MURPHY CRITICIZES CONTINUED NEGLIGENCE AND ABUSE AT HOMES FOR DEVELOPMENTALLY DISABLED; DEMANDS ACCOUNTABILITY & INCREASED TRAINING

HHS Inspector General report released today shows Massachusetts, like Connecticut, failed to protect residents of group homes and state institutions from negligence and abuse; Murphy called for an investigation following Hartford Courant investigative series

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WASHINGTON— Following continued alarming reports of negligence and abuse at homes for developmentally disabled residents, **U.S. Senator Chris Murphy (D-Conn.)**, a member of the U.S. Senate Health, Education, Labor, and Pensions Committee, committed to introduce legislation to address this issue. The second investigation released today by the Office of the Inspector General (OIG) of the Department of Health and Human Services outlined issues in Massachusetts similar to those found in the OIG investigation into Connecticut, which was released on May 24, 2016. The investigation was requested by Murphy in March 2013 after reports of widespread neglect and abuse in an investigative series by the Hartford Courant.

"Today's alarming report should make us all stop in our tracks," said Murphy. **"What's clear from this report is that widespread negligence and abuse is a problem in Connecticut, and Massachusetts, and I know other states around the country. It's time for the federal government to step in.**

"I requested the investigation as soon as I got to the Senate because I know the men and women who rely on these facilities. They are our sons, daughters, brothers and sisters – and they trust all of us to take care of them. I've also met the people who care for the residents – it's hard, often thankless work. And while I understand the very real struggle over resources, we cannot accept the status quo of a system that can so easily fail the people it was created to protect.

"Later this year, I will introduce legislation to address these unacceptable issues. There must be mandatory training for staff, including ongoing online training; more rigorous mandatory reporting requirements; increased access to Medicaid claims data for state agencies to create additional safeguards for residents who slip through the cracks; and a

universal standard of critical incidents to clear up what seems like widespread misinterpretation of what must be reported. My office and I have spoken to federal and state officials, as well as disability advocates and group home operators. I hope we can all work together to fix this."

Specifically, today's report found that the Massachusetts Executive Office of Health and Human Services, Office of Medicaid, did not comply with federal and state requirements for reporting and monitoring critical incidents involving developmentally disabled residents in group homes. The report identified staff failure to comply with reporting and monitoring critical incidents due to inadequate training and lack of access to appropriate Medicaid claims data. The report's findings are similar to those in Connecticut.