THE STEPHEN GROUP

MASSACHUSETTS DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CRITICAL INCIDENTS INVOLVING DEVELOPMENTALLY DISABLED MEDICAID BENEFICIARIES

The COFAR Blog (Massachusetts Coalition of Families and Advocates, Inc) reports on a July 2016 report by the US HHS Inspector General (IG). An investigation of community-based care for the developmentally disabled in Massachusetts (https://oig.hhs.gov/oas/reports/region1/11400008.pdf) found that:

> The State agency did not comply with Federal waiver and State requirements for reporting and monitoring critical incidents because group home staff did not always follow procedures for reporting critical incidents:
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> - 15% of incidents of abuse and neglect in group homes were not reported to the Department of Developmental Services investigators (88 of 587 ER visits)
> - 58% of 175 critical incidents not reported to Disabled Persons Protection Commission by DDS and group homes, as required by state law
> - 29% of incident reports sampled by the IG did not contain action steps to prevent future injury

Both COFAR and providers acknowledge that inadequate oversight is a result of inadequate pay and training and high staff turnover. A lawsuit filed by a coalition of human and social service providers in June 2016 seeks to compel the administration to complete the process of setting new contract rates for services as required under legislation passed in 2008, the first adjustment of provider rates since 1987. (http://www.masslive.com/politics/index.ssf/2014/07/human_service_providers_sue_ma.html)

The HHS IG investigation was a result of a 2013 request by US Senator Chris Murphy from Connecticut to investigate "the alarming number of deaths and cases of abuse of developmentally disabled individuals in [privately run] group homes" (http://www.vor.net/images/SenChrisMurphyIGLtr.pdf). A May 2016 report on Connecticut showed similar findings as the July 2016 Massachusetts report (https://oig.hhs.gov/oas/reports/region1/11400002.pdf). Senator Murphy will introduce legislation this year to address training anASSACHUSETTS DID NOT COMPLY WITH FEDERAL AND STATE REQUIREMENTS FOR CRITICAL INCIDENTS INVOLVING DEVELOPMENTALLY DISABLED MEDICAID BENEFICIARIES d reporting requirements and additional safeguards for residents.

COFAR believes that the investigations completed in New York (2015), Connecticut (2016) and Massachusetts did not address the overall level of care and the impact of privatization in group homes or those deaths that did not involve a visit to the emergency room, but focused on the reporting of incidents of abuse and neglect among residents who went to the Emergency Room.

COFAR believes privatization leads to a corporate, bottom-line approach to care and cites the example of a family who contends their relative suffered 16 years of abuse and neglect while the state refused to move her from a provider-operated group home to a state-operated residence. After filing a lawsuit in 2013 which resulted in placement in a state-operated residence, the family reports a marked improvement – loss of weight, nutritious food, no more psychotropic drugs and blood pressure under control.

COFAR believes that a lack of comprehensive investigations of privately run group homes and the refusal of the legislature to hold hearings on problems of abuse are a result of federal and state emphasis on closing down state-operated facilities.