

**SUFFOLK COUNTY COURT
SPECIAL GRAND JURY**

**SEPTEMBER 19, 2005
TERM 1E**

**GRAND JURY REPORT
CPL §190.85(1)(C)**

Dated: June 29, 2006

**FOREPERSON
COUNTY COURT
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PRELIMINARY STATEMENT

The Suffolk County Court Special Grand Jury, Term 1E, was empanelled on September 19, 2005, and thereafter extended to June 30, 2006, and to September 29, 2006, by order of the Honorable Ralph Gazzillo, to complete its investigation into matters involving the New York State Medicaid Program.

The Grand Jury heard testimony from 35 witnesses, and considered 190 exhibits, many consisting of multiple pages and documents.

As a result of this investigation, the following report has been adopted pursuant to New York State Criminal Procedure Law Section 190.85(1)(c), and is respectfully submitted to the Court.

FINDINGS OF FACT

I. Introduction:

Medicaid is a federal medical assistance program, which began in 1975. It was initially implemented in order to assist low-income people with their medical bills. In recent years, it has become a source of health insurance, rather than payment for an existing medical need.

There are a variety of Medicaid programs available in the State of New York for both the uninsured and underinsured. The New York State Department of Health (NYSDOH) is the regulating agency for Medicaid, and it is that agency's policies, coupled with Federal and State law, that determine the parameters, including the rules and regulations governing eligibility for the various Medicaid programs available. It is the responsibility of the local departments of social services to administer these programs. In Suffolk County, it is the Suffolk County Department of Social Services (DSS) that is tasked with this responsibility.

One of these medical assistance programs involves participation in a managed care plan, paid by the State, through Medicaid. As opposed to medical assistance on a "fee for service" basis (whereby a medical service is provided to a Medicaid recipient, and the fee for that service is paid by Medicaid), in a Medicaid managed care plan, Medicaid pays health insurance premiums to a health insurance company for a managed care plan. In turn, the health insurance company administers a health plan whereby a principal provider, usually a family physician or internist, manages the recipient's health care. The principal provider determines whether to refer the recipient to a specialist or

for necessary therapy. The medical providers are paid directly by the health insurance company.

In order to be eligible for a Medicaid managed care plan, an individual or a family first must be eligible for one of the available Medicaid programs. Generally, the factors considered in determining eligibility are household composition, the legal responsibility of parents for children and spouses for each other, the amount of household income, financial resources, residency in the State of New York, and citizenship/alien status. The Federal poverty level for the relevant time period is used as a reference point to calculate basic income levels that determine eligibility, given the other factors that are considered.(Grand Jury exhibits 1 and 2).

In 2001, a new Medicaid program called Family Health Plus was instituted. This is a Medicaid managed care program made available specifically for people who are not financially eligible for traditional Medicaid, but still have incomes that do not exceed certain eligibility levels. Until 2005, there was no financial resource test regarding eligibility for this program. So long as your income was below a certain maximum, you could have untold thousands in a bank account, and still be eligible for this program.

In order to be permitted to operate as a provider of a Medicaid managed care plan, a health insurance company must apply for and receive approval from the NYSDOH. There are six managed care organizations (MCOs) which are approved to operate Medicaid managed care plans in New York State.

Up until the end of the year 2000, a person of low income who met the Medicaid eligibility requirements, could apply for Medicaid health insurance for his or her children by simply going to the offices of the Department of Social Services and filing an

application. The applicant would be interviewed by a Department of Social Services employee, who would make all of the appropriate inquiries regarding eligibility requirements, and obtain all of the required documentation in support of that application. Ultimately, that same Department of Social Services employee would determine whether or not the applicant was eligible for benefits.

Towards the end of the year 2000, New York State began a program called “Facilitated Enrollment”. The stated purpose of the program was to enroll as many eligible people as possible in a health insurance program. In essence, it enabled employees of the managed care organizations participating in the Medicaid managed care program, as well as employees of community-based organizations (CBOs)¹, to go into the community and solicit Medicaid applications. These individuals, known as “facilitated enrollers”, would interview applicants, assist applicants in completing applications, obtain required documentation, and submit applications to the Department of Social Services. The program was established in this manner ostensibly to reach out into the community to people who were unaware they might be eligible for these benefits, to expand the ability of applicants to apply outside of normal business hours, and to lessen the stigma of applying for the benefit at a government office building.

Since the inception of the Facilitated Enrollment program, there has been a virtual explosion in the number of Medicaid managed care applications received by the Department of Social Services for processing. Almost immediately after the program was instituted, examiners at DSS who were receiving applications submitted by facilitated enrollers for processing noted that applications were poorly documented, and

¹ This is a term used in social services. A community-based organization (CBO) is any organization within the community that typically seeks grant money or other funding to serve the community. CBOs are usually, but not always, non-profit organizations.

the applications themselves were of poor quality, and questionable accuracy. These observations were brought to the attention of the administration of the Department of Social Services, and ultimately to the Commissioner's attention. Ultimately it was determined by the DSS that it would be appropriate to conduct a formal review of the applications received from facilitated enrollers.

A review was conducted, with alarming results. Applications submitted by facilitated enrollers from each of the six managed care organizations, as well as the two community-based organizations, were analyzed. A large number of the applications analyzed were found to be inaccurate, most importantly in areas that impacted on the eligibility of the applicant for the program. The results of this review were shared and discussed with the entities involved. Despite this, no observable change in the quality of the applications received by DSS was evident. Two more reviews were conducted by DSS, with similar results, and each time the results were shared with the relevant managed care organizations and community-based organizations. No perceptible change took place in the quality or quantity of the applications submitted to DSS.

Ultimately, representatives of DSS, deeply concerned about the implications of potential fraud and waste that their reviews had exposed, met with two deputy commissioners, as well as other administrators, of the NYSDOH, to share the results of the reviews, and express the concerns they raised. Also present was the Commissioner of a Department of Social Services from another county in New York State, who had noted similar problems with facilitated enrollment applications in her county, conducted a similar survey, and had observed similar findings. There appeared to be no change in the policies or practices of NYSDOH as a result of this meeting.

Finally, representatives of DSS met with representatives of the Suffolk County District Attorney's Office to request an investigation. The result was the instant Special Grand Jury investigation.

The Grand Jury heard from numerous witnesses, and examined many documents. The Grand Jury has come to the conclusion that the Facilitated Enrollment program is a fraud-friendly program, destined to result in inevitable waste of huge amounts of taxpayer money. The Grand Jury also concludes that the Suffolk County Department of Social Services, due to many factors not within its control, is helpless to stem the tide of this waste. The recommendations of the Grand Jury that follow are based upon the findings of fact that led to these conclusions.

II. Facilitated Enrollment: A Fraud-Friendly Program

A: The program itself:

The Facilitated Enrollment program was established for the laudable purpose of enrolling as many eligible New Yorkers as possible in a health insurance program. The program was designed specifically to address obstacles that might exist in meeting this admirable goal. There was concern that individuals in the community might be unaware they were eligible for Child Health Plus², or Medicaid. There was worry that the stigma of applying for medical assistance at a government office building (DSS) would discourage eligible applicants. There was also concern that it was simply too inconvenient for potential applicants to complete applications during normal business hours.

Enrollers, given the mandate to enroll as many eligible people as possible into a health insurance program, embraced their task with gusto. They were permitted and as of this writing still actively solicit clients whenever and wherever they feel it would be fruitful to do so. “Enrollers go to soccer games, they go to churches, they go to grocery stores. Citizens have been approached in grocery store parking lots pushing shopping carts and especially if they are accompanied by a child they have been approached by someone who says as one witness testified, [‘]excuse me, do you have insurance for that child?['] They aggressively attempt to enroll clients and sell a policy, right in the parking lot. There are also facilitated enroller plans who have large [recreational

² Child Health Plus is a children’s health insurance program in the State of New York. It is for children who are not eligible for Medicaid. It was specifically implemented to help people who work, but do not have a great deal of income, and do not have health insurance available to them. The parent, depending on income, will pay anywhere from nothing, up to \$143 per month in premiums per child. (Grand Jury Exhibit 3).

vehicle]s. They park them in restaurant parking lots, grocery store parking lots and they, as another witness testified “um, come out of the RV and they go to people who are going to the grocery store, you know, going wherever, and they offer them balloons and other little presents and, you know, [‘I want to tell you all about my health insurance company[‘]. . .”

The responsibility of an enroller does not end with the successful recruiting of new clients. Enrollers are legally obligated to assist applicants in completing an accurate application. Part of that assistance entails the enroller asking all of the appropriate questions to determine eligibility, specifically, in the areas of household composition, income, citizenship status of the applying individuals, and any other information relevant to eligibility for benefits. Enrollers are also legally required to obtain the necessary documentation to support these applications. Enrollers must fully educate the applicant as to the entire panoply of managed care plans available to them. They are prohibited from advocating only the plan that employs the enroller. Enrollers must help applicants make an educated decision as to which plan would be best for the applicant to select for their family. Once the application has been successfully completed, the enroller submits the application and supporting documentation to DSS for processing.

Although the authority to accept and approve Medicaid applications lies solely with the local departments of social services, the applications submitted by facilitated enrollers to DSS are expected to have been appropriately screened for eligibility by the enroller. The NYSDOH is responsible for oversight of the Facilitated Enroller program. Facilitated enrollers are allegedly required to receive training regarding their obligations under the program, including the documentation required, and the parameters of

eligibility. Training of facilitated enrollers is the responsibility of the NYSDOH, and the individual health care plans (MCOs), and the lead agencies that employ the enroller.

B. The floodgates are opened:

Since the inception of the Facilitated Enrollment program in late 2000, there has been a flood of applications for Community Medicaid benefits³ registered by DSS. Naturally, there has been a commensurate increase in the Community Medicaid benefit caseload of DSS. These numbers have been on a steady rise, as reflected in the following chart (Grand Jury Exhibit 184):

COMMUNITY MEDICAID GROWTH*
(Excludes Hospital, Chronic Care and SSI)

<u>Year:</u>	<u>Apps Registered Per Month:</u>	<u>FE Apps Per Month:</u>	<u>Caseload:</u>
2001	2,147	541	23,076
2002	2,855	1,237	32,459
2003	3,305	1,540	41,219
2004	3,360	1,403	49,666
2005	3,203	1,219	51,079 ⁴
Mar/06	3,250	1,091	51,423

Similarly, the numbers of individuals actually receiving Community Medicaid benefits at the end of each year, in the same time frame, has more than doubled: in 2001,

³ “Community Medicaid benefits” or “Community Medicaid” is a term of art. It refers to health insurance coverage that is paid for by Medicaid, as distinguishable from other forms of Medicaid health benefits, such as hospital care, chronic care, and SSI benefits. Facilitated enrollers can only sign up applicants for Community Medicaid benefits. During the period in question (the end of 2000 to March, 2006), these other areas of Medicaid have stayed at relatively stable levels.

⁴ There is a decrease in these numbers between 2004 and 2005 due in large measure to an increase in scrutiny that DSS was able to impose upon the applications from October 2005 to March, 2006. This is discussed in much greater detail later on in this report.

the number of individuals at the end of the year on Community Medicaid was 47,294, and, as of March, 2006, that number had risen to 98,039 (Grand Jury Exhibit 184).

Coincidentally there, of course, has been a commensurate rise in the Medicaid expenditures for Suffolk County. Reviewing these expenditures for the past ten years, reveals that in the period preceding the commencement of the facilitated enrollment program (1995 through 1999), there were fairly moderate increases in the total Medicaid expenditures for Suffolk County (in fact, from 1996 to 1997, there was an approximate eighteen million dollar decrease in those expenditures). An examination of identical expenditures from the institution of the facilitated enrollment program (2000) to the end of 2005, discloses expenditures rising at an exponential rate, so that in the year 2005, the total Medicaid expenditures for Suffolk County was approximately 1.5 billion dollars. This is an increase of over 550 million dollars from the year 2000 expenditure figure of \$933,541,822 (Grand Jury exhibit 185).

Proponents of the Facilitated Enrollment program argue that this huge increase in the area of Community Medicaid is merely evidence of the success of the program in reaching its overarching goal: to enroll as many eligible people as possible in New York's health insurance program. However, the Grand Jury has found that this increase is due in substantial part to financial incentives offered to participating managed care organizations to garner as many Medicaid clients as their enrollers could muster. The Grand Jury has further found that, due to many factors beyond its control, DSS has been unable to stem this tidal wave of applications, and most disturbingly there is strong evidence that many of the applications are inaccurate and in many instances outright fraudulent.

C. A complete lack of quality control:

When the Facilitated Enrollment program was instituted, towards the end of the year 2000, New York offered grant money to community based organizations willing to act as lead agencies. They approved one lead agency for Suffolk County (the Suffolk lead agency), and one for Nassau County (the Nassau lead agency). Those agencies were tasked with subcontracting to other community based organizations for enrollment, and with the responsibility for reviewing every application from both their subcontractors and participating MCOs. This review was meant to entail a complete check for both the accuracy⁵ and credibility⁶ of applications, as well as a review to ensure that the applications were fully documented⁷. Finally the application was required to demonstrate on its face that someone on the application was eligible for a Medicaid program.

Remarkably, the Suffolk lead agency hired only one person to conduct the quality control review of the facilitated applications. The volume of review was simply too large for this poor, hapless employee, who was justifiably unable to handle it. The NYSDOH's answer to this predicament was to direct DSS to simply accept the applications directly from all of the enrollers: those hired by the MCOs, and those from the community-based organizations.

⁵ "Accuracy", in this context is defined as follows: a facilitated application should contain a worksheet which the facilitated enroller completes. This worksheet sets forth a basic family budget which should demonstrate that the applying individual or family is eligible for Medicaid, based upon their income. This worksheet, in order to be "accurate", should be arithmetically accurate, and should also reflect numbers that are based upon the information in the application itself.

⁶ "Credibility", in this context, is defined as follows: an application for assistance should represent a "credible" situation. One should be able to look at an application, and believe that the information in it is true. For example, if an application suggests that a family pays \$1,000.00 per month in rent, but the family acknowledges only \$800.00 per month in total income, that application would not be "credible".

⁷ A "fully documented" application would be an application that included appropriate documentation of the acknowledged income (e.g. pay stubs or a copy of a letter explaining a benefit that the family receives, such as Social Security), or, if there are acknowledged resources, copies of bank statements should be included. Additionally, a fully documented application should include copies of birth certificates or social security cards for the applicants.

As a result of this directive, it fell upon the shoulders of DSS to engage in quality control of the facilitated applications. Due to the sheer volume of these applications, as well as a lack of staff and resources at DSS, this has proven to be a virtually impossible task.

When a facilitated application is received by DSS, the application is date stamped. It then goes to a clerk who checks a statewide computer database to ensure that there is not an active case for the individual(s) who are applying already in existence. The application is then registered in the statewide database for individuals who are applicants for Medicaid. The application is then given to a DSS examiner who reviews it for credibility.

It is clear to the Grand Jury that DSS is understaffed in this area. As of the fall of 2005, there were 15 examiners available for review of the facilitated applications, with an average of between 1,750 to 2,000 applications being received per month. Based upon this volume, each examiner would have to review approximately 150 applications over the course of a month. However, as a practical matter, if an examiner were to properly review facilitated applications for accuracy, credibility, proper documentation, and eligibility, he or she would only be able to review approximately 16 applications per week.

Added to the pressure imposed upon DSS by the sheer volume of applications being received for review, are the time constraints involved. If an applicant actually goes to the offices of DSS and applies there, the NYSDOH requires the Medicaid application be processed 30 days from the date a signed and completed application is submitted, if the applicant is under the age of 21, and within 45 days if the applicant is

over the age of 21. Where DSS is required to determine whether or not an applicant meets the Social Security definition of disability, the processing deadline expands to 90 days.

In the case of facilitated enrollment applications, the deadlines begin to run when an application is completed by the enroller⁸.

Because of these pressures, when a DSS examiner receives a facilitated application for review, the Grand Jury learned that, if he or she does not see something “. . . blatantly incredible, the documentation does not appear to have been horribly altered, [the application] seems like it might be accurate, [he or she will] do a financial determination to see whether or not the circumstances would make the case eligible and, if so, [he or she] will open the case.”

D. Adding insult to injury: the recertification process:

Once an application has gone through this concededly cursory review for accuracy and credibility, and a case has been opened, the applicant is now a recipient of Medicaid benefits. All recipients must complete an annual recertification or renewal process. In almost all instances, this is done entirely by mail.

In the past, at the recertification stage, a recertification application, which was almost identical to the original application for Medicaid benefits, would have to be completed by the recipient. Additionally, there would be a face-to-face interview between the recipient and a DSS examiner, so that the application could be questioned. This process would enable a DSS employee to learn whether there were any changes in the circumstances of

⁸ An application is considered completed by the enroller when the application is fully documented, the budget worksheet is done, and every piece of documentation has been completed by the applicant and the enroller is ready to send it to DSS.

the case, and question any anomalies that may have arisen in the interim between the original application for benefits, and the recertification of the case.

The recertification process is now a stream-lined, mail-in process. The NYSDOH mails a recertification notice to the recipient family. This is a multi-paged document that simply sets forth what the original case circumstances were in terms of acknowledged income and household composition, and seeks to determine if anything has changed in those circumstances. The recipient is required to acknowledge in writing whether there have been any changes or note that there have been none, sign the document, and send it to the local DSS. It is not required that this document be notarized.

Once the recertification form is received by DSS, a clerk date-stamps the form, and notes in a central computer database that the recertification form has been received from this particular recipient. This is done to prevent the responding recipient from receiving a closing notice for failure to return the form. The form is then distributed to an undercare⁹ examiner at DSS responsible for recipients as determined both alphabetically and by geography.

As with the facilitated enroller application process, DSS is unable to do anything more than a cursory review for credibility and accuracy. As of late 2005, DSS undercare examiners were carrying 1,800-2,000 cases per examiner.

As a result, the recertification review consists of looking to see if the information on the recertification form appears to match the application form. Incredibly, the examiner does not even pull the actual case record. Rather, the examiner simply checks the stored budget information in DSS's computer system to see if the gross

⁹ Undercare cases are those cases where the applicant was found eligible for Medicaid benefits, and is an active recipient of those benefits.

acknowledged wages are different, and if there have been any changes in the number of household members reported in the original case. If something obvious has changed, the examiner might pull the case record (which contains all of the original documentation of the case), and send a letter to the recipient asking for documentation of the current situation. If no extreme changes are noted, the case is recertified.

E. Reviews of facilitated applications: is negligence or even fraud afoot?:

Almost immediately after the facilitated enrollment program was instituted, DSS examiners who were reviewing the applications noticed that they were poorly documented, many were “blatantly incredible”, and the general quality of the applications was “extremely poor”. These observations were brought to the attention of the administrative staff of DSS, and ultimately to the Commissioner.

Unfortunately, DSS was not in a position, because of the tremendous influx of facilitated applications, to conduct the type of investigation that was warranted. DSS decided that the best course of action would be to bring the problem to the attention of its source: in January, 2003, they met with representatives from all of the managed care organizations involved in the program, as well as the Suffolk lead agency, and the Nassau lead agency. At that meeting, DSS clearly articulated their concerns about the quality of the applications, and the need for improvement. DSS advised the attendees that they intended to conduct formal reviews of the applications they had received thus far.

As promised, DSS completed three formal reviews. A protocol was developed whereby DSS examined a random and statistically valid sample of approximately 10% of the average number of applications submitted by each MCO and lead agency per month

(e.g. if an MCO submitted 100 applications per month , then 10 applications received from that MCO were reviewed). The review itself consisted of a qualified DSS examiner re-interviewing the applicants, and asking the questions they would ask if the applicant had been applying for benefits through DSS rather than a facilitated enroller.

The results of these reviews demonstrated that an unacceptably large number of applications were factually inaccurate especially in the areas of income (income was either unreported or under-reported)¹⁰ and household composition¹¹, both of which critically impact upon eligibility for benefits. As one administrator from DSS observed: “. . . [I]t appeared that basically the right questions were not being asked . . . by the enrollers.”

The reviews covered the following time periods: the first quarter of 2003; the fourth quarter of 2003, and the third quarter of 2004. The results are summarized as follows (Grand Jury exhibit numbers 18 and 19):

¹⁰ Unreported income would generally be unacknowledged wages, child support income, or social security income. Under-reported income typically would be acknowledged income that was inadequately reported. For example, an applicant might have wages from two jobs, and only acknowledge wages from one of them, or an applicant might indicate that he or she was earning less than he or she was actually earning at a job that he or she acknowledged on the application.

¹¹ Incorrect household composition would generally be either that there was a parent living in the household that was not acknowledged on the application, or there were additional children listed on the application as living in the household, who actually did not live there.

FIRST REVIEW:

Total number of applications reviewed:	122
Total number of telephone interviews conducted: ¹²	89

	<u># of Apps</u>	<u>Error Rate</u>
Incorrect household composition:	6	5%
Incorrect income:	31	25%
Missing documentation:	35	29%
Applicant not advised to read application prior to signing:	30	25%
Filed application not accurate representation of case circumstance:	40	33%
Application denied or withdrawn due to review:	39	32%

SECOND REVIEW:

Total number of applications reviewed:	172
Total number of telephone interviews conducted:	147

	<u># of Apps</u>	<u>Error Rate</u>
Incorrect household composition:	34	20%
Incorrect income:	55	32%
Missing documentation:	71	41%
Applicant not advised to read application prior to signing:	14	8%
Filed application not accurate representation of case circumstance:	78	45%
Application denied or withdrawn due to review:	59	34%

During the third review, the methodology remained the same, but a different analysis was performed. The results were analyzed by health plan (i.e. the six managed care organizations, and the two lead agencies). If a determination was made that at least some of the people in the case were eligible for Medicaid benefits, then DSS accepted the

¹² DSS attempted to contact the applicants by telephone. There were some instances wherein the application could be resolved by mail, and other instances in which the applicants were unreachable because their phones were disconnected, or they never returned telephone messages left by DSS.

application, and marked it as “accepted”. If it was determined that none of the individuals were eligible for Medicaid benefits, then the benefits were denied, and the application was marked as “denied”. A compilation of the results from the third review follows (Grand Jury exhibit 20):

THIRD REVIEW:

	<u>Apps Reviewed:</u>	<u>Accepted:</u>	<u>Denied:</u>	<u>% Denied:</u>
MCO-e	35	14	21	60.00%
MCO-f	21	11	10	47.62%
MCO-a	67	28	39	58.21%
MCO-b	14	7	7	50.00%
Suffolk lead agency	13	8	5	38.46%
Nassau lead agency	19	9	10	52.63%
MCO-d	16	7	9	56.25%
MCO-c	15	7	8	53.30%
<u>TOTAL:</u>	200	91	109	54.50%

Thus, despite DSS efforts to correct the persistent failures of the facilitated enrollers by the third review, more than half of the applications were rejected because the applicants were, in fact, ineligible for Medicaid benefits.

F. Shared concerns about facilitated enrollment:

After the first review of facilitated enrollment applications was complete, representatives of DSS met with representatives of the MCOs and lead agencies, and

shared the results with them. The results and DSS efforts at corrective action were also forwarded to the NYSDOH.

Despite this effort, the second review demonstrated that there had been no significant change in the accuracy of the facilitated enroller applications being received by DSS. At the conclusion of the second review, DSS again shared the information with the subject MCOs, and the two lead agencies. Some of the agencies met with representatives of DSS, and the results of the second review and their implications were discussed. The conclusions reached after the second review were also shared with the NYSDOH.

The NYSDOH responded by asking DSS to provide specific examples of cases of particularly poor quality. DSS provided the NYSDOH with photocopies of the applications, survey forms, and documentation, as well as descriptions of errors.

About a month later, a meeting was held in Albany attended by the Commissioner and an administrator of Suffolk DSS, deputy commissioners and other administrators of the NYSDOH, as well as the then Commissioner of the Department of Social Services of Orange County. It was revealed that the Orange County DSS had conducted a review of facilitated enrollment applications, and had come to the same conclusions as Suffolk. The various reviews, and the issues attendant to the results, were discussed at this meeting *ad nauseum*.

During the review process, DSS had quarterly meetings with all six of the MCOs, and the two lead agencies, to discuss the problems with the facilitated enrollment applications, and to clarify DSS expectations and needed improvements. These meetings were held jointly with the Nassau County Department of Social Services.

In this atmosphere of alleged cooperation and information sharing, the third review was conducted. Sadly, there was no significant difference in the results.

Failing to observe any significant change in the quality of the facilitated enroller applications being submitted to them, and no action by the NYSDOH, the entity charged with oversight of the facilitated enrollment program, DSS asked the Suffolk County District Attorney to conduct an investigation, which ultimately led to the empanelling of this Special Grand Jury.

The Grand Jury finds that it is not just Suffolk County that had reason to call the efficacy of the facilitated enrollment program into question. As recently as August of 2005, the Commissioner of Investigations for Nassau County conducted an investigation into the program, reaching similar conclusions.

The Commissioner of Investigations for Nassau County, under the Nassau County charter, has the authority to investigate the activities of any Nassau County department, office, agency, or employee of Nassau County, as well as individuals who do business with Nassau County. The five insurance companies that participate in the facilitated enrollment program in Nassau County are the same companies that do so in Suffolk County (MCO-a, MCO-b, MCO-c, MCO-e and MCO-f). Two community-based organizations also participate in Nassau County.

The investigation there was prompted by an anonymous tip alleging there might be facilitated enrollers who were helping complete applications in a less than honest way. Private investigators, utilizing concealed recording devices, posed as potential Medicaid applicants. Investigators went to each of the insurance companies and community based organizations and attempted to apply for Medicaid benefits. They gave information to

enrollers regarding their household composition and income that fell just under the qualifying guidelines. At some point during the interview, they told the enroller they had another job that was off-the-books, which would disqualify them for benefits. The investigators would ask the enroller if they had to report or acknowledge that other income. Approximately ten of these interviews took place. Of the ten, two resulted in the enroller assuring the undercover investigator that he or she did not have to report this second, off-the-books income. Those two enrollers worked for MCO-b and MCO-f, respectively.

There is a serious concern statewide, by DSS and others, about the honesty and efficiency of the facilitated enrollment program as it is currently administered. At monthly meetings in Albany attended by all of the commissioners of all of the New York State departments of social services, there is consensus that the quality of applications being submitted to the local departments from facilitated enrollers has been and continues to be poor.

G. Facilitated enrollment: A financial incentive:

The Grand Jury finds that the facilitated enrollment program has created an unacceptable financial incentive to participating providers to enroll as many clients as possible, by whatever means available to them.

One need only examine the amount of money that participating insurance companies received in Suffolk County in 2005, in premiums alone, to understand how lucrative the facilitated enrollment program has been. (Grand Jury exhibit 186):

2005 MEDICAID PAYMENTS TO MCOS:

<u>MCO:</u>	<u>AMOUNT PAID:</u>
MCO-a	\$39,730,760
MCO-b	\$38,604,530
MCO-c	\$36,245,932
MCO-d	\$31,582,698
MCO-e	\$21,751,257
MCO-f	\$16,893,509
<u>TOTAL:</u>	<u>\$184,808,686</u>

On a statewide level, the numbers are even more staggering. In 2004, the participating providers received approximately \$5.1 billion dollars in premiums alone. The 2005 and 2006 figures are currently unavailable, but are likely to be comparable, if not higher, given an analysis of the current trend in Medicaid expenditures on both the county and state level.

It does not strain credulity to suggest that all providers participating in the facilitated enrollment program are highly motivated to do whatever possible to get as big a piece of this financial pie as possible. One of the most abusive ways they do this is through the use of a simple quota system.

The Grand Jury heard from two individuals currently employed as DSS Medicaid examiners, each of whom had previously worked as a facilitated enroller. DSS Examiner A worked as a facilitated enroller for MCO-a, and DSS Examiner B worked as a facilitated enroller for MCO-e, MCO-d, and a community-based organization overseen by the Nassau County lead agency.

DSS Examiner A's experience as an enroller for MCO-a and DSS Examiner B's experience as an enroller for MCO-e were remarkably similar. In each instance, they

were required to meet a weekly application quota. It was DSS Examiner A's experience that the longer one worked as an enroller with MCO-a, the higher the quotas became. They started at 8-10 applications per week for the first two weeks, and were then raised to 15 per week. By the time DSS Examiner A had been working for MCO-a four months, his quota was 25-30 per week. DSS Examiner B, working for MCO-e, had a quota of 15 completed applications per week, but did not stay employed by MCO-e long enough to experience an increase in her quotas. It was made clear to the MCO-a enrollers that if their quotas were not met, the offending enroller would be fired.

In the case of DSS Examiner A's experience with MCO-a, bonuses were awarded if an enroller exceeded their quota. For example, if they exceeded the quota by 5 applications, they got a fifty or sixty dollar bonus. DSS Examiner B was aware that, at one time MCO-e had a bonus system in place, but the practice had stopped prior to her employment.

Both examiners testified that a rejection by DSS of an application had no impact upon the enroller quotas. Disturbingly, neither examiner, in their role as a facilitated enroller, was required to check the application or the supporting documentation for accuracy or credibility, or to verify that the information or documentation they had been provided by the applicant was accurate and/or legitimate. As DSS Examiner B said, "My job was just to collect the information, screen them. If they say they earn \$100 a week, and there is [sic] six people in the household, I know logically nobody could live on that, but I'm just collecting the information."

The pressure to meet these quotas was intense. DSS Examiner A described mandatory weekly meetings of enrollers, presided over by his immediate supervisor, as

well as the supervisors for the entire Suffolk and Nassau territories. Applications would be submitted at these meetings. The emphasis was the ubiquitous specter of the quotas: whether the quotas were being met and, if not, what the supervisors could do to help the lagging enroller to meet the quotas, and a reminder that if the quotas were not met, your career as an enroller would be over.

Due to the tremendous pressure that enrollers were under to meet quotas, it came as no surprise to either examiner when they learned of sharp practices engaged in by facilitated enrollers to make their applications appear, at least superficially, accurate. DSS Examiner A had fellow enrollers suggest that income reported by applicants that was too high to make them eligible for Medicaid benefits should be lowered on the application to an amount that would make them eligible. This could be accomplished by lowering the amount of a single income, or omitting to report a source of income (e.g. if the husband's income alone would make the family eligible, but including the wife's income would make them ineligible, then the wife's income would be omitted). DSS Examiner A also learned enrollers doctored supporting documentation in order to make the application pass muster (e.g.: the enroller would suggest to the applicant that he or she change the amount on an income verification letter from their employer to an amount that would make the applicant eligible for benefits.)

DSS Examiner B became aware of inappropriate practices by enrollers, not only in her capacity as an enroller for MCO-e, but during the course of her employment as a facilitated enroller for MCO-d, and a community-based organization overseen by the Nassau lead agency. As a facilitated enroller for MCO-e, she observed clients asking to omit spousal income in order to qualify for benefits, and enrollers accommodating them.

When DSS Examiner B was employed as an enroller for MCO-d, she was advised that there was no longer a quota system there because MCO-d had previously been shut down for problems caused by utilizing quotas: apparently, enrollers were adding people to applications, and enrolling non-existent people to meet quotas. Ironically, DSS Examiner B, as a facilitated enroller, dealt with applicants who had applied for and been rejected for Medicaid benefits by DSS who came to DSS Examiner B in her capacity as a facilitated enroller to reapply.

During her employment as a facilitated enroller with the community-based organization overseen by the Nassau lead agency, DSS Examiner B did not observe inappropriate practices. However, she frequently met applicants at the community-based organization who told her they had been enrolled for Medicaid benefits by an enroller from one of the six MCOs, and income that would normally have rendered them ineligible for benefits had been deliberately omitted by the enroller. Applicants unsuccessfully sought similar treatment at the community-based organization. Although, pursuant to the provisions of the community-based organization's grant, each enroller was required to complete 50 applications per month, there was no bonus program in place. The number of expected applications did not change monthly and enrollers' salaries were in no way impacted if they either failed to meet or exceeded that goal. Enrollers were never threatened with termination based on their lack of completed applications.

The Grand Jury also found profit-motivated practices on the part of managed care organizations, when it came to applicants choosing a health plan. One of the obligations of the facilitated enroller is to educate applicants about all health care plans, not just the

plan that employed the enroller, and to assist the applicants in selecting the one that best served the applicant's family. When an applicant applies for Medicaid benefits directly through DSS, there is a mechanism in place to assure the applicant will make a fully informed decision about the health care plan. At DSS, once the applicant has been interviewed by an examiner, he or she is sent to a representative of Maximus, an enrollment broker. The Maximus representative is stationed in the hallway of DSS, so that the applicant does not have to make a separate appointment for this service. The Maximus representative goes over the details of each of the plans available, and must follow a script, so as to avoid omitting information. . The representative interviews the applicant to determine if they are currently under the care of any physician affiliated with one of the available plans, obviously a significant factor in any selection. The Maximus representative must provide literature to the applicant describing the plans, along with clear information that the plan selection must occur within sixty days. Maximus is an enrollment broker under contract with the State of New York to provide this service. The Maximus representative who deals with the applicant does not work for DSS, or for any of the managed care organizations involved in the facilitated enrollment program. The representative has no vested interest in any particular managed care organization, and has no agenda other than assisting the applicant in selecting an appropriate plan.

A facilitated enroller is directly employed by a managed care organization, that receives health insurance premiums for each client enrolled for Medicaid benefits with their company. Both DSS Examiners A and B told the Grand Jury that they were not encouraged by their respective employers to educate applicants about health plans offered by other insurance companies. The training received by DSS Examiner A at MCO-a was

very clear on this point: the enrollers were there to sell MCO-a's product. Despite requirements to the contrary, MCO-a employees were told to only briefly mention the availability of other health plans. They were to name the other plans, but to enroll the applicants in MCO-a. Similarly, DSS Examiner B, as an enroller for MCO-e, was trained to provide applicants with information regarding MCO-e's plan only. The MCO-e enrollers would distribute a form to the applicant containing information regarding the other plans, but none of this information was discussed verbally with the applicant. This was markedly different from DSS Examiner B's experience as an enroller for the community-based organization overseen by the Nassau County lead agency. There, enrollers were not urged to promote one health plan over another as no financial benefit resulted.

H. Enroller X: A case study in facilitated enrollment gone awry:

In the Spring of 2005, Applicant A was on his patio when Enroller X emerged from the patio next door, and initiated a conversation with Applicant A. Enroller X was visiting her sister, who lived in the building next to Applicant A's home. Enroller X asked Applicant A if he was interested in free health insurance. Naturally, he said yes, and Enroller X revealed herself to be an enroller for an insurance company. She made an appointment with Applicant A to meet him at his home the next day. At that time Enroller X completed an application for Medicaid benefits for Applicant A. Once completed, Enroller X gave Applicant A a copy of the application. (Grand Jury Exhibit 176). A few months later, Applicant A received a phone call from an examiner at DSS. The DSS examiner noted that the application indicated Applicant A's household

consisted of Applicant A and his pregnant wife. Strangely, the application was seeking Medicaid benefits only for Applicant A.(Grand Jury Exhibit 177). The DSS examiner called Applicant A to inquire why he was not seeking benefits for his wife and unborn child.

Applicant A was confused by this inquiry, because he was not married, had never been married, and knew nothing of a pregnant wife. He faxed a note expressing this to DSS, enclosing the copy of the application he had been given by Enroller X.

The Grand Jury learned that in fact, Enroller X had submitted an application to DSS and inserted a pregnant wife onto the application (Grand Jury Exhibit 177). In order to document the existence of this fictional wife, as well as her pregnancy, Enroller X submitted a letter on hospital stationary verifying that the fictional wife was, in fact, pregnant, and indicating the due date of the child (Grand Jury Exhibit 178). The motivation for Enroller X was very clear: as the original application stood, Applicant A was not eligible for Medicaid benefits. However, with the addition of the faux pregnant wife, Applicant A's household increased from a household of one to three. When Applicant A's income supported three, he became eligible for benefits.

Four additional applications submitted to DSS by Enroller X were examined by the Grand Jury. In all instances, Enroller X submitted the applications to DSS in her capacity as a facilitated enroller for MCO-f. All of these applications contained household income and financial resource information that was strikingly similar. The numbers on these applications were there not because they were an accurate reflection of the applicant's status but because they made the applicants eligible for benefits. In each instance, the applicants were allegedly earning \$150.00 per week, and had resources

below \$2,000.00. Applicant B earned this amount as a “taxita” (Grand Jury exhibit 180); Applicant C earned it as a bartender (Grand Jury Exhibit 181); Applicant D earned it as a landscaper (Grand Jury exhibit 182), and Applicant E earned it as a housecleaner (Grand Jury Exhibit 183). According to each of the applications, none of these earnings could be documented, and no explanation was provided as to why this was the case.

In comparing and contrasting the four applications, the Grand Jury observed similarities that clearly demonstrated fraud. Applicants B, C, and E, each completely independent of the other, gave the exact same home address. The submitted proof of residence for each was equally suspicious. A “Fair Notice of Towing” was submitted with the application for Applicant B (Grand Jury exhibit 180A), as well as with the application for Applicant C (Grand Jury exhibit 181A). Each of these notices was addressed to Applicant B and Applicant C, respectively, as the purported registered owner of a certain license plate number, and provided notice that their vehicle was about to be towed. Unbelievably, the plate number was the same on each of these notices. Records from the New York State Department of Motor Vehicles revealed that, at the time that these applications were submitted to DSS, the plate number on these “Fair Notices of Towing” was not registered to either Applicant B or Applicant C, but rather to Enroller X (Grand Jury exhibits 192 and 193).

As proof of residency in support of the applications submitted to DSS by Enroller X for Applicants D and E, the exact same cable bill, for the exact same time period, for exactly the same amount, for the same account number, was submitted.

Application A was denied by DSS for obvious reasons: the applicant himself refuted the assertions on the application about his alleged, but in fact, fictitious pregnant

wife. Applications B through D were all rejected by DSS, for lack for adequate documentation as to income. Luckily, none of these egregiously false applications caused DSS to mete out benefits to individuals who were not entitled to them. Nevertheless the applications demonstrate the extent to which the facilitated enrollment program encouraged blatantly false applications.

In the case of Application A, it was only due to the diligence of a DSS examiner, looking to extend benefits that had not been requested, that led to the discovery of false statements which were compounded by the submission of a forged letter purportedly from a hospital. A less diligent DSS examiner reviewing Applicant A's application, would have opened the case resulting in insurance premiums paid to MCO-f for two people who did not exist.

Applications B through E, revealed an appalling lack of documentation in support of the bald assertions of household income. Even a cursory review by supervisory staff at MCO-f of these applications prior to their submissions to DSS, should have stopped them in place. Moreover, the Grand Jury had the benefit of examining all four of these applications side by side, exposing them as fraudulent. If anyone at MCO-f had been monitoring the work of Enroller X, their employee, they might well have discovered this for themselves.

While the case of Enroller X is a particularly egregious example of the actions of an unscrupulous enroller, unfortunately the system, as it is currently structured, provides none of the safeguards that could expose or prevent such fraud.

There is currently no system to allow applications to be cross-checked to see if the same addresses are being provided for different applicants, or if the same documents are being provided in support of different applications.

The Grand Jury finds that the facilitated enrollment program, as it is currently constituted, is a fraud-friendly program, driven by a substantial financial incentive for the participating providers with the result that enrollers are pressured to sign up as many clients as possible, recklessly turning a blind eye to inappropriate fraudulent practices. There is absolutely no disincentive for this recklessness: there are no consequences to MCOs or CBOs if they submit inaccurate or fraudulent applications.

III: The Suffolk County Department of Social Services:

As noted, the facilitated enrollment program has created an upsurge in Medicaid applications and recertifications, at DSS. As a result, current DSS staff have been overwhelmed in their ability to properly process these applications and recertifications. This situation results in consistently inadequate reviews of these matters before they are approved. DSS is the agency charged with determining both the initial and continuing eligibility of the applicants/recipients for Medicaid benefits and it is incumbent upon them to detect and investigate Medicaid fraud and abuse. For a number of reasons, the agency is incapable of doing this effectively.

A. The Special Investigations Unit: On the frontlines of Medicaid fraud investigation:

DSS does, in fact, have an investigatory unit known as the Special Investigations Unit (SIU). This unit investigates allegations of fraud or misuse of the various public assistance programs, including temporary aid to needy families, safety net, the home energy assistance program, the food stamp program, and Medicaid. SIU also investigates allegations of lost or stolen checks issued by DSS to landlords. Finally, SIU investigates allegations of improprieties by DSS employees.

A unit within SIU known as the Front End Detection Unit, (FEDS) investigates information on initial applications for public assistance programs or child care services. The underlying concept behind the FEDS unit is that it is more cost-efficient to stop fraud “. . . at the front door than wait until cases are open and may not be looked at for years.”

SIU receives allegations from a number of sources: DSS employees and units, the general public (via telephone calls, mail, and email), Suffolk County officials, law enforcement agencies, the NYSDOH, and the New York Office of Temporary Disability and Assistance.

Unfortunately, SIU is understaffed to properly address all of the allegations received. Ironically, SIU has been losing staff and resources continuously since the year 2000, the same year that the facilitated enrollment program began. In 2000, SIU had 15 field investigators who uncovered approximately \$2.1 million in fraud. Since then, there has been a reduction in staff due both to retirees not being replaced and vacant positions being abolished. At one time there was a DSS examiner specifically assigned to SIU, whose function was to calculate fraud. This is no longer the case. Now, fraud is calculated for SIU by DSS examiners who must do it on overtime. There are now only 8 field investigators in SIU. Five of these are assigned to the FEDS unit, and the remaining three are assigned to investigate all of the other fraud allegations received by SIU. Sadly, currently of these three investigators, only one is available to actually conduct investigations, as the other two are out on extended leaves of absence.

The 2005 SIU statistics are reflective of this reduced staff. SIU received approximately 2,000 allegations of fraud in 2005. Of the 2,000 allegations, 1,200 of them were assigned for investigation. Of those, approximately 1,075 resulted in completed investigations, totaling 228 cases of actual fraud uncovered. This translated into approximately \$673,000.00 in actual fraud dollars. In 2006, SIU referred twenty cases to the Suffolk County District Attorney's Office for prosecution. There are approximately 2,500 backlogged cases that have yet to be assigned for investigation.

The Grand Jury concludes that, with such a limited staff, SIU cannot adequately investigate the hundreds of allegations of fraud that it receives.

This understaffing of SIU, as well as the prioritization of cases investigated by the FEDS unit, has had a profoundly negative impact on DSS examiners. More importantly it directly impacts the recourse they have when examiners suspect applicant or recipient Medicaid fraud. The FEDS unit receives its mandate to conduct investigations from the New York State Department of Social Services, more currently known as the New York State Office of Temporary Disability Assistance. The New York State Office of Temporary Disability Assistance requires that FEDS prioritize certain mandated investigations¹³, and only consider investigations involving allegations of Medicaid fraud if it can be determined that the investigation would be cost effective. Cost effective, in this context, means that the cost of the investigation is less than the money likely to be recovered. In instances of recipient Medicaid fraud, recovering money is a difficult and extremely labor-intensive process. The benefits have typically gone to providers, not to the individuals actually committing fraud (the recipient). DSS cannot simply recoup the fraudulently obtained benefit from the recipient. DSS is able to obtain liens against property owned by the recipient, but cannot force the sale of the property. They are unable to confiscate it. Furthermore, no lien can be levied without a court order, a time consuming and potentially costly process.

In the past, a DSS examiner who suspected recipient Medicaid fraud could request that SIU conduct an investigation. Now, given the personnel limitations in SIU,

¹³ The mandated investigations are relative to public assistance: DSS is periodically provided with lists based on demographic information (names, dates of birth, social security numbers) of people who are currently in prison and actively receiving assistance. The FEDS unit is required to investigate those cases to determine if anyone on those lists is receiving assistance that they are not eligible for by virtue of their status as a prison inmate.

and the low priority afforded cases of recipient Medicaid fraud, DSS examiners do not bother to make what amounts to a futile request. Applicant Medicaid fraud is even more difficult to pursue. DSS cannot impose any penalty for applicant fraud unless the matter is referred to the District Attorney's office for possible prosecution. Typically these criminal investigations have not been a priority for the District Attorney. Thus, they are virtually ignored by SIU. Out of sheer practicality, cases of applicant Medicaid fraud are never referred to SIU for investigation and are not investigated.

B. DSS Medicaid examiners operating in an information vacuum:

Unquestionably, applications and recertification forms that are received by DSS are not closely examined for credibility and accuracy. Even where a DSS examiner is conducting a face-to-face interview with an applicant for Medicaid benefits, the examiner is still hamstrung by the complete lack of access to vital information and databases that would assist to effectively verify the information provided by an applicant or recipient, potentially preventing or ending Medicaid fraud and abuse.

The majority of DSS examiners do not have access to the Internet, because it is considered a luxury. In fact, only supervisors have their own stand-alone computers.

DSS does not have easy access to the records of agencies or organizations that could assist in conducting a proper review of applications for benefits. For example, the records of the New York State Insurance Fund, the agency that administrates worker's compensation benefits are unavailable to DSS examiners. The Grand Jury heard evidence demonstrating an example of how this lack of interface with worker's compensation records led to fraud. Recipient A was allegedly totally disabled due to a

work-related injury. He applied for and received worker's compensation benefits, as well as supplemental social security income for himself and his two children. He also applied for and received Medicaid benefits, but only acknowledged the supplemental social security income that he and his family were receiving on his applications. He did not report the income he was receiving from worker's compensation. Then, utilizing a different name and social security number, Recipient A worked full time for a private company. He did not report this income to the State Insurance Fund or DSS. Ultimately, Recipient A received in excess of \$33,000 in worker's compensation benefits, and \$17,000 in Medicaid benefits that he was not entitled to. Although Recipient A's utilization of a different name and social security number made his fraud more difficult to track by the agencies that he defrauded, DSS could not have cross-referenced Recipient A with another state agency to see if he were receiving benefits from them in any event. Clearly, all DSS examiners authorizing benefits must have the capability to determine what other state or federal benefits the individual is receiving.

DSS examiners have limited and faulty access to records from the New York State Department of Taxation and Finance, and no access to information regarding 1099¹⁴ income. By virtue of a system known as the Resource File Integration system (RFI), the New York State Department of Taxation and Finance provides information to DSS for Medicaid recipients regarding income. The information that is provided is based upon an employer reporting wages earned to the state, and paying income tax on behalf of the employee. The information is keyed to the applicant/recipient's social security number, and obviously excludes illegal aliens and children. The problem is that the information in

¹⁴ 1099 income is income that is not earned by a regular employee, e.g.: rental income, or income earned by an individual who has incorporated himself.

the RFI system is never current. For example, if a DSS examiner were looking at the RFI system in January, 2006, the most current information he would be receiving is for the fourth quarter of 2005. However, typically wage information has not yet been fully reported for that fourth quarter. The DSS examiner who is receiving RFI information in January, 2006, would most likely be getting information based upon the third quarter of 2005, or earlier. Moreover, the information in the RFI is not always correct.

DSS has absolutely no access to information regarding income paid on a 1099 basis. There could easily be a situation wherein a Medicaid applicant/recipient had set up their own corporation and was receiving hundreds of thousands of dollars of 1099 income per year, but claiming to be unemployed to DSS, and DSS would be none the wiser.

DSS examiners do not have easy access to records regarding unemployment benefits from the New York State Department of Labor. Most examiners do not have any access to this information. An examiner with a particular suspicion that an applicant or recipient failed to report unemployment income, could request a supervisor to check with the Department of Labor. Given the tremendous caseloads that DSS examiners are faced with, the likelihood of this process taking place is almost nil. Again, the failure of coordination and information sharing between agencies contributes to the ease of fraudulent practices.

DSS examiners do not have easy access to records of property ownership, credit reports, and bank records. This is mostly due to their lack of access to the internet. The case of Recipient B is an example of how this lack of access encourages Medicaid fraud. Recipient B lied on her applications and recertification forms, in that she did not acknowledge that her husband was part of her household. In fact, Recipient B's husband,

as it turns out, was contributing a significant income to the household from a job that was off the books. Additionally, this family owned two homes, and was collecting rental income, all of which was not reported to DSS. A forensic analysis of bank records revealed that this family was receiving thousands of dollars a month in income that remained unreported to DSS, making them ineligible for Medicaid benefits. Had the DSS examiner on Recipient B's case had ready access to property records, bank records, and Recipient B's credit report, Recipient B would not have been successful in her fraud.

DSS does not have access to NYSDOH records except under very limited and special circumstances. A database within NYSDOH known as the "data warehouse" contains information about every payment made through Medicaid according to category of service, the individual who was paid, and the patient. This database also contains information that is confidential, regarding diagnosis and treatment. Because of the extreme confidential nature of this information, the NYSDOH guards it closely: only two individuals from DSS have license and permission to access any of this information, one is the Managed Care Coordinator for Suffolk County. This lack of access to the NYSDOH records has led to some anomalous circumstances. For example, there is a non-Medicaid program which is administered by the NYSDOH called Child Health Plus. This is a program that facilitated enrollers work with. Because DSS has no access to the records of NYSDOH, a situation can exist where an applicant/recipient has obtained dual coverage under both Child Health Plus and Medicaid, unbeknownst to either DSS or the NYSDOH. Additionally, it is the NYSDOH that is the keeper of records regarding deaths in New York State. DSS relies upon the NYSDOH to provide them with lists of individuals who have died, so anyone who is on the list who is receiving Medicaid

benefits can be removed. Unfortunately, the NYSDOH provides these lists sporadically: as of April, 2006, DSS had not received such a list in over a year. This has led to circumstances where Medicaid premiums or benefits have been paid for individuals who were dead: clearly a waste of taxpayer funds.

C. Recipients C and D: the poster children for fraud slipping through the cracks at DSS:

These partners in crime were a man (Recipient D) and woman (Recipient C) living together with Recipient C's four children. They held themselves out to various government agencies as two separate households: Recipient C and her children being one household, and Recipient D being the other.¹⁵ Recipient C applied for and received Medicaid benefits, food stamp benefits, and Section 8 housing benefits from two jurisdictions far in excess of the amount she would have received if she had accurately reported her income, and that Recipient D was living with her, and contributing financially to the household. Recipient D benefited from all of these benefits. In addition, he applied for and received Medicaid benefits that he would not have been entitled to receive if he had accurately reported his income, as well as payment for services that he supposedly performed as an informal child care provider for Recipient C's children that he was clearly not entitled to.

Recipient's C and D lied about their household composition, and their employment. They stayed off the DSS radar by never working any particular job for an extended period of time. Both of them were serially employed at jobs obtained through temp agencies, or jobs that they did not stay at for more than several months. Although

¹⁵ See, for example, Grand Jury exhibit numbers 110, 111, 112, 113, 117, 119, 133A, 134A, 134B, 82, 85, 72, 138, 139, 146, 147, 148, 149, 150, 151, 152, 153, and 154.

all of these jobs were “on the books”, in the sense that the income was reported to the appropriate taxing authorities by their respective employers, given the lag time in the records received by DSS from the New York State Department of Taxation and Finance through the RFI system, DSS never caught either of these recipients.

A recipient of Medicaid benefits, like Recipients C and D, is obligated to immediately inform DSS of any change in their financial circumstances or household composition that might impact on their eligibility for benefits. This must be done as often as is appropriate so that, in the cases of Recipients C and D, respectively, they could have and should have advised DSS every time they were employed, and then every time they became unemployed, so that DSS could adjust their Medicaid benefits accordingly. This obligation is set forth in a long, complex paragraph that can be found on Medicaid applications and recertification forms (e.g. Grand Jury exhibits 72 and 82). However, this obligation appeared to have been of little moment to either Recipient C or D, and the system, especially at the recertification phase, only served to enable the Medicaid fraud in this case.

Medicaid applications such as the ones filed by Recipient C and D, inquire of the applicant the following, “If not employed, when was the last time you or anyone who lives with you worked?” In Recipient D’s case, he indicated on his Medicaid application that he was not employed or self-employed, that no one in his household was employed or self-employed, and he left the question as to when he or a household member last worked blank (Grand Jury exhibit 82). Overburdened DSS examiners, seeing this question unanswered are likely to do nothing to follow up with more complete information from an applicant/recipient. At some point during the period of time that

Recipient D was receiving Medicaid benefits, an examiner did, in fact, send a letter to Recipient D asking him how, if unemployed, he was supporting and maintaining himself. He responded by writing that his girlfriend was supporting him, and he supplied a letter from this girlfriend averring that this was true. This was accepted by DSS at face value. There is no question on either the Medicaid application or recertification form asking the applicant/recipient how it is that they support themselves and/or their family, if they are unemployed.

On the current recertification forms, there is no question asking the recipient “If you are not employed, when was the last time that you worked?” (e.g. Grand Jury exhibit 85). Therefore, in instances wherein either Recipient C or D were completing recertification forms, they were not even asked the relevant question that would have captured the information about their respective on again/off again employment. Clearly, if the face-to-face interview were still in place at the recertification phase, the DSS examiner could make the appropriate inquiries, and put the credibility of the case to the test. Recipient C and D, determined to defraud every system they could think of, were fortunate that DSS was in no position to catch them.

The only reason DSS did, in fact, eventually expose Recipients C and D was that two special agents from HUD were investigating Recipient C for Section 8 housing fraud and, during the course of their investigation, they discovered that Recipient D was living with Recipient C. These special agents reported their findings to the head of SIU, who conducted his own investigation. The SIU investigator, by pulling case records, employment records, obtaining unemployment records from the New York State Department of Labor, discovered that, indeed, Recipient C and D had been and were

receiving Medicaid and food stamp benefits through DSS, and were either underreporting or failing to report income from various sources. By charting out the addresses that both Recipients C and D gave as their home addresses on Medicaid applications and recertification forms, as well as to their various employers, the investigator was able to confirm what the HUD investigators had asserted, that these recipients were living together, a fact that they each failed to report to the various agencies that they defrauded.

D. DSS unwittingly pays a convicted child abuser to babysit children:

Unquestionably the most egregious of the frauds committed by Recipients C and D was discovered during the course of the SIU investigation: that DSS had paid Recipient D as an informal child care provider for Recipient C's children. Recipient D did not report these payments as a source of income to DSS. It was not discovered by an automatic cross-checking of DSS's records, because there is no such thing: there is no way for a DSS examiner to find out if an applicant/recipient is an employee of Suffolk County through a common database within DSS. Moreover an examiner could not discover this information through tax records, since the income received by informal child care providers from DSS is reported via an Internal Revenue Service Form 1099 basis. DSS does not have access to Form 1099 information.

This particular aspect of Recipient D's Medicaid fraud case was discovered by the SIU investigator, who pursuant to his investigation interviewed one of Recipient C's employers, who reported day care forms containing material misrepresentations. The investigator obtained Recipient C's day care records, and discovered that she listed Recipient D as the day care provider for her children in those records.

Perhaps the most disturbing aspect of this fraud comes from the records of the Child Care Bureau of the Suffolk County Department of Social Services. According to those records, Recipient D was paid by DSS as an informal child care provider¹⁶ in an amount exceeding fifteen thousand dollars. On the forms that are jointly filed by the parent seeking a child care provider (in this case, Recipient C), and the provider (in this case, Recipient D), the provider must affirmatively state whether or not he has ever been indicated in a case of child abuse or maltreatment, and whether he has ever been convicted of any of certain enumerated crimes, including Endangering the Welfare of a Child. On the original set of papers filed with DSS, these questions were not answered and the application was denied (Grand Jury exhibit 133A).

Not to be deterred from defrauding DSS of taxpayer money, Recipients C and D jointly filed applications for this benefit which did answer these questions: each time asserting that Recipient D had never been so indicated or convicted (Grand Jury exhibits 134A and 134B). This was a bald-faced lie: Recipient D had, in fact, been convicted of the crime of Endangering the Welfare of A Child upon a plea of guilty to that charge. The original charges that resulted in that plea were Attempted Rape in the First Degree, Burglary in the Second Degree, Sexual Abuse in the First Degree, Endangering the Welfare of a Child, and Petit Larceny (Grand Jury exhibit 130).

It is no small wonder that Recipient D did not answer these questions when the original application was filed, and then lied on the subsequent applications: he would not have been, and in fact was not, eligible for these benefits due to his conviction for one of the enumerated crimes. This is clearly enunciated on the applications themselves: the

¹⁶ Informal child care providers are providers who are not required by law to be registered or licensed by the state. They form a significant portion of the child care provider population, and consist of neighbors, relatives, and friends of the child.

proposed provider must sign a statement indicating, in sum and substance, that: “I understand that I am not eligible to provide child care if I . . . [have] been convicted of any of the following crimes unless extenuating circumstances exist: . . . Endangering the Welfare of a Child.” (see Grand Jury exhibits 133A and 134A).

Recipient D was able to get away with this because, unlike formal child care providers (dare care centers), DSS has no legal authority to fingerprint or run criminal history checks on potential informal child care providers. Moreover, at the time that Recipient D was enrolled as an informal child care provider, DSS was not able to check the records of its own agency, or other child protective agencies, to determine whether an informal child care provider had ever been indicated for child abuse or arrested and/or convicted for a case involving child abuse. Hence, Recipient D could deceive and defraud DSS, get paid as a child care provider even though he was ineligible to do so due to his conviction for Endangering the Welfare of a Child, and he could do so without fear of discovery: Because they did not have the resources to do otherwise, DSS was forced to accept his lies at face value.

Although certain modifications to prevent this have been made, the Grand Jury finds that the changes are inadequate. As of March of 2004, the Child Care Bureau of DSS is permitted to check the official records kept by its own agency (DSS) in the Child Protective Services Department, to cull out any cases where a case of child abuse has been indicated against a potential informal child care provider. These records are for Suffolk County only. DSS is still ignorant in this area, even in circumstances where they discover an indicated case. Child Protective Services records are legally confidential. DSS can ask the informal child care provider to share the information regarding the case

to the parent in question. The provider is required to share this information in writing to the parent, and a copy of this writing is provided to DSS, so that DSS can make sure that the information in the writing is accurate. If it is not accurate, all DSS can do is complain to the provider that they were not truthful. DSS can, at no point, go to the parent, whose child will be in the care of this indicated provider, and tell them what the provider is alleged to have done to another child.

DSS still has no authority to fingerprint or run criminal history checks on informal child care providers. If a provider has a criminal conviction, even for a violent crime like rape or felony assault, and that conviction does not involve a child, there is no way for DSS to learn of this unless the child care provider voluntarily divulges this information. Even if DSS were to learn of such a conviction, this would not result in an automatic disqualification of the potential child care provider: he or she can still qualify if they can somehow show “extenuating circumstances”.

E. Increased scrutiny of Community Medicaid applications by DSS has dramatic results:

From the inception of the Facilitated Enrollment program in 2000 up to 2005, the number of Medicaid applications received by DSS doubled. At the same time there was zero growth in DSS staff. This changed in October of 2005, when Suffolk County permitted DSS to hire approximately twenty to thirty new staff members. These new staff members were assigned to various functions, including community eligibility and facilitated enrollment functions, thereby permitting DSS to scrutinize applications from the facilitated enrollment program on a closer basis.

This increased scrutiny consisted of looking at the applications to see if they were credible, and following up when there appeared to be something wrong: e.g., noting that children were listed in the application, but the applicant was not applying for benefits for them, an indication that they were being added simply to increase the household size in order to make the applicant eligible; calling purported employers when only employer letters were provided, instead of pay stubs, in order to determine whether the salary reported in the letter was accurate (often, it turned out that the salaries were significantly higher than set forth in the employer letters), etc.

The results of this increased scrutiny were dramatic. During the first nine months of 2005 (January through September), the rejection rate for community Medicaid applications was 40.3%. During the months that this increased scrutiny was imposed (October 2005 through March 2006, and continuing), the rejection rate of applications was 47.5%, representing a 7.2% increase in the rejection rate. Translated into dollars and cents, this 7.2% increase is truly meaningful. The average cost per community Medicaid case on a yearly basis, in 2005, was \$11,175.00. DSS received approximately 40,000 applications in 2005. The 7.2% increase in the rejection rate, conservatively speaking, equates to 3,100 applications not being opened that would have otherwise been opened in the first nine months of 2005. This translates to approximately \$35 million on an annualized basis in applications that are now being denied.

Unfortunately, this increased scrutiny only involved community Medicaid applications. It does not reflect the thousands of ongoing community Medicaid cases DSS is administering (“undercare” cases). The following represents the community Medicaid cases currently open, (Grand Jury Exhibit number 187):

COMMUNITY MEDICAID CASES
STILL OPEN FROM PREVIOUS YEARS:

<u>YEAR:</u>	<u># CASES STILL OPEN:</u>
2002	5,118
2003	7,360
2004	10,613
2005	19,264
<u>TOTAL:</u>	<u>42,355</u>

If DSS were to apply a similar increased scrutiny to the undercare community Medicaid cases currently open, and obtain comparable results, that is an ineligible rate of 7.2%, the resultant savings would be in the millions. The hypothetical increase in the rejection rate translates into approximately 3,000 cases. Applying the approximate yearly cost of \$11,175.00 per case, discloses a conservative savings of \$31 million dollars.¹⁷ Obviously, DSS would have to increase its staff in the area of community undercare Medicaid in order to make this hypothetical result a reality.

Adding staff and resources devoted to the Medicaid program would be cost-effective, at least to Suffolk County taxpayers. Currently, all County Medicaid administrative costs are 100% reimbursed by New York State and the Federal government. If Suffolk County were to add even 100 staff members to DSS, the net cost to the county to administer its Medicaid program would remain exactly the same.

¹⁷ E.g., in 2002, the average rejection rate was only 35%, and in 2003, the average rejection rate was 37%. The hypothetical rejection rate of 47.5% for undercare community Medicaid cases would actually be a 12.5% increase in rejection for the cases that are still active that were opened in 2002. So the \$31 million figure is extremely conservative.

Clearly, based upon the results of the increased scrutiny of Medicaid applications recently imposed by DSS based on a relatively small increase in staff, the infusion of resources to DSS could significantly impact the tremendous cost of Medicaid currently being experienced by taxpayers.

IV. Conflicting messages from the New York State Department of Health:

The primary responsibility of DSS is to meet the needs of the poor and the vulnerable in Suffolk County. Within it are departments that administer adult protective services, child protective services, foster care, and adoption, as well as traditional welfare programs such as temporary assistance, home energy assistance, and food stamps. DSS also meets the needs of all of the homeless individuals of Suffolk County, making sure that they have shelter each night. Finally, it is responsible for administering the Medicaid program.

As an entity, DSS has found itself, in essence, caught between a rock and a hard place when it comes to the administration of the Medicaid program. At the time when the Facilitated Enrollment program was instituted and getting under way, there was a culture that existed that sought a growth in the Medicaid program so that more people had health insurance coverage. Toward that end, the message from the NYSDOH, the agency charged with oversight of DSS in the administration of the program, was very clear: don't look too hard at the applications: just move them along. Indeed, the facilitated enrollment program reflects a general negative attitude towards the local departments of social services in the "buzz words" that were being utilized: they stopped calling the programs in question "Medicaid" programs, and started calling them things like "Family Health Plus" and "Child Health Plus", and sent enrollers, instead of DSS examiners, into the community to enroll clients away from traditional government office settings. The local commissioners of the various departments of social services were upset about this attitude towards their agencies: "We were not perceived as being friendly. We were not warm and fuzzy."

Another aspect of this problem is the dichotomy that exists within the NYSDOH in its capacity as the agency charged with oversight not only of DSS in the administration of the Medicaid program, but of the managed care organizations that participate in the facilitated enrollment program. Within the NYSDOH, oversight of the departments of social services' administration of the Medicaid program and oversight of the managed care side of this equation enjoy equal status, and involve two separate departments or structures within the NYSDOH, each communicating separately with its respective charges.

So, DSS was and is being urged to move applications along, and mete out health insurance coverage to as many eligible people as possible. However, DSS, unlike the managed care organizations, is also charged with determining eligibility for that coverage, and, as the administering governmental agency, must adhere to the laws, rules and regulations governing that determination. Eligibility is determined based upon certain very specific guidelines, and cannot be deviated from by a DSS examiner, no matter how pure his or her motivation is to do so.¹⁸ A DSS examiner can be conducting an interview of a potential Medicaid recipient who clearly needs health insurance, but must make the painful decision to reject the claim because the individual is earning fifty dollars above the eligibility limit.

As discussed at great length in this report, DSS, charged with the responsibility to adhere to the rules and regulations regarding the administration of the Medicaid program, discovered significant problems with the accuracy of the applications it was and continues to receive from managed care organizations participating in the facilitated

¹⁸ These guidelines are on a needs basis, taking into account certain factors, such as household composition, income, and resources. The current Federal poverty level is used as a base to calculate the threshold monthly income that a household can receive, and still be eligible for Medicaid benefits.

enrollment program. Reviews were conducted, and the Commissioner met with representatives of both sides of the facilitated enrollment equation at the NYSDOH to bring this serious problem to the attention of NYSDOH. Much to the disappointment of the Commissioner, there was no discernible action taken by the NYSDOH.

Only in recent months has the NYSDOH taken any action discernible to DSS in an attempt to remedy the problem of inaccurate applications being submitted to DSS by facilitated enrollers. The NYSDOH has issued an appendix to the contracts between itself and the participating managed care organizations which sets forth, in a section of the contract entitled “Marketing/Facilitated Enrollment Integrity”, certain policies and procedures that it requires the managed care organization to implement, such as:

“. . . the CONTRACTOR’S quality assurance reviewers must confirm that: . . . The signature on the application appears to match the signature on any supporting documentation, if applicable. *The applicant signature must not appear to match the signature of the marketer/facilitator in the ‘For Office Use Only’ section of the application.* . . . No white out was used on any documents and that information pertinent to eligibility was not changed in any way without being initialed by the applicant. . . . For all applications . . . the CONTRACTOR shall check that the household income is adequate to support the monthly housing payment listed on the application. . . . The CONTRACTOR must, prior to processing applications that indicate the monthly housing payment is more than 50 percent of the total monthly income, further review the application to determine how the household is meeting its basic financial needs. This includes contacting the family for an explanation. The CONTRACTOR must include an explanation on a comment sheet included with the application as to how the household is meeting its financial obligations.” (Grand Jury exhibit number 189, emphasis supplied).

It is disturbing to the Grand Jury that a copy of these new contractual obligations was not provided to DSS by the NYSDOH. A copy was obtained by an administrator of DSS from one of the managed care organizations. The NYSDOH wrote to the lead agencies, advising them that these new contractual changes had been forwarded to the

managed care organizations participating in the facilitated enrollment program, attaching copies of same, and advising the lead agencies that they were expected to comport with these provisions as well (see Grand Jury exhibit number 190). Again, an administrator at DSS obtained a copy of such a missive from one of the lead agencies participating in the program: the NYSDOH did not send any of this information directly to DSS. Said that administrator: “It doesn’t affect us, according to the Department of Health.”

The Grand Jury finds that the fact that, after all of the hue and cry raised by various local departments of social services regarding the quality of applications submitted by facilitated enrollers, the NYSDOH has recently seen fit to revise its contracts with insurance companies and community-based organizations to include such basic requirements to check for accuracy to be a tacit acknowledgement that there is a significant problem with the applications being submitted by facilitated enrollers. As an administrator from DSS observed, “Now, I would [be] embarrassed to send a contract amendment statewide that says you have to make sure the signature of the applicant is different from the person taking the application; that you should look at the application to make sure the income matches household cost”

In the end, there has to be a clear and unambiguous message to DSS from the NYSDOH and the powers that be as to what the agenda is when it comes to providing health insurance through Medicaid. Is the message that little scrutiny for eligibility should be applied? Is the message that DSS should grant Medicaid health insurance only to those who are eligible and, as guardians of the taxpayers’ money, detect and prevent fraud and waste? If so, then DSS should be provided with the support and tools to accomplish this. The Grand Jury finds that one of the ways to do this would be to

eliminate the profit motive from the system, by eliminating the Facilitated Enrollment program as it is currently constituted. The Grand Jury finds that another way to effectuate this would be to provide DSS with the staff and resources, both financial and informational, to do the job that the NYSDOH wants it to do effectively.

CONCLUSIONS:

The Grand Jury makes the following conclusions based upon the stated findings of fact:

The Facilitated Enrollment program was instituted with good intentions: to make available no cost health insurance to poor families in New York State. However, the program as currently constituted encourages fraud in the application and recertification process costing untold millions. There is an inappropriate and irresistible financial motive for participating health insurance companies to recruit as many clients as possible. This has led to unacceptable waste and criminal abuse. Enrollers, pressured by quota systems, and their employers, turn a blind eye to the resultant recklessness in the process and ignore the fraud that ensues. DSS continues to be overwhelmed by the number of applications submitted by facilitated enrollers. Understaffing and a lack of resources, cause DSS to routinely open cases based upon these inadequate applications with little more than a perfunctory review.

Significant numbers of these applications are inaccurate, and many result in open cases for applicants who are not eligible for Medicaid benefits. The Grand Jury concludes that this untenable situation will continue unabated, unless the Facilitated Enrollment program is either abolished, or is changed so that the participating insurance companies are held accountable for the waste and abuse of the system.

The Grand Jury finds that the problems created by the fraud-friendly facilitated enrollment process are compounded by the manner in which recipients are recertified. The recertification forms do not seek sufficient information, and do not require the

recipient swear to the truthfulness of the answers even on this limited form. Without benefit of a face-to-face interview with a trained DSS examiner, it is too easy for a recipient, who may be receiving benefits that he or she is not eligible for based upon an inaccurate application, to continue committing fraud undetected.

The Grand Jury finds that DSS is not able to properly provide health insurance benefits to those who need and are eligible for them while also trying to detect and prevent fraud and abuse in the system. DSS does not have adequate staff to properly review the thousands of applications and recertification forms that it receives every year. DSS does not have adequate investigatory staff to detect and prevent or prosecute applicant or recipient fraud. DSS does not have the access to information that would assist staff in determining true eligibility for Medicaid benefits, including: (1) access to identifying information from participating health insurance companies and community-based organizations of their enrollers, including linkage between the enrollers and their enrollees; (2) access to records of the NYSDOH to determine if an applicant/recipient is receiving duplicate benefits from another program, or to determine if a recipient in fact has died, and a managed care organization is still collecting premiums for a dead person; (3) access to Federal and state tax records; (4) access to records regarding unemployment benefits, worker's compensation benefits, child support payments, and other sources of income; (5) access to credit reports, bank records, property ownership records, and other indicia of financial resources. DSS has an antiquated computer system, and does not even afford its Medicaid examiners access to the Internet, due to a lack of resources to update computer operating systems. DSS lacks the resources to provide computer terminals to all of the examiners in any event.

The Grand Jury finds that, in the area of the DSS-administered informal child care provider system, DSS is forbidden to fingerprint or run criminal history checks on its providers, has extremely limited access to the records of child protective agencies, and is permitted to do very little with what limited information it can obtain from such agencies. As a result, the Grand Jury finds that there is the potential that DSS could unwittingly pay for child abusers to watch children.

The Grand Jury finds that the Facilitated Enrollment program as it is currently constituted cannot continue. The Grand Jury further finds that DSS has been and will continue to be crushed under the weight of the community Medicaid program, in part because of faults in the program, and because of a lack of staff and resources. The Grand Jury finds the underlying public policies behind the community Medicaid program to be laudable. The Grand Jury urges the state legislature and other elected officials to adopt the recommendations that follow.

RECOMMENDATIONS:

Based upon the stated findings of fact and all of the evidence heretofore had before this Grand Jury, and in order to afford government-funded health insurance to the poor and needy; to increase accountability where fraud and waste in the Medicaid system occurs; and in order to aid the administering governmental agencies in the performance of their dual responsibilities to meet the needs of the poor and vulnerable, as well as to safeguard taxpayer money from waste and abuse; NOW THEREFORE, by the authority vested in this Grand Jury by Criminal Procedure Law Section 190.85(1)(c); the following legislative, executive, and administrative actions are recommended in the public interest:

Legislative:

- I. The Facilitated Enrollment program should be abolished in New York State.
- II. In the event that the Facilitated Enrollment program is abolished, the New York State Legislature must institute a statutory scheme requiring that local departments of social services send qualified Medicaid examiners into local communities to actively educate and enroll eligible Medicaid applicants.
- III. In the alternative, if the Facilitated Enrollment program is not abolished in New York State, the New York State Legislature must enact a statutory scheme providing that if more than 10% of the Medicaid applications submitted by any managed care organization or community based organization through the facilitated enrollment program are inaccurate, said organization shall be subjected to fines, and ultimately removal from the program.

- IV. The New York State Legislature must include in this scheme a requirement that all participating managed care and community based organizations shall provide to the administering local department of social services identifying information as to all of its employees operating as facilitated enrollers, and linking those facilitated enrollers with their respective enrollees.
- V. The New York State Legislature must include in this scheme a requirement that all participating managed care and community-based organizations advise the administering local department of social services, with particularity, should it discover that one of their enrollers has falsified documentation or engaged in other inappropriate practices regarding Medicaid applications.
- VI. Regardless of whether the Facilitated Enrollment program is abolished in New York State or not, the New York State Legislature must enact a statutory scheme directing computer access by departments of social services to the records of the New York State Department of Taxation and Finance, the New York State Department of Labor, and, to the extent allowable, the Internal Revenue Service.
- VII. The New York State Legislature must include in this scheme that, as a condition precedent to receiving Medicaid benefits, all adults applying for benefits must provide the local department of social services with a written authorization permitting the department of social services to obtain a current credit report.
- VIII. The New York State Legislature must include in this scheme that local departments of social services have the option of demanding a face-to-face interview of Medicaid recipients at the recertification phase.

- IX. The New York State Legislature must include in this scheme a requirement that all legally responsible adults in a household applying for Medicaid benefits be required to sign the Medicaid application, and be registered as part of it.
- X. The New York State Legislature must include in this scheme a requirement that Medicaid applicants diligently pursue, through the Child Support Enforcement Bureau, financial support from all legally responsible relatives, parents and spouses, and permit the denial of benefits if the applicant fails to do so.
- XI. The New York State Legislature must include in this scheme a requirement that all adult Medicaid recipients obtain a Medicaid photographic identification card.
- XII. The New York State Legislature must include in this scheme a requirement that, if an applicant cannot produce current pay stubs as proof of income, that the applicant must produce a notarized letter from an employer evidencing alleged income; further, as to proof of residency/address, the applicant shall be required to produce correspondence including an envelope addressed to the applicant with cancelled postage, not a window envelope.
- XIII. The New York State Legislature must increase the income eligibility levels of Medicaid, to make the program more inclusive.
- XIV. The New York State and Suffolk County Legislatures shall commit appropriate budgetary resources necessary to increase the staff and resources available to local departments of social services for the administration of the community Medicaid program.

- XV. The New York State Legislature must enact a statutory scheme that requires all potential informal childcare providers to submit to a fingerprint criminal history check.
- XVI. The New York State Legislature must include in that scheme a requirement that a check by local departments of social services of all child protective services registers within New York State be conducted regarding a potential informal child care provider for cases where that provider has been indicated in a case of child abuse and/or neglect and further permitting the administering department of social services to deny any potential child care provider from participating in the program should he or she be so indicated.

Administrative:

- I. The Suffolk County Department of Social Services must increase its scrutiny of Medicaid applications and recertification forms by: (a) Increasing staff in both the Medicaid application and undercare departments, as well as its Special Investigations Unit; (b) Affording easy access to the internet to all of its Medicaid examiners, and then utilizing that access by actively checking records that are relevant to eligibility for Medicaid benefits; (c) Updating its computer database systems so that it can cross-reference its own records, have Medicaid applications submitted to it electronically, and have automated computer reviews of applications.
- II. The New York State Department of Health shall treat the local departments of social services and the managed care organizations and community-based organizations participating in the Facilitated Enrollment program as a partnership.
- III. The New York State Department of Health shall grant local departments of social services access to their records of underinsured and uninsured health insurance payments, as well as current birth and death records.
- IV. State and local agencies affected by the changes implied in the legislative recommendations should be given the necessary authority to adopt administrative rules and regulations necessary for the effective implementation and execution of the legislative recommendations.

Executive:

I. The Governor of the State of New York should introduce legislation consistent with the legislative recommendations in this report or, in the alternative, he should support legislation introduced by others. The Governor should commit appropriate budgetary resources necessary to implement the legislative recommendations including appropriating additional resources to the local departments of social services.

II. The Suffolk County Executive should introduce legislation consistent with the legislative recommendations in this report or, in the alternative, he should support legislation introduced by others. The Suffolk County Executive should commit appropriate budgetary resources necessary to implement the legislative recommendations including appropriating additional resources to the Suffolk County Department of Social Services.

