scrutiny stays limited because the utilization data is deliberately hidden.
27. No public directory prevents easy FOIA comparisons of corrupt referral volumes.
28. Keeping people invisible protects the false narrative that "community integration is too expensive."
29. Outsourcing gatekeeping diffuses political blame from the state government itself.
30. Long waitlists are falsely blamed on "high demand" instead of deliberate systemic design.

Category 4: Institutional Provider Revenue Protection

31. Filled hospital and nursing-home beds generate steady, guaranteed revenue for those facilities.
32. Successful community placements empty beds and severely cut institutional income.

33. A hidden program keeps the demand for institutional care artificially high.
34. No broad outreach means fewer transitions out of highly profitable nursing homes.
35. Care managers steer to favored agencies that maintain quiet institutional ties.
36. Long waitlists ensure beds stay occupied for years longer than medically necessary.
37. Limited choice prevents families from demanding faster hospital discharges.
38. The internal directory favors providers comfortable with institutional handoffs.
39. Outsourcing protects the original institutional funding streams from disruption.
40. Public success stories would accelerate bed-emptying pressure on hospitals.

Category 5: Administrative & Operational Control

41. Care managers acting as single gatekeepers are easier to control than decentralized, free choice.
42. An internal directory is simpler for the state to manipulate than a public, searchable one.
43. Limited slots ensure predictable, easy caseloads for contracted Access Agencies.
44. No public marketing deliberately reduces application volume and state workload.
45. Steering maintains a highly consistent, controlled referral pipeline to favored agencies.
46. Waitlist processing is entirely centralized and hidden from public view.
47. Outsourcing creates an impenetrable buffer layer of bureaucracy against consumer complaints.
48. Hidden choice entirely avoids disputes over provider selection.
49. Internal processes limit the ability of external auditors to track referral patterns.
50. Capped program design keeps the administrative burden artificially minimal.

Category 6: Concealment of Systemic Failures

51. Visible community living exposes poor state outcomes or severe service gaps.
52. A hidden program prevents families from comparing the quality of real options.
53. No public list hides the state's over-reliance on favored, low-quality support models.
54. Institutional placement looks like "care" when consumers have no alternatives to compare it to.
55. Long waitlists are falsely framed to the public as "supply failure" rather than engineered delays.
56. Outsourced steering masks extreme favoritism and kickback patterns.
57. Outsourcing hides direct state involvement in choice violations.

58. No public outreach completely avoids documenting the true scale of unmet need publicly.
59. Invisible consumers mean there are no public statistics on illegal institutionalization rates.
60. Systemic failures safely stay locked behind institutional walls.

Category 7: Retaliation & Whistleblower Suppression

61. Targeting early-growing, compliant providers (like ABI Resources) sends a chilling message to the market.
62. Outsourcing care management immediately after reports began protects the original scam.
63. Steering consumers away from whistleblower agencies financially punishes exposure.
64. A hidden directory limits competition from honest, transparent providers.
65. Limited publicity intentionally starves small, compliant agencies of clients.
66. Internal controls prevent the easy FOIA documentation of retaliatory patterns.
67. Care-manager gatekeeping directly bypasses consumer complaints about lack of choice.
68. Waitlist delays punish families who manage to find the program independently.
69. Refusing to educate consumers on choice rights discourages legal challenges.
70. The opaque system design makes mass whistleblowing nearly impossible to prove without federal subpoenas.

Category 8: Societal & Institutional Bias

71. Deeply rooted belief among leadership that ABI consumers "belong" in institutions.
72. State fear of the public visibility of severe brain-injury challenges.
73. State preference for controlled, confined environments over independent community living.
74. False assumption that community integration is inherently too risky to manage.
75. Cultural view within DSS that TBI survivors need to be "protected" from the public view.
76. Bias against the word-of-mouth growth of independent, successful community providers.
77. Preference for a sterile medical-model over a person-centered community model.
78. Fear that visible community success would challenge long-held institutional norms.
79. Societal discomfort with brain-injury survivors participating in everyday public life.
80. Institutional mindset thoroughly entrenched at the highest leadership levels.

Category 9: Federal Reporting & Statistics Manipulation

81. Low, controlled enrollment keeps "cost-neutral" reports exceptionally clean for CMS.
82. A hidden waitlist scale avoids federal scrutiny of the state's massive unmet need.
83. An internal directory prevents easy federal audits of 42 CFR § 431.51 choice compliance.
84. Blatant steering patterns never surface in sanitized public Medicaid data.
85. Endless institutional stays inflate certain federal matching categories for state benefit.
86. Suppressed outreach keeps total application numbers artificially, safely low.
87. Outsourced care management intentionally diffuses reporting responsibility away from the State.
88. There are zero public metrics tracking actual community integration success.
89. Waitlist and discharge data stays strictly internal, unverified, and highly controllable.
90. Capped slots satisfy federal waiver terms on paper while violating the spirit of the law.

Category 10: Economic & Network Protection

91. Favored, previously failing agencies are allowed to grow massively without real competition.
92. The hidden system rigorously maintains closed, cartel-like referral networks.
93. Small, honest, compliant providers stay deliberately starved of clients to prevent growth.
94. Care-manager relationships rigorously protect insider providers from market forces.
95. The lack of a public directory entirely blocks fair market entry for new, innovative businesses.
96. Outsourcing creates a protected, untouchable contractor class funded by the state.
97. Steering ensures steady, guaranteed Medicaid revenue for select insider networks.
98. Manipulated waitlists prevent market saturation and control the flow of money.
99. Limited publicity protects the exact economic status quo that whistleblowers attempt to disrupt.
100. The overall design perfectly funnels federal Medicaid dollars exclusively to controlled players.

Thank you America for protecting poor vulnerable people and families.

With Honor, Love, Gratitude and Respect.

David Medeiros

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