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12.19.2024

Comprehensive Demand and Request for Immediate Action

Date: December 19, 2024

To:
U.S. Office of Special Counsel (OSC)
Department of Justice (DOJ)
Office of Government Information Services (OGIS)
Government Accountability Office (GAO)
Federal Bureau of Investigation (FBI)
Equal Employment Opportunity Commission (EEOC)

From:
David Medeiros
Founder, ABI Resources

Subject: Demand for Immediate and Comprehensive Action Addressing Constitutional Violations, Whistleblower Retaliation, Gross Mismanagement, Obstruction of Justice, Taxpayer Harm, and ADA Violations

Introduction

This communication serves as a formal demand for immediate and comprehensive action by the respective agencies named above to address gross violations of constitutional rights, whistleblower protections, taxpayer oversight principles, and the Americans with Disabilities Act (ADA). These demands arise from documented actions and inactions by the U.S. Office of Special Counsel (OSC), which undermine public trust, obstruct justice, and threaten systemic accountability.

Below, I outline the critical actions requested and the legal and moral justifications supporting these demands.

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1. Immediate Investigation into Constitutional Violations

Requested Action:

- Launch an immediate investigation into the systemic violations of my **First Amendment**, **Fifth Amendment**, and **Fourteenth Amendment** rights by OSC and related entities.

Why This Is Critical:

- **First Amendment**: Denial of access to records and retaliation obstruct my ability to petition the government for redress of grievances.
- **Fifth Amendment**: OSC's refusal to provide due process in handling FOIA requests and whistleblower disclosures deprives me of a fair mechanism to challenge decisions.
- **Fourteenth Amendment**: ADA violations constitute systemic discrimination, denying me equal protection under the law.

Agencies Responsible:

- DOJ Civil Rights Division
- DOJ Office of the Inspector General

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2. Enforcement of Whistleblower Protections

Requested Action:

- Investigate OSC's failure to process complaint DI-12112024134, misrepresentation of records, and retaliatory conduct under the **Whistleblower Protection Act (5 U.S.C. § 1213)**.

- Ensure whistleblower disclosures are properly documented, processed, and resolved without retaliation.

Why This Is Critical:

- Whistleblower protections are foundational to preventing fraud, abuse, and corruption. OSC's failure to fulfill its statutory mandate undermines federal accountability.
- Retaliatory suppression of my complaint (DI-12112024134) deters others from coming forward and emboldens misconduct.

Agencies Responsible:

- DOJ Civil Division
- DOJ OIG
- OSC

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3. Independent Criminal Investigation into Obstruction of Justice

Requested Action:

- Conduct a full criminal investigation into OSC's actions under **18 U.S.C. § 1505**, including the denial of records, contradictory statements, and suppression of whistleblower complaints.

Why This Is Critical:

- OSC's refusal to acknowledge complaint DI-12112024134, despite documented submission and acknowledgment, constitutes obstruction of justice.
- Misrepresentation of records and non-compliance with FOIA create a chilling effect on transparency and whistleblower protections.

Agencies Responsible:

- FBI
- DOJ Criminal Division

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4. Resolution of FOIA and Transparency Violations

Requested Action:

- Compel OSC to immediately release all requested records related to DI-12112024134 and FOIA-2025-063.
- Require OSC to submit a sworn affidavit detailing search methods, personnel involved, and reasons for record denials.

Why This Is Critical:

- Transparency is essential to public trust in government operations.
- OSC's contradictory responses undermine FOIA's intent to ensure accountability and access to public records.

Agencies Responsible:

- OGIS
- DOJ OIG

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5. Investigation into Gross Mismanagement and Waste of Funds

Requested Action:

- Conduct an audit and investigation into OSC's systemic mismanagement, including failure to process disclosures and mishandling of taxpayer resources.

Why This Is Critical:

- Taxpayer funds are allocated to OSC to ensure accountability and safeguard whistleblower rights. Mismanagement wastes resources and erodes public confidence.
- Failure to address mismanagement enables fraud, waste, and abuse of federal funds.

Agencies Responsible:

- GAO

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6. Enforcement of ADA Compliance

Requested Action:

- Mandate immediate compliance with all ADA accommodation requests, including:
    - Accessible formats for all records (e.g., screen-reader-compatible PDFs).
    - Plain-language summaries for technical documents.

- Exclusive communication via accessible platforms such as email.

Why This Is Critical:

- OSC's refusal to implement ADA accommodations creates systemic barriers, violating federal disability rights laws.
- Equitable access to public services and records is a fundamental right under **42 U.S.C. § 12132**.

Agencies Responsible:

- EEOC
- DOJ Civil Rights Division

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7. Public Accountability and Oversight

Requested Action:

- Hold OSC leadership accountable for systemic failures and violations.
- Publish audit findings and investigation results to restore public trust.

Why This Is Critical:

- Public confidence in government accountability mechanisms is paramount.
- Transparency and oversight deter future misconduct and promote systemic reforms.

Agencies Responsible:

- Congressional Oversight Committees
- GAO

Conclusion

The systemic failures outlined above represent an urgent threat to constitutional rights, public trust, and the integrity of federal oversight mechanisms. Immediate and coordinated action by the named agencies is essential to address these violations, protect whistleblowers, ensure ADA compliance, and restore accountability.

I respectfully demand acknowledgment of this complaint and expect substantive progress on all requested actions by **January 5, 2025**. Failure to act will necessitate further escalation to oversight bodies, judicial remedies, and public advocacy.

Sincerely,
David Medeiros
Founder, ABI Resources

I have attached all relevant documents, detailed requests, and supporting evidence to this communication. These include:

1. **Complaint Submissions:** Copies of my initial filings, including complaint DI-12112024134, and the associated acknowledgments from the U.S. Office of Special Counsel (OSC).
2. **Evidence of Mismanagement and Violations:** Detailed records and communications highlighting the violations, contradictions, and failures to act in compliance with legal and constitutional mandates.
3. **Document Requests and Responses:** Correspondence related to FOIA-2025-063, including OSC's contradictory and non-compliant responses.
4. **Legal and Procedural Frameworks:** References to the laws, regulations, and constitutional protections violated, alongside a timeline of relevant events.

These materials substantiate my allegations and provide the necessary context for immediate and comprehensive action. If additional information is required, I am prepared to furnish further documentation upon request.

I urge you to act with integrity, courage, and an unwavering commitment to justice. The path forward demands not just adherence to the law, but a moral duty to uphold the principles that define fairness, accountability, and equality.

Do what is right—not because it is easy, but because it is necessary. Honor the trust placed in your position to safeguard the truth, protect the vulnerable, and ensure that no voice is silenced by injustice. Every action taken to correct these wrongs sends a powerful message: that the system works for the people, that accountability matters, and that justice prevails.

The opportunity to restore faith in the process and affirm the values of transparency and equality is before you. I trust that you will rise to meet this

challenge with the dignity and resolve it deserves. Let this be a moment where doing what is right becomes a beacon for lasting change.

Escalated Complaint and Appeal
Subject: Demand for Immediate Compliance with Constitutional Rights, Whistleblower Protections, Taxpayer Oversight, and ADA Laws

Date: December 19, 2024

To:
Barbara Wheeler Jones, Acting Chief FOIA Officer
Jennifer Wheeler, FOIA Team Office of the Clerk
U.S. Office of Special Counsel (OSC)
1730 M Street, N.W., Suite 218
Washington, DC 20036-4505

CC:
Relevant Congressional Oversight Committees
Office of Government Information Services (OGIS)
U.S. Department of Justice (DOJ) Civil Rights Division

Introduction

This escalated complaint and appeal demands immediate resolution of systemic violations committed by the U.S. Office of Special Counsel (OSC) related to FOIA request #FOIA-2025-063 and whistleblower filing DI-12112024134. Despite documented evidence of submission and acknowledgment, OSC has obstructed access to records, denied ADA accommodations, and failed to process my complaint as required by law.

These actions constitute:

1. Violations of constitutional rights.
2. Non-compliance with whistleblower protection laws.
3. Breach of taxpayer oversight principles.
4. Failure to fulfill ADA requirements.

Immediate corrective action is required to uphold federal law, constitutional obligations, and public trust.

Violations and Legal Framework

1. Constitutional Violations

First Amendment – Right to Petition the Government

- OSC's denial of access to records obstructs my constitutional right to petition the government for redress, a fundamental right established in *NARA v. Favish* (541 U.S. 157, 2004).
- By withholding records and providing contradictory statements, OSC impedes oversight of government operations and accountability.

Fifth Amendment – Due Process

- OSC's procedural failures deprive me of fair mechanisms to address my FOIA request and whistleblower complaint.
- Under *Goldberg v. Kelly* (397 U.S. 254, 1970), due process guarantees timely and fair resolution of disputes involving public records. OSC's actions fail this standard.

Fourteenth Amendment – Equal Protection

- OSC's refusal to provide ADA accommodations violates the Equal Protection Clause as interpreted in *Tennessee v. Lane* (541 U.S. 509, 2004).
- By failing to accommodate individuals with disabilities, OSC perpetuates systemic discrimination.

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2. Whistleblower Protection Violations

Failure to Process Disclosure – 5 U.S.C. § 1213

- OSC has neglected its statutory duty to document and process whistleblower complaint DI-12112024134, violating the Whistleblower Protection Act.

Obstruction of Justice – 18 U.S.C. § 1505

- By denying the existence of a documented complaint, OSC has obstructed the lawful review of whistleblower disclosures.

Retaliation or Neglect

- OSC's behavior raises concerns of retaliation or willful neglect, undermining federal safeguards and deterring whistleblowers from exposing fraud or misconduct.

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3. Taxpayer Oversight Rights

Public Accountability

- FOIA (5 U.S.C. § 552) guarantees transparency in federally funded programs. OSC's refusal to release records contradicts this mandate and undermines public trust.

Economic Harm

- By obstructing oversight, OSC increases the risk of fraud, waste, and abuse, depriving taxpayers of their right to monitor government operations.

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4. ADA Non-Compliance

Failure to Implement ADA Accommodations – Title II of the ADA (42 U.S.C. § 12132)

- OSC has failed to honor requests for accessible formats, plain-language summaries, and email-only communication, violating ADA and Section 504 of the Rehabilitation Act.

Systemic Discrimination

- Under *Lane v. Peña* (518 U.S. 187, 1996), public entities are required to ensure equal access. OSC's failure reflects systemic non-compliance with federal disability rights laws.

Demands for Immediate Action

1. **Full Disclosure**
    - Release all records related to DI-12112024134 and FOIA-2025-063, including communications, decisions, and ADA accommodation handling.
2. **Transparent Search Methodology**
    - Provide a sworn affidavit detailing search methods, personnel involved, and offices queried.
    - Explain the contradictory claim that DI-12112024134 is invalid despite documented confirmation.
3. **ADA Compliance**
    - Resend all communications in accessible formats (e.g., screen-reader-compatible PDFs).
    - Provide plain-language summaries for technical records.
    - Ensure all future correspondence adheres to ADA accommodation requirements.
4. **Identification of Responsible Personnel**

- Disclose the names, titles, and roles of all individuals handling FOIA-2025-063 and DI-12112024134.

5. **Compliance Timeline**
   - Confirm a timeline for full resolution by December 26, 2024.

Consequences of Continued Non-Compliance

1. **Formal Complaints**
   - File with OGIS, DOJ Civil Rights Division, and relevant Congressional Oversight Committees.
2. **Legal Action**
   - Pursue remedies under FOIA, ADA, and constitutional law, seeking injunctive relief and damages.
3. **Public Advocacy**
   - Highlight systemic failures through media outlets, advocacy organizations, and taxpayer watchdog groups.

Attachments

Supporting documents include:

1. Confirmation of complaint DI-12112024134 submission (December 11, 2024).
2. PDF file containing detailed complaint information.
3. OSC acknowledgment of FOIA request #FOIA-2025-063 (December 16, 2024).
4. OSC denial of records related to DI-12112024134 (December 18, 2024).

These attachments substantiate the claims outlined above.

Conclusion

OSC's actions undermine federal law and constitutional principles, jeopardizing public trust and accountability. Immediate corrective measures are essential to restore compliance and address systemic deficiencies.

I expect a substantive response addressing all demands by December 26, 2024. Failure to comply will result in escalatory measures as outlined.

Sincerely,
David Medeiros
Founder, ABI Resources

Who Took the Action?

Individual 1: Barbara Wheeler Jones

- **First Name:** Barbara
- **Last Name:** Wheeler Jones
- **Title:** Acting Chief FOIA Officer
- **Position in Chain of Command:** Responsible for overseeing OSC's FOIA operations and compliance. As the Acting Chief FOIA Officer, Barbara Wheeler Jones is directly accountable for ensuring adherence to FOIA and legal standards for transparency and record accessibility.

Individual 2: Jennifer Wheeler

- **First Name:** Jennifer
- **Last Name:** Wheeler
- **Title:** FOIA Team Office of the Clerk
- **Position in Chain of Command:** Member of the OSC FOIA team, responsible for processing FOIA requests. Likely delegated tasks to respond to FOIA #FOIA-2025-063 and ensure proper documentation.

Individual 3: Henry J. Kerner

- **First Name:** Henry
- **Last Name:** Kerner
- **Title:** Special Counsel
- **Position in Chain of Command:** Head of the U.S. Office of Special Counsel. As the leader of OSC, Kerner is ultimately accountable for the actions and compliance of the agency under federal laws, including FOIA, ADA, and whistleblower protection statutes.

Additional Individuals (Unidentified):

- **First Name:** Unknown
- **Last Name:** Unknown
- **Title/Role:** Attorney(s) or case officers responsible for handling complaint DI-12112024134.

- **Position in Chain of Command:** Likely reporting to the FOIA Officer or Special Counsel, tasked with managing specific whistleblower complaints and ADA accommodations.

These individuals, through direct action or supervisory responsibility, have contributed to or overseen the actions leading to this complaint. Further investigation is required to determine the specific roles and involvement of additional OSC personnel.

Violation of Law, Rule or Regulation 1. Who took the action?

The U.S. Office of Special Counsel (OSC), specifically through its Acting Chief FOIA Officer, Barbara Wheeler Jones, and the FOIA Team Office of the Clerk led by Jennifer Wheeler, took the actions in question. These actions include:

- **Failure to process and acknowledge a whistleblower complaint** (DI-12112024134) despite documented receipt confirmations.
- **Denial of the existence of relevant records** linked to FOIA request #FOIA-2025-063 and the associated whistleblower filing.
- **Obstruction of justice** by providing contradictory and evasive responses regarding the existence of the complaint and associated records.
- **Violation of ADA requirements** by failing to provide legally mandated accommodations, including accessible formats and plain-language summaries.

These individuals, acting in their official capacities at the OSC, are accountable for the administrative actions and omissions leading to these violations.

The U.S. Office of Special Counsel (OSC), through Barbara Wheeler Jones, Jennifer Wheeler, and associated personnel, took the following actions:

1. **Denied the Existence of Valid Records**:
    - Refused to acknowledge the existence of whistleblower complaint DI-12112024134, despite documented confirmations of receipt via email and attached filings.
2. **Obstructed Justice**:
    - Provided contradictory responses regarding the status of the whistleblower complaint and related FOIA request (#FOIA-2025-063), impeding transparency and accountability.
    - Delayed and hindered access to critical records required for whistleblower protections and federal oversight.
3. **Violated Federal Disclosure Laws**:
    - Failed to comply with FOIA requirements under 5 U.S.C. § 552, including timely processing and the provision of records related to whistleblower disclosures and ADA accommodations.
4. **Failed to Process a Whistleblower Disclosure**:
    - Neglected their statutory duty under 5 U.S.C. § 1213 to review, process, and act upon the whistleblower disclosure associated with DI-12112024134, thereby undermining protections for reporting misconduct.
5. **Violated ADA and Rehabilitation Act Requirements**:
    - Refused to provide requested accommodations for a documented disability, including:
        - Accessible, screen-reader-compatible formats for all documents.
        - Plain-language summaries for complex records.
        - Exclusive email communication as requested.
6. **Failed to Identify Responsible Personnel**:
    - Did not disclose the names, titles, or roles of the individuals involved in the search, review, and handling of the FOIA and whistleblower requests, further obstructing accountability.

These actions collectively violated federal laws, constitutional rights, whistleblower protections, taxpayer rights, and ADA mandates.

This occurred between **December 11, 2024, and December 19, 2024**, with key events as follows:

1. **December 11, 2024**:
    - The whistleblower complaint **DI-12112024134** was submitted and acknowledged by the U.S. Office of Special Counsel (OSC) via email.
    - OSC sent confirmation of receipt, including the detailed filing document, confirming the complaint submission and case number.
2. **December 16, 2024**:
    - OSC acknowledged receipt of FOIA request **#FOIA-2025-063** and assigned it a tracking number. This acknowledgment confirmed the request for records related to DI-12112024134.
3. **December 18, 2024**:
    - OSC provided a contradictory response, claiming that complaint DI-12112024134 was not a valid record and requested clarification, despite prior confirmation of its existence and processing.
4. **December 19, 2024**:
    - As of this date, OSC has continued to deny the existence of complaint DI-12112024134, obstructing justice, violating whistleblower and ADA laws, and failing to comply with FOIA and constitutional requirements.

These actions occurred within the stated timeframe and remain unresolved as of December 19, 2024.

I discovered this action through direct correspondence and official communications from the U.S. Office of Special Counsel (OSC). Specifically:

1. **December 11, 2024**:
    - I submitted whistleblower complaint **DI-12112024134** to OSC. Shortly after submission, I received an email confirmation from OSC acknowledging receipt and providing documentation that included the complaint details and case number.
2. **December 16, 2024**:
    - I submitted a FOIA request (**#FOIA-2025-063**) seeking records related to the whistleblower complaint. OSC acknowledged receipt of this FOIA request, confirming their obligation to respond under federal law.
3. **December 18, 2024**:
    - OSC issued a contradictory response, stating that complaint **DI-12112024134** was invalid or nonexistent. This claim directly conflicted with their earlier acknowledgment of receipt and confirmation emails.

The conflicting responses and refusal to recognize complaint **DI-12112024134** exposed OSC's obstruction of justice, non-compliance with whistleblower laws, and violations of ADA and FOIA requirements. These were confirmed through the discrepancies in OSC's official communications, which I tracked and documented.

The following additional facts substantiate my allegation:

Official Documentation Contradicting OSC's Denial

1. **December 11, 2024 – Confirmation of Complaint Filing (DI-12112024134):**
   - Upon submitting whistleblower complaint **DI-12112024134**, I received an email from OSC's automated system acknowledging receipt of the complaint.
   - Attached to the email was a PDF document confirming the full submission details, including the complaint's specific identifier, **DI-12112024134**, and advising me of the next steps in the process.
2. **December 16, 2024 – FOIA Request Submission (#FOIA-2025-063):**
   - I submitted a FOIA request seeking all records related to **DI-12112024134**. OSC confirmed receipt of this request and assigned tracking number **#FOIA-2025-063**, indicating their responsibility to process the request under the Freedom of Information Act (5 U.S.C. § 552).
3. **December 18, 2024 – Contradictory Response from OSC:**
   - OSC issued a written response stating that complaint **DI-12112024134** did not exist or was invalid. This directly contradicted their prior acknowledgment of the filing and the attached confirmation document.

Legal Obligations and OSC's Violations

1. **FOIA Requirements (5 U.S.C. § 552):**
   - OSC's denial of records and refusal to process a valid FOIA request violates FOIA, which mandates transparency and timely access to government-held information.
   - Their conflicting responses suggest either a failure to conduct a proper search or an intentional suppression of records, constituting obstruction of justice.
2. **ADA Compliance:**
   - I submitted ADA accommodation requests to OSC, including the provision of accessible formats and simplified summaries. OSC ignored these legally mandated accommodations, violating Title II of the ADA (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
3. **Whistleblower Protection Act Violations (5 U.S.C. § 1213):**
   - OSC's denial of the existence of a validly submitted whistleblower complaint indicates a systemic failure to comply with its statutory duty to protect whistleblowers and process their disclosures in good faith.

Documented Evidence:

1. **Emails and Attachments from OSC:**
    - The acknowledgment email and the attached confirmation document (dated December 11, 2024) confirm that complaint **DI-12112024134** was successfully filed and entered into OSC's system.
    - The FOIA acknowledgment email (dated December 16, 2024) demonstrates that OSC received my request for records related to this complaint.
2. **OSC's Contradictory Statement (December 18, 2024):**
    - OSC's claim that the complaint was "invalid" or "nonexistent" directly contradicts their own documented confirmations.

Patterns of Obstruction and Neglect:

- OSC's refusal to process a valid complaint and their contradictory statements suggest intentional suppression of whistleblower disclosures.
- Their failure to provide legally required accommodations under ADA indicates systemic neglect of accessibility requirements, further obstructing my ability to obtain information.

Public Interest and Urgency:

This case involves potential misuse of federal funds, violations of whistleblower protection laws, and non-compliance with ADA and FOIA statutes. OSC's actions undermine public confidence in government accountability and transparency. Immediate corrective action is required to prevent further harm.

Who Took the Action? (Gross Mismanagement)

First Name: Barbara
Last Name: Wheeler Jones
Title: Acting Chief FOIA Officer
Position in Chain of Command: Responsible for overseeing FOIA compliance, handling records management, and ensuring adherence to federal transparency and whistleblower protection laws.

First Name: Jennifer
Last Name: Wheeler
Title: FOIA Team Member, Office of the Clerk
Position in Chain of Command: Tasked with processing FOIA requests and ensuring proper response under 5 U.S.C. § 552.

Agency/Office:

- U.S. Office of Special Counsel (OSC)
- FOIA Division

Additional Individuals Who Took Action (Direct or Oversight Roles)

High-Level Oversight Roles

1. **Henry J. Kerner**
   - **Title:** Special Counsel, OSC
   - **Position in Chain of Command:** Overall leader of the OSC, with responsibility for ensuring the organization complies with its statutory duties, including FOIA compliance, whistleblower protections, and ADA accommodations.
2. **Michael E. Horowitz**
   - **Title:** Inspector General, U.S. Department of Justice (DOJ)
   - **Position in Chain of Command:** Responsible for overseeing accountability at federal agencies, including potential systemic failures at OSC.
3. **Kristen Clarke**
   - **Title:** Assistant Attorney General, Civil Rights Division, DOJ
   - **Position in Chain of Command:** Oversees federal enforcement of ADA compliance and civil rights violations in public agencies.

OSC Personnel Handling Your Complaint

1. **Barbara Wheeler Jones**
   - **Title:** Acting Chief FOIA Officer, OSC
   - **Position in Chain of Command:** Responsible for OSC FOIA processes and ensuring timely and accurate responses.
2. **Jennifer Wheeler**
   - **Title:** FOIA Team Member, Office of the Clerk, OSC
   - **Position in Chain of Command:** Direct involvement in managing your FOIA requests and subsequent denial of records.

Agency-Wide Leadership

1. **Xavier Becerra**
   - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
   - **Position in Chain of Command:** HHS oversees CMS (Centers for Medicare & Medicaid Services), which has a vested interest in whistleblower claims affecting Medicaid programs.
2. **Chiquita Brooks-LaSure**
   - **Title:** Administrator, CMS (Centers for Medicare & Medicaid Services)
   - **Position in Chain of Command:** Oversee Medicaid-related compliance and investigations potentially connected to your whistleblower disclosures.

Relevant Congressional Oversight Committees

1. **James Comer**

- **Title:** Chair, House Committee on Oversight and Accountability
- **Position in Chain of Command:** Congressional oversight of federal agency compliance with FOIA and whistleblower protection laws.

2. **Gary Peters**
   - **Title:** Chair, Senate Committee on Homeland Security and Governmental Affairs
   - **Position in Chain of Command:** Responsible for investigating systemic failures and mismanagement in federal agencies.
3. **Jamie Raskin**
   - **Title:** Chair, House Subcommittee on Civil Rights and Civil Liberties
   - **Position in Chain of Command:** Investigates civil rights and whistleblower retaliation claims in federal agencies.

Potentially Relevant OSC Legal Team Members

1. **Acting General Counsel, OSC**
   - Directly responsible for ensuring legal compliance with whistleblower laws and FOIA responses. Specific name can be verified by OSC organizational directory.
2. **Assigned Investigator for DI-12112024134**
   - The attorney or investigator responsible for handling your whistleblower disclosure and ensuring its progression under 5 U.S.C. § 1213.

Internal FOIA and Records Management Staff

- Specific records management officers and clerical personnel who handled your submission and were involved in declaring DI-12112024134 as invalid despite previous acknowledgment. Names can be identified through OSC records.

Other Agencies Implicated

1. **Office of Government Information Services (OGIS)**
   - Mandated to mediate FOIA disputes and address systemic failures in FOIA compliance.
2. **Federal Bureau of Investigation (FBI)**
   - Investigates potential obstruction of justice related to OSC's handling of whistleblower complaints and FOIA non-compliance.

What Action Did They Take?

The following actions, or failures to act, demonstrate **gross mismanagement** at the U.S. Office of Special Counsel (OSC) and related entities:

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1. Mishandling of Whistleblower Complaint (DI-12112024134)

- **Refusal to Acknowledge Filing:**
  Despite OSC confirming the submission of complaint **DI-12112024134** via email and issuing a detailed filing receipt, it later denied the existence of the case. This constitutes systemic mismanagement and failure to process whistleblower complaints under **5 U.S.C. § 1213**.
- **Failure to Assign or Investigate:**
  OSC failed to assign a responsible investigator or attorney to address the complaint, violating whistleblower protection statutes and undermining accountability.
- **Obstruction of Justice:**
  The contradictory claims and lack of progress in handling the complaint suggest intentional suppression or systemic inefficiency, violating **18 U.S.C. § 1505** (obstruction of proceedings).

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2. Non-Compliance with FOIA Request (#FOIA-2025-063)

- **Failure to Conduct Adequate Search:**
  OSC's FOIA staff failed to perform a thorough search for records related to **DI-12112024134**, directly violating **5 U.S.C. § 552**.
- **Falsification of Records Status:**
  OSC falsely claimed the complaint did not exist, despite having acknowledged its receipt. This undermines transparency and public trust in government processes.
- **Delays in Responding:**
  OSC failed to comply with statutory timelines for FOIA processing, denying lawful access to records within the required 20 business days.

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3. Systemic Non-Compliance with ADA Requirements

- **Failure to Provide Reasonable Accommodations:**
  OSC did not implement requested accommodations under **Title II of the ADA** and **Section 504 of the Rehabilitation Act**, including:
  - Providing accessible formats for records (e.g., screen-reader-compatible PDFs).

    - Summarizing technical or complex documents in plain language.
    - Ensuring communication through email-only platforms as requested.
- **Discrimination Against Individuals with Disabilities:**
  The lack of accommodations constitutes systemic exclusion and unequal treatment, violating **42 U.S.C. § 12132**.

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4. Suppression of Transparency and Accountability

- **Gross Mismanagement of Whistleblower Protections:**
  By failing to process the complaint, OSC has discouraged whistleblower disclosures, undermining public oversight and violating the **Whistleblower Protection Act**.
- **Lack of Oversight or Escalation:**
  No steps were taken to involve higher authorities (e.g., DOJ Inspector General, Congressional Committees) to address or resolve systemic failures.
- **Failure to Document Decision-Making:**
  OSC has not provided any written justification for its denial of records or its contradictory responses, violating transparency mandates under **FOIA** and **5 U.S.C. § 1214**.

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5. Mismanagement of Taxpayer Resources

- **Wasting Public Funds:**
  The failure to process valid whistleblower complaints and FOIA requests has wasted taxpayer dollars and resources, constituting **gross mismanagement of funds**.
- **Loss of Public Confidence:**
  OSC's failure to uphold its statutory duties damages its credibility as a federal oversight agency, undermining its core mission.

These actions collectively represent systemic **gross mismanagement** within OSC and related entities, with significant consequences for whistleblowers, taxpayers, and public accountability.

When Did This Occur?

The **gross mismanagement** at the U.S. Office of Special Counsel (OSC) occurred over the following timeline:

1. **December 11, 2024:**
   - Complaint **DI-12112024134** was submitted and acknowledged by OSC via email, with a receipt confirmation and filing details sent to the complainant.
   - Supporting evidence was attached, including detailed documentation of whistleblower allegations and violations.
2. **December 16, 2024:**
   - FOIA request **#FOIA-2025-063** was submitted to OSC for records related to **DI-12112024134**.
   - OSC acknowledged receipt of the FOIA request, assigned a tracking number, and confirmed processing was underway.
3. **December 18, 2024:**
   - OSC issued a contradictory response denying the existence of complaint **DI-12112024134**, despite previous acknowledgment and associated documentation.
   - OSC failed to provide any statutory justification for the denial or the inability to locate records.
4. **Ongoing:**
   - OSC has failed to process the complaint or escalate it to the appropriate investigative authorities.
   - There has been no evidence of corrective action, transparency, or compliance with statutory deadlines for whistleblower protections, FOIA requests, or ADA accommodations.

The pattern of systemic failures and mismanagement has persisted from **December 11, 2024**, and continues to the present date (**December 19, 2024**). These ongoing delays, denials, and contradictions constitute gross mismanagement in violation of federal laws and regulations.

How Did You Discover This Action?

The actions constituting **gross mismanagement** were discovered through the following sequence of events:

1. **Acknowledgment of Filing:**
   On **December 11, 2024**, I received an email confirmation from the U.S. Office of Special Counsel (OSC) acknowledging receipt of my whistleblower complaint **DI-12112024134**. The acknowledgment included filing details and a reference to OSC's role in processing whistleblower disclosures.
2. **FOIA Request Submission:**
   On **December 16, 2024**, I submitted a FOIA request (**#FOIA-2025-063**) to OSC seeking records and communications related to **DI-12112024134**. This request was acknowledged by OSC, confirming its receipt and processing.
3. **Contradictory Response:**
   On **December 18, 2024**, OSC issued a response to the FOIA request, claiming that complaint **DI-12112024134** does not exist, despite the previously documented acknowledgment and the provided filing reference.
4. **ADA Non-Compliance:**
   Throughout the process, OSC failed to implement requested ADA accommodations (e.g., accessible formats, plain-language summaries) despite repeated and legally justified requests. This pattern revealed systemic deficiencies in OSC's adherence to accessibility standards.
5. **Cross-Referencing Documentation:**
   By cross-referencing the complaint confirmation email, FOIA tracking information, and subsequent denials, I identified clear contradictions and failures in OSC's handling of both the complaint and FOIA request. These contradictions revealed severe procedural lapses and possible intentional suppression of records.
6. **Ongoing Lack of Action:**
   Continued failure to address the complaint, respond to the FOIA request, or comply with statutory and constitutional obligations further confirmed systemic **gross mismanagement** within OSC operations.

What Additional Facts Support Your Allegation?

The following facts substantiate the allegation of **gross mismanagement** by the U.S. Office of Special Counsel (OSC):

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1. Documented Acknowledgment of Complaint Submission

- On **December 11, 2024**, OSC acknowledged the receipt of whistleblower complaint **DI-12112024134** through an official confirmation email. This acknowledgment provided:
  - A unique filing number (DI-12112024134).
  - Confirmation of the complaint's submission and details on how OSC would process it.
  - Attached documentation of the filing, establishing its authenticity and receipt by OSC.

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2. Contradictory FOIA Responses

- On **December 16, 2024**, OSC acknowledged receipt of my FOIA request **#FOIA-2025-063**, seeking records related to complaint **DI-12112024134**.
- On **December 18, 2024**, OSC issued a contradictory response claiming that complaint **DI-12112024134** does not exist, despite the previously documented acknowledgment.
  - The discrepancy indicates either systemic procedural breakdowns or intentional suppression of records.

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3. Violations of ADA Accommodations

- Despite multiple requests for ADA accommodations under **Title II of the ADA** and **Section 504 of the Rehabilitation Act**, OSC failed to:
  - Provide records in accessible formats.
  - Include plain-language summaries of complex documents.
  - Respond exclusively through accessible electronic means (e.g., email).
- This non-compliance with legally mandated accommodations highlights systemic management failures and potential discrimination against individuals with disabilities.

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4. Failure to Process Whistleblower Complaint

- Under **5 U.S.C. § 1213**, OSC is mandated to:
  - Accept and process whistleblower disclosures.
  - Conduct investigations or appropriately refer complaints to relevant agencies.
- OSC has failed to provide any substantive updates, actions, or resolution regarding complaint **DI-12112024134**, despite legal requirements and my repeated inquiries.

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5. Obstruction of Justice

- The refusal to acknowledge or act upon a valid whistleblower complaint constitutes obstruction under **18 U.S.C. § 1505**. This behavior raises serious concerns about intentional efforts to suppress or retaliate against whistleblowers.

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6. Systemic Lack of Transparency and Accountability

- The combination of:
  - Contradictory responses to FOIA requests.
  - Failure to act on the whistleblower complaint.
  - Non-compliance with ADA accommodations.
  - Lack of communication or explanation regarding procedural lapses.
- This pattern reflects systemic **gross mismanagement** and a failure to uphold OSC's statutory responsibilities under **FOIA**, the **Whistleblower Protection Act**, and the **ADA**.

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7. Economic and Ethical Implications

- By failing to address whistleblower disclosures, OSC allows potential **fraud, waste, and abuse** of federal resources to go unchecked.
- Such failures undermine public trust in OSC's ability to safeguard whistleblower protections and ensure government accountability.

Conclusion

These facts demonstrate a consistent pattern of gross mismanagement within OSC, including procedural lapses, ADA non-compliance, suppression of whistleblower complaints, and obstruction of justice. These actions violate federal law, constitutional principles, and OSC's statutory mission to protect whistleblowers and ensure government accountability.

Abuse of Authority - Who Took the Action?

First Name: Barbara
Last Name: Wheeler Jones
Title: Acting Chief FOIA Officer
Position in Chain of Command: Senior leadership overseeing FOIA requests, ADA compliance, and whistleblower-related disclosures at the U.S. Office of Special Counsel (OSC).

First Name: Jennifer
Last Name: Wheeler
Title: FOIA Team Member, Office of the Clerk
Position in Chain of Command: Staff member responsible for processing FOIA requests, maintaining records, and corresponding with whistleblower filers.

First Name: Henry J.
Last Name: Kerner
Title: Special Counsel, U.S. Office of Special Counsel
Position in Chain of Command: Chief official responsible for the oversight, management, and enforcement of whistleblower protections and compliance with statutory mandates at OSC.

First Name: Michael E.
Last Name: Horowitz
Title: Inspector General, U.S. Department of Justice
Position in Chain of Command: Oversight authority for misconduct, systemic issues, and whistleblower retaliation across federal agencies, including OSC.

These individuals hold key roles in ensuring compliance with laws and regulations related to FOIA, whistleblower protections, and ADA accommodations. Their actions (or inactions) in processing disclosures, responding to FOIA requests, and implementing ADA accommodations are directly relevant to the allegations of abuse of authority.

Additional Individuals Who Took or Enabled the Action:

OSC Personnel:

First Name: Erica
Last Name: Hamrick
Title: Deputy Special Counsel for Investigation and Prosecution

Position in Chain of Command: Directly responsible for overseeing investigations of whistleblower disclosures and allegations of misconduct. Likely involved in decisions related to DI-12112024134 and FOIA-2025-063.

First Name: William
Last Name: Reukauf
Title: Associate Special Counsel
Position in Chain of Command: Senior official managing legal and procedural compliance for OSC operations. Played a role in determining the handling of disclosures and compliance with federal laws.

DOJ Oversight Personnel:

First Name: Kristen
Last Name: Clarke
Title: Assistant Attorney General, Civil Rights Division
Position in Chain of Command: Responsible for ensuring ADA compliance and investigating systemic violations of civil rights within federal agencies.

First Name: Alina
Last Name: Semo
Title: Director, Office of Government Information Services (OGIS)
Position in Chain of Command: Federal FOIA Ombudsman tasked with resolving disputes, ensuring compliance, and addressing systemic FOIA processing failures.

HHS Personnel (Relevant to CMS Oversight and ADA Complaints):

First Name: Xavier
Last Name: Becerra
Title: Secretary of Health and Human Services
Position in Chain of Command: Chief executive of HHS, ultimately accountable for oversight of Centers for Medicare & Medicaid Services (CMS) and compliance with federal laws, including ADA and whistleblower protections.

First Name: Chiquita
Last Name: Brooks-LaSure
Title: Administrator, CMS
Position in Chain of Command: Directly responsible for oversight of Medicaid-funded programs, including ADA accommodations and compliance.

Connecticut State Officials (Related to Medicaid Waiver Mismanagement):

First Name: Andrea
Last Name: Barton Reeves
Title: Commissioner, Connecticut Department of Social Services (DSS)
Position in Chain of Command: Responsible for implementing the Acquired Brain Injury Medicaid Waiver Program and ensuring ADA compliance at the state level.

First Name: William
Last Name: Tong
Title: Connecticut Attorney General
Position in Chain of Command: Legal oversight for state agencies and responsible for addressing potential violations of state and federal laws, including whistleblower retaliation.

Key Contributors to the Systemic Issues:

- **Senior OSC Legal Counsel:** Individuals advising on procedural denials of DI-12112024134 and FOIA-2025-063.
- **FOIA Officers or Records Custodians at DOJ, HHS, and OSC:** Likely involved in suppressing, mismanaging, or obstructing the disclosure of records tied to these complaints.

These additional individuals hold roles that intersect with the abuse of authority allegations through oversight responsibilities, decision-making, and systemic enforcement of federal laws.

Actions Taken by Individuals Involved in Abuse of Authority:

1. **Denial of Records (FOIA and Whistleblower):**
   - Falsely claimed that **DI-12112024134** does not exist despite documented evidence of its receipt and acknowledgment by the Office of Special Counsel (OSC).
   - Refused to provide requested records under **FOIA request FOIA-2025-063**, obstructing access to information protected under **5 U.S.C. § 552** (FOIA) and whistleblower protection laws (**5 U.S.C. § 1213**).
2. **Obstruction of Justice:**
   - Intentionally delayed or misrepresented the status of the whistleblower complaint (DI-12112024134), preventing timely investigation and enforcement of whistleblower protections.
   - Suppressed whistleblower disclosures by failing to document or act upon reported violations, contravening **18 U.S.C. § 1505**.
3. **Failure to Implement ADA Accommodations:**
   - Ignored explicit requests for ADA-mandated accommodations, including accessible formats for communication, plain-language summaries, and exclusive email communication. This violates **Title II of the ADA (42 U.S.C. § 12132)** and **Section 504 of the Rehabilitation Act (29 U.S.C. § 794)**.
4. **Systemic Mismanagement and Retaliation:**
   - Allowed procedural mismanagement to undermine the integrity of OSC's whistleblower protection and complaint resolution processes.
   - Created an environment of retaliation or neglect, deterring whistleblowers from filing complaints or seeking recourse for misconduct.
5. **Misinformation and Lack of Transparency:**
   - Misrepresented the chain of custody, procedural steps, and investigative actions related to DI-12112024134.
   - Failed to disclose search methodologies, personnel involved, or databases queried, undermining trust in OSC's operations and violating public accountability standards.
6. **Collusion or Neglect in Oversight:**
   - Federal and state officials failed to intervene despite evident non-compliance with federal statutes, contributing to systemic failures.
   - Key personnel, including FOIA officers, legal counsel, and program administrators, allowed procedural delays, denials, and suppressions to persist unchallenged.

Summary:

The actions taken demonstrate a pattern of abuse of authority through procedural obstruction, denial of legal rights under FOIA and whistleblower statutes, systemic mismanagement, and the failure to implement disability accommodations. These actions collectively undermine public

trust, transparency, and accountability while violating multiple federal laws and constitutional protections.

Timeline of Abuse of Authority:

1. **Initial Submission and Confirmation (December 11, 2024):**
   - Whistleblower complaint **DI-12112024134** was submitted to the Office of Special Counsel (OSC) and acknowledged via email. Supporting documents were attached, and acknowledgment emails confirmed receipt of the submission.
2. **FOIA Request Submission (December 16, 2024):**
   - FOIA request **FOIA-2025-063** was submitted, requesting all records related to DI-12112024134. OSC acknowledged receipt of the request, confirming the tracking number.
3. **OSC's Denial of Records (December 18, 2024):**
   - OSC claimed that **DI-12112024134** is "not a valid OSC record number," contradicting earlier acknowledgment emails and submitted evidence.
4. **Escalated Communications and ADA Requests (December 19, 2024):**
   - Multiple communications were sent demanding compliance with FOIA, ADA accommodations, and whistleblower protection statutes. OSC failed to respond substantively or address the inconsistencies.
5. **Ongoing Delays and Obstruction (December 2024):**
   - OSC failed to release records, provide ADA-compliant formats, or substantiate its claim that DI-12112024134 does not exist. This obstruction continues as of December 19, 2024.

Summary:

The actions of denial, delay, and obstruction began immediately following the submission of whistleblower complaint DI-12112024134 on **December 11, 2024**, and continue to date (**December 19, 2024**), demonstrating a pattern of systemic abuse of authority and non-compliance.

I discovered this abuse of authority through:

1. **Confirmation Emails from OSC (December 11, 2024):**
    - After submitting my whistleblower complaint **DI-12112024134**, I received confirmation emails from the OSC acknowledging receipt of the complaint and assigning it a filing identifier. These emails included details of my submission and assured me that further communication would follow.
2. **FOIA Submission and Acknowledgment (December 16, 2024):**
    - When I submitted FOIA request **FOIA-2025-063**, OSC acknowledged receipt of the request and provided a tracking number, reaffirming that my complaint and related records existed within their system.
3. **Contradictory Response from OSC (December 18, 2024):**
    - OSC claimed that **DI-12112024134** was "not a valid OSC record number" despite previous confirmations. This directly contradicted the acknowledgment emails and attached supporting documents I had received and provided.
4. **Failure to Provide ADA Accommodations and Records (Ongoing):**
    - OSC failed to respond to ADA accommodation requests, release records, or address discrepancies in its contradictory claims. This obstruction became evident as I attempted to resolve these issues through direct communication with OSC officials.

These actions demonstrated a clear pattern of obstruction, inconsistency, and abuse of authority, which I identified through OSC's own contradictory communications and their failure to fulfill statutory obligations.

Additional facts supporting the allegation of abuse of authority include:

1. **Documented Confirmation of Complaint Submission:**
   - On **December 11, 2024**, OSC acknowledged receipt of my whistleblower complaint **DI-12112024134** via multiple confirmation emails. These included a detailed record of my submission and the assigned filing identifier. These documents demonstrate that the complaint was submitted and recognized by OSC.
2. **Contradictory Denial of Complaint's Existence:**
   - On **December 18, 2024**, OSC claimed that **DI-12112024134** was "not a valid OSC record number," directly contradicting their earlier acknowledgment emails. This inconsistency suggests intentional misrepresentation or systemic mismanagement.
3. **Failure to Respond to FOIA Request:**
   - Despite acknowledging receipt of FOIA request **FOIA-2025-063** on **December 16, 2024**, OSC has failed to produce any responsive records. This delay violates FOIA's statutory time limits and suggests deliberate obstruction of transparency.
4. **Ignored ADA Accommodation Requests:**
   - My requests for ADA-compliant communication formats and plain-language summaries—required under **Title II of the ADA** and **Section 504 of the Rehabilitation Act**—have been systematically ignored, further obstructing my ability to participate in the process.
5. **OSC's Statutory Responsibilities:**
   - As mandated by **5 U.S.C. § 1213**, OSC is required to process whistleblower disclosures promptly and ensure transparency. Its failure to address my complaint or provide records undermines its statutory obligations and raises concerns about internal accountability.
6. **Pattern of Non-Compliance:**
   - OSC's refusal to act on confirmed submissions and its contradictory responses highlight systemic issues of neglect, mismanagement, and potential retaliation against whistleblowers.
7. **Impact on Public Trust and Transparency:**
   - By obstructing the processing of my disclosure and withholding records, OSC has not only harmed me as a whistleblower but also undermined public trust in its oversight functions.

These facts collectively establish a pattern of abuse of authority by OSC officials, who have failed to fulfill their statutory duties, comply with legal obligations, and uphold the principles of transparency and accountability.

Individuals Responsible for Gross Waste of Funds

1. **Barbara Wheeler Jones**
   - **Title**: Acting Chief FOIA Officer
   - **Position in Chain of Command**: Oversees FOIA compliance and record management within the OSC.
2. **Jennifer Wheeler**
   - **Title**: FOIA Team Member, Office of the Clerk
   - **Position in Chain of Command**: Directly responsible for processing FOIA requests and ensuring accurate responses to records requests.
3. **Henry J. Kerner**
   - **Title**: Special Counsel of the U.S. Office of Special Counsel
   - **Position in Chain of Command**: The ultimate authority overseeing the operations and accountability of the OSC, including FOIA compliance and whistleblower protection processes.

Additional Individuals and Entities Involved in the Gross Waste of Funds

6. **Michael E. Horowitz**
    - **Title**: Inspector General, U.S. Department of Justice (DOJ)
    - **Position in Chain of Command**: Responsible for overseeing systemic accountability within federal agencies, including OSC. His oversight role implicates indirect involvement when failures in monitoring or corrective action occur.
7. **Alina M. Semo**
    - **Title**: Director, Office of Government Information Services (OGIS)
    - **Position in Chain of Command**: Provides mediation services and ensures compliance with FOIA processes across federal agencies, including OSC. Her office's lack of enforcement contributes to resource mismanagement.
8. **Merrick B. Garland**
    - **Title**: Attorney General of the United States
    - **Position in Chain of Command**: As the head of the DOJ, he oversees the actions of federal entities like OSC. Neglecting systemic accountability measures permits continued wasteful practices.
9. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Related to systemic failures in transparency and management of federally funded programs impacting Medicaid whistleblower complaints.
10. **OSC Administrative Division**
    - **Title**: Departmental Unit within OSC
    - **Position in Chain of Command**: Manages internal administrative resources, funding allocations, and processes related to recordkeeping and compliance. Mismanagement at this level exacerbates inefficiencies and waste.
11. **Unidentified Contracted Service Providers**
    - **Role**: Third-party vendors or contractors used by OSC for processing, technology, or support. Misallocation of funds or substandard services directly contributes to inefficiencies and financial loss.
12. **Oversight Committees**
    - **Examples**:
        - House Committee on Oversight and Accountability
        - Senate Committee on Homeland Security and Governmental Affairs
    - **Role**: Failure to ensure OSC accountability allows systemic waste of taxpayer funds to persist without remedial action.

Entities and Their Roles

These individuals and entities collectively demonstrate systemic failure and gross mismanagement leading to the unnecessary allocation of public funds, inefficient complaint

handling, and obstructed whistleblower processes. Their direct and indirect roles warrant scrutiny under gross waste of taxpayer resources.

Actions Taken Contributing to Gross Waste of Funds:

1. **Mismanagement of Whistleblower Complaints**
   - Failure to properly process and investigate whistleblower complaints, including **DI-12112024134**, resulted in prolonged delays, duplicated efforts, and unresolved issues. Resources allocated for complaint handling were misused or underutilized.
2. **Denial and Obstruction of Records**
   - Systematic denial of FOIA requests (#FOIA-2025-063) and other related disclosures required extensive follow-up, appeals, and escalations, wasting administrative time and taxpayer funds.
3. **Non-Compliance with ADA Accommodations**
   - OSC failed to provide legally mandated ADA accommodations, resulting in redundant efforts, communication inefficiencies, and the need for escalations to external entities (e.g., DOJ Civil Rights Division, OGIS). This non-compliance caused significant delays and misallocation of resources.
4. **Inefficient Recordkeeping and Search Processes**
   - OSC's internal disorganization and failure to maintain accessible records led to repeated claims of "no responsive records," requiring additional searches, appeals, and administrative time that could have been avoided.
5. **Failure to Utilize Oversight and Accountability Mechanisms**
   - OSC neglected its statutory responsibility to ensure proper oversight of whistleblower complaints and resource management. This resulted in unchecked misallocation of funds and lack of resolution for key cases.
6. **Improper Resource Allocation to Legal and Administrative Support**
   - Resources intended for whistleblower protection and investigation were diverted to address unnecessary legal disputes, FOIA denials, and appeals. These actions reflect a lack of prioritization and accountability.
7. **Inadequate Training and Oversight of Staff and Contractors**
   - OSC failed to adequately train staff and contractors on compliance with FOIA, ADA, and whistleblower statutes. This led to inefficient complaint processing, record management, and communication practices.
8. **Engagement in Repetitive and Unnecessary Correspondence**
   - OSC repeatedly sent contradictory responses, including acknowledgment of complaints followed by claims of nonexistence. These actions consumed excessive resources and created confusion, requiring escalations to external oversight bodies.
9. **Neglect of Transparency Obligations**
   - Systemic lack of adherence to transparency mandates under FOIA and whistleblower statutes undermined trust, requiring unnecessary intervention from higher authorities and advocacy organizations, further wasting public resources.
10. **Failure to Collaborate with Other Agencies**
    - OSC failed to collaborate effectively with the DOJ, OGIS, and Congressional Oversight Committees to resolve systemic issues, leading to duplication of efforts and misallocation of funds.

Consequences of These Actions

These actions demonstrate a systemic failure to efficiently manage taxpayer funds, undermining OSC's mission and violating legal obligations under FOIA, ADA, and whistleblower statutes. This gross mismanagement reflects a lack of internal accountability and effective leadership, warranting immediate investigation and corrective action.

Timeline of Actions Contributing to Gross Waste of Funds:

1. **Initial Complaint Filing**
   - **December 11, 2024**: Complaint DI-12112024134 submitted to the U.S. Office of Special Counsel (OSC). Confirmation of receipt provided within minutes.
2. **FOIA Request Submission**
   - **December 16, 2024**: FOIA request #FOIA-2025-063 submitted, seeking records related to DI-12112024134. Confirmation of receipt was provided the same day.
3. **Contradictory Communications Begin**
   - **December 18, 2024**: OSC claims that complaint DI-12112024134 is "not a valid OSC record," despite previously acknowledging its receipt. Contradictory responses ensue, requiring clarification and escalation.
4. **ADA Accommodation Failures Persist**
   - Throughout December 2024: OSC repeatedly failed to honor ADA accommodation requests for accessible formats and plain-language summaries, resulting in delays and inefficient communication.
5. **Repeated Record Search Denials**
   - **December 19, 2024**: OSC denies the existence of records responsive to FOIA request #FOIA-2025-063, necessitating appeals and escalations to external oversight bodies.
6. **Escalations and Appeals**
   - **December 19–Present**: Repeated appeals filed with the DOJ Civil Rights Division, OGIS, and Congressional Oversight Committees due to OSC's obstruction and mismanagement.

Ongoing Violations:

- The systemic issues and gross mismanagement are ongoing, with OSC failing to resolve its contradictory responses, fulfill FOIA obligations, or implement ADA accommodations effectively. These failures continue to waste taxpayer funds and undermine whistleblower protections.

How This Action Was Discovered

1. **Direct Involvement in Filing and Submission**
    - On **December 11, 2024**, I personally filed a whistleblower complaint (DI-12112024134) with the U.S. Office of Special Counsel (OSC). I received immediate email confirmation acknowledging the filing and detailing its contents.
2. **Contradictory Responses from OSC**
    - Following the submission, on **December 16, 2024**, I submitted a Freedom of Information Act (FOIA) request (#FOIA-2025-063) to obtain records related to the complaint. OSC confirmed receipt of the FOIA request. However, on **December 18, 2024**, OSC claimed that DI-12112024134 was "not a valid OSC record," directly contradicting its initial acknowledgment of the complaint.
3. **Review of FOIA and ADA Non-Compliance**
    - Upon receiving OSC's contradictory statements and denial of records, I reviewed their responses in detail and found repeated failures to comply with FOIA statutory obligations and ADA accommodation requests.
4. **Analysis of Escalation Delays and Repeated Denials**
    - Despite documented evidence of complaint submission and FOIA confirmation, OSC's subsequent denial of valid records raised concerns about systemic failures, waste, and abuse. Analysis of their responses revealed a pattern of obstruction and mismanagement.
5. **Supporting Documentation**
    - Documentation from OSC emails, FOIA responses, and submitted appeals, along with corroborative evidence of ADA accommodation requests and denials, further demonstrated the breadth of mismanagement.

These actions were discovered through firsthand experience, official correspondence, and analysis of inconsistencies in OSC's handling of statutory responsibilities.

Additional Facts Supporting the Allegation

1. **Contradictory Documentation from OSC**
   - **Complaint Submission Acknowledged:** On **December 11, 2024**, OSC sent an email confirmation acknowledging the submission of complaint DI-12112024134, attaching a detailed PDF of the filing and indicating that an assigned attorney or investigator would follow up.
   - **FOIA Acknowledgment:** On **December 16, 2024**, OSC acknowledged receipt of FOIA request #FOIA-2025-063, indicating compliance with its legal obligation to search for and provide relevant records.
   - **Contradictory Claim:** On **December 18, 2024**, OSC claimed that DI-12112024134 was "not a valid OSC record," contradicting their prior acknowledgment and raising concerns about record tampering or intentional obstruction.
2. **Violation of FOIA Requirements**
   - OSC's refusal to produce records violated the Freedom of Information Act (5 U.S.C. § 552), which mandates timely responses, thorough searches, and transparency in public records. The refusal to acknowledge records they previously confirmed demonstrates systemic non-compliance.
3. **Failure to Comply with ADA Accommodations**
   - Multiple ADA accommodation requests, including accessible formats, plain-language summaries, and email-only communication, were ignored or denied, violating Title II of the ADA (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
4. **Impact on Whistleblower Protections**
   - By refusing to act on DI-12112024134, OSC violated its statutory duties under the Whistleblower Protection Act (5 U.S.C. § 1213), which requires documentation, investigation, and action on whistleblower complaints. Their inaction undermines federal protections and deters others from reporting wrongdoing.
5. **Evidence of Systemic Gross Waste of Funds**
   - OSC's handling of this matter reflects gross waste of taxpayer funds, as public resources are being used to obstruct rather than fulfill statutory obligations. This undermines the integrity of federal oversight processes.
6. **Failure to Address Escalated Appeals**
   - Despite multiple appeals and documentation sent to OSC and oversight authorities, there has been no substantive resolution. This pattern of neglect highlights systemic issues and potential abuse of authority within OSC operations.
7. **Pattern of Mismanagement and Obstruction**
   - OSC's actions and inactions collectively demonstrate a pattern of mismanagement, obstruction of justice, and disregard for legal obligations under FOIA, ADA, and whistleblower protection laws.

These additional facts underscore the seriousness of OSC's violations and the need for an independent investigation to ensure accountability and transparency.

Danger to Public Health: Who Took the Action?

1. **Barbara Wheeler Jones**
    - **Title:** Acting Chief FOIA Officer
    - **Position in Chain of Command:** Responsible for overseeing FOIA compliance and ensuring timely and accurate responses to requests related to public disclosures and records.
2. **Jennifer Wheeler**
    - **Title:** FOIA Team, Office of the Clerk
    - **Position in Chain of Command:** Assigned to handle the processing of FOIA request #FOIA-2025-063 and to provide records related to complaint DI-12112024134.
3. **U.S. Office of Special Counsel (OSC)**
    - **Agency Head:** Henry J. Kerner (Special Counsel)
    - **Position in Chain of Command:** Overall responsible for the agency's compliance with statutory mandates, including whistleblower protections, FOIA compliance, and ADA accommodations.
4. **Additional Individuals/Departments:**
    - Any internal investigators, legal counsel, or administrative personnel involved in handling or suppressing the processing of DI-12112024134 or FOIA-2025-063.
    - Internal ADA coordinators responsible for implementing reasonable accommodations related to communication and accessibility for individuals with disabilities.

These individuals and entities were in positions of authority or responsibility for actions and decisions that directly endangered public health by failing to act on a critical whistleblower disclosure and obstructing access to information necessary to address and mitigate risks.

Additional Individuals or Entities Involved in Danger to Public Health:

5. **Michael E. Horowitz**
    - **Title:** Inspector General, Department of Justice (DOJ)
    - **Position in Chain of Command:** Oversight authority for systemic failures in whistleblower protection and compliance with transparency laws, including FOIA and ADA. Neglect or failure to investigate reports of obstruction could indirectly contribute to endangering public health.
6. **Henry J. Kerner**
    - **Title:** Special Counsel, U.S. Office of Special Counsel (OSC)
    - **Position in Chain of Command:** Ultimately accountable for ensuring that all whistleblower disclosures and FOIA requests are properly addressed. Failure to enforce protocols on DI-12112024134 implicates systemic negligence.
7. **Ned Lamont**
    - **Title:** Governor, State of Connecticut

- **Position in Chain of Command:** Responsible for oversight of state agencies involved in federally funded programs related to Medicaid and public health. Failure to act on systemic issues contributes to continued risks to public health.

8. **Andrea Barton Reeves**
   - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
   - **Position in Chain of Command:** Direct oversight of Medicaid-funded programs, including the ABI Waiver. Mismanagement or failure to address whistleblower concerns could exacerbate risks to public health.
9. **William Tong**
   - **Title:** Attorney General, State of Connecticut
   - **Position in Chain of Command:** Legal oversight for ensuring that state agencies comply with constitutional and statutory requirements regarding public health and whistleblower protections.
10. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command:** Responsible for overseeing federal programs related to Medicaid, including enforcing compliance with funding and care standards in the ABI Waiver Program.
11. **Kristen Clarke**
    - **Title:** Assistant Attorney General, Civil Rights Division, DOJ
    - **Position in Chain of Command:** Oversight of ADA compliance and ensuring access for individuals with disabilities to government programs and processes.
12. **Internal ADA Coordinators (OSC and DSS)**
    - **Title:** Designated individuals tasked with ensuring compliance with ADA requirements.
    - **Position in Chain of Command:** Direct responsibility for providing accessible formats and reasonable accommodations for individuals filing FOIA requests or whistleblower complaints.
13. **Unidentified FOIA Staff Members**
    - **Title:** Administrative personnel processing or denying FOIA-2025-063.
    - **Position in Chain of Command:** Individuals tasked with record searches and communication with the complainant. Neglect, errors, or intentional obstruction contribute to the failure to disclose critical information.

These individuals and departments collectively hold roles in oversight, management, and compliance. Their inaction or obstruction amplifies risks to public health by delaying transparency, accountability, and corrective measures required to mitigate potential harms.

Actions Taken in Danger to Public Health:

1. **Systematic Obstruction of Justice**
   - Denied the existence of whistleblower complaint DI-12112024134 despite documented confirmation of its filing.
   - Provided contradictory responses, creating delays and confusion regarding the status of the complaint and associated FOIA requests.
2. **Failure to Address Medicaid Program Mismanagement**
   - Neglected oversight and enforcement of standards in Medicaid-funded programs, including the ABI Waiver Program, which supports individuals with brain injuries and disabilities.
   - Allowed potential fraud, waste, and abuse in federally funded health programs to go unchecked, increasing the risk of harm to vulnerable populations.
3. **Suppression of Critical Public Health Disclosures**
   - Failed to process whistleblower complaints regarding systemic failures in Medicaid and public health programs.
   - Ignored or obstructed disclosure of mismanagement and violations of law that could directly impact public health outcomes.
4. **Neglecting ADA Mandates**
   - Denied ADA-compliant accommodations, obstructing access to information for individuals with disabilities and impeding their ability to participate in oversight and accountability processes.
   - Created systemic barriers for disabled individuals to access critical healthcare and complaint resolution processes.
5. **Gross Mismanagement of FOIA Requests**
   - Mishandled FOIA-2025-063, obstructing access to vital records related to Medicaid programs and public health oversight.
   - Refused to conduct thorough searches or provide sworn affidavits detailing search methodologies, thereby delaying transparency and accountability.
6. **Endangerment of Public Health and Safety**
   - Allowed systemic failures in oversight to persist, potentially exacerbating risks to the health and safety of Medicaid beneficiaries reliant on adequate care and services.
   - Failed to investigate and rectify structural issues within state and federal programs critical to public health.
7. **Concealment of Key Records and Evidence**
   - Obstructed access to evidence that could reveal systemic negligence, regulatory violations, and mismanagement within Medicaid programs, further endangering public health.
   - Actively delayed the release of critical documentation by misrepresenting the validity of DI-12112024134 and other associated records.

Collective Impact:

The actions above represent deliberate obstruction and systemic neglect, leading to heightened risks for vulnerable populations dependent on transparent and accountable Medicaid services. These actions directly endanger public health by delaying oversight, exacerbating inequities, and preventing corrective measures.

Timeline of Events:

1. **Initial Filing of Complaint**
   - **December 11, 2024, 8:34 AM:** Complaint DI-12112024134 was filed with the U.S. Office of Special Counsel (OSC). Confirmation of receipt was provided via email, with an acknowledgment of the filing and the assignment of a case number.
2. **Subsequent FOIA Requests**
   - **December 16, 2024:** FOIA request #FOIA-2025-063 was submitted to OSC, seeking all records and correspondence related to complaint DI-12112024134.
3. **OSC Contradictory Response**
   - **December 18, 2024:** OSC claimed that complaint DI-12112024134 was invalid and denied having records related to the FOIA request, despite previous confirmations of receipt.
4. **Ongoing Non-Compliance**
   - Between **December 11, 2024, and December 19, 2024**, OSC failed to provide requested records, obstructed justice, and did not comply with ADA-mandated accommodations, such as accessible formats and plain-language summaries.
5. **Impact on Public Health**
   - The actions occurred over the course of multiple days and continue as of **December 19, 2024**, contributing to delays in addressing systemic failures in Medicaid programs and endangering public health.

Pattern of Neglect:

The above timeline demonstrates a continuous and escalating failure to process critical disclosures, obstruct justice, and ensure public accountability, with direct consequences for public health and safety.

Additional Facts Supporting Allegations:

1. **Contradictory Documentation:**
   - On **December 11, 2024**, OSC confirmed receipt of complaint DI-12112024134 through an automated email, assigning it a tracking number and confirming its entry into their system.
   - On **December 18, 2024**, OSC denied the existence of the same complaint in response to FOIA request #FOIA-2025-063. This directly contradicts their earlier confirmation, demonstrating gross mismanagement of case records and possible deliberate obstruction.
2. **Failure to Provide ADA Accommodations:**
   - OSC ignored multiple requests for ADA-compliant communication, including accessible formats, plain-language summaries, and exclusive email correspondence. These omissions are violations of the Americans with Disabilities Act (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
3. **Non-Compliance with FOIA Obligations:**
   - OSC failed to produce requested records within the statutory timeframe, as required by 5 U.S.C. § 552. Their refusal to acknowledge or locate records, despite proof of submission, constitutes a breach of federal transparency laws.
4. **Pattern of Obstruction and Retaliation:**
   - The denial of the complaint's existence raises concerns about deliberate retaliation or negligence by OSC personnel. This obstructs whistleblower protections outlined under 5 U.S.C. § 1213 and may deter other whistleblowers from reporting critical issues.
5. **Danger to Public Health and Safety:**
   - The mismanagement and suppression of whistleblower disclosures undermine accountability and oversight mechanisms. This has the potential to allow unchecked violations of law or harmful practices within federal agencies, posing a broader risk to public health, safety, and trust in government.
6. **Financial Implications:**
   - Gross waste of federal funds is evident in the failure to manage whistleblower disclosures, ADA requests, and FOIA compliance. These actions erode taxpayer confidence and increase the risk of undetected fraud or mismanagement within OSC operations.

Supporting Evidence:

- Emails confirming submission and acknowledgment of DI-12112024134.
- FOIA correspondence (Request #FOIA-2025-063) highlighting OSC's contradictory statements.
- Documented requests for ADA accommodations, which were ignored or inadequately addressed.

- Legal analysis showing violations of constitutional rights, FOIA obligations, and ADA requirements.

Conclusion:

The evidence reveals systemic failures within OSC, including gross mismanagement, obstruction, and non-compliance with legal and constitutional obligations. These actions demand immediate investigation and corrective measures to prevent further harm to whistleblowers, public trust, and government accountability.

Danger to Public Safety: 1. Who Took the Action?

Primary Individuals:

- **Barbara Wheeler Jones**
  - **Title:** Acting Chief FOIA Officer
  - **Position in Chain of Command:** Responsible for overseeing FOIA requests and ensuring compliance with federal transparency laws.
  - **Role in Action:** Oversaw the denial of the existence of complaint DI-12112024134 and failed to ensure the proper processing of ADA accommodations and whistleblower protections.
- **Jennifer Wheeler**
  - **Title:** FOIA Team, Office of the Clerk
  - **Position in Chain of Command:** Directly involved in responding to FOIA requests and providing status updates.
  - **Role in Action:** Issued contradictory statements about the status and existence of DI-12112024134, contributing to the concealment of critical disclosures.

Other Potentially Involved Individuals:

- **Henry J. Kerner**
  - **Title:** Special Counsel, U.S. Office of Special Counsel
  - **Position in Chain of Command:** Head of OSC, ultimately responsible for all agency operations and compliance with whistleblower and public safety mandates.
  - **Role in Action:** Failed to ensure accountability and transparency in OSC operations and oversight of whistleblower complaint processing.
- **Unnamed OSC Staff**
  - Involved in case management, FOIA compliance, and ADA accommodation requests.
  - Role in Action: Mishandled or obstructed the processing of complaint DI-12112024134, directly impacting public safety by suppressing whistleblower disclosures related to violations of law, health, and safety concerns.

This systemic failure by individuals at multiple levels of OSC highlights negligence, mismanagement, and potential obstruction, directly endangering public safety by undermining mechanisms for accountability and oversight.

Additional Individuals Who Took Action:

1. **Michael E. Horowitz

- **Title:** Inspector General, U.S. Department of Justice (DOJ)
- **Position in Chain of Command:** Oversees DOJ investigations, including compliance with whistleblower protection statutes and agency misconduct.
- **Role in Action:** Potential failure to intervene or provide oversight despite documented violations and complaints filed with the DOJ OIG concerning OSC's handling of DI-12112024134.

2. Alina M. Semo

- **Title:** Director, Office of Government Information Services (OGIS)
- **Position in Chain of Command:** Responsible for mediating FOIA disputes and ensuring government agencies comply with transparency obligations.
- **Role in Action:** Failure to take effective action in addressing complaints about OSC's non-compliance with FOIA requests and ADA accommodations.

3. Henry Kerner's Deputy or Designee

- **Title:** Deputy Special Counsel or Senior Leadership Member of OSC
- **Position in Chain of Command:** Directly assists the Special Counsel in managing agency operations and compliance.
- **Role in Action:** Negligence in monitoring agency processes and ensuring that whistleblower protections, ADA accommodations, and FOIA requests were handled correctly.

4. Xavier Becerra

- **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
- **Position in Chain of Command:** Responsible for overseeing public health-related programs and ensuring federal agencies comply with health and safety mandates.
- **Role in Action:** Failure to ensure coordination with OSC regarding public health-related whistleblower disclosures involving Medicaid programs.

5. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** Manages Medicaid programs and ensures compliance with federal regulations.
- **Role in Action:** Lack of follow-up or accountability in addressing disclosures related to health and safety violations within Medicaid-funded programs.

6. Merrick Garland

- **Title:** Attorney General, DOJ
- **Position in Chain of Command:** Provides oversight and leadership for DOJ operations, including FOIA compliance and civil rights enforcement.
- **Role in Action:** Failure to ensure enforcement of transparency and accountability within OSC and related agencies, contributing to the systemic suppression of public safety disclosures.

These individuals represent additional layers of responsibility within the federal government, where inaction or failure to enforce compliance has exacerbated risks to public safety stemming from OSC's mishandling of whistleblower disclosures and related complaints.

2. What Action Did They Take?

1. **Henry Kerner (Special Counsel, OSC):**
   - **Action Taken:** Failed to ensure the proper handling, acknowledgment, and investigation of whistleblower disclosure DI-12112024134. Specifically, Kerner's office obstructed justice by denying the existence of a documented submission while simultaneously confirming its receipt in earlier communications. The refusal to process or act on the disclosure created systemic barriers to oversight.
   - **Impact:** Undermined OSC's statutory duty to protect whistleblowers, investigate disclosures, and ensure accountability for agency wrongdoing.
2. **Michael E. Horowitz (Inspector General, DOJ):**
   - **Action Taken:** Neglected to enforce accountability for OSC's non-compliance with FOIA and whistleblower statutes, despite receiving detailed complaints highlighting systemic obstruction of justice and non-compliance with federal laws. Failed to initiate or escalate an investigation into OSC's handling of whistleblower submissions.
   - **Impact:** Allowed systemic failures within OSC to persist, creating a chilling effect on whistleblowers and compromising oversight mechanisms.
3. **Alina M. Semo (Director, OGIS):**
   - **Action Taken:** Failed to mediate or intervene effectively in the FOIA dispute between the complainant and OSC. Did not address OSC's refusal to provide requested records or adhere to ADA accommodations, despite OGIS's mandate to resolve such disputes.
   - **Impact:** Prolonged the delay in accessing critical records and failed to enforce government transparency requirements.
4. **Barbara Wheeler Jones (Acting Chief FOIA Officer, OSC):**
   - **Action Taken:** Provided contradictory responses to FOIA request #FOIA-2025-063, confirming receipt of DI-12112024134 and later denying its existence. Refused to disclose records or justify exemptions as required by FOIA.
   - **Impact:** Directly obstructed justice and undermined public confidence in government accountability.
5. **Xavier Becerra (Secretary, HHS):**
   - **Action Taken:** Failed to act on whistleblower disclosures related to public health concerns, including systemic non-compliance within Medicaid-funded programs. Did not coordinate with OSC to address overlapping issues affecting public health.
   - **Impact:** Increased risks to public health by neglecting whistleblower disclosures and failing to enforce compliance with Medicaid oversight requirements.
6. **Chiquita Brooks-LaSure (Administrator, CMS):**
   - **Action Taken:** Neglected to investigate or address disclosures involving systemic issues within Medicaid-funded programs. Failed to collaborate with OSC or provide guidance on health and safety violations highlighted in the complaint.
   - **Impact:** Allowed potential harm to public health to escalate due to lack of intervention and oversight.

7. **Merrick Garland (Attorney General, DOJ):**
    - **Action Taken:** Did not enforce compliance or investigate OSC's failures to handle whistleblower complaints, respond to FOIA requests, or honor ADA accommodations. Failed to address systemic misconduct despite being the head of the DOJ, which oversees OSC operations.
    - **Impact:** Contributed to the erosion of public trust in government accountability and whistleblower protections.

Summary of Actions:

These individuals, through inaction, obstruction, or negligence, failed to uphold their legal obligations to ensure transparency, accountability, and public safety. Their collective actions (or lack thereof) constitute violations of constitutional rights, whistleblower protection laws, and taxpayer accountability principles.

3. When Did This Occur?

1. **Initial Submission and Confirmation:**
   - **Date:** December 11, 2024, at approximately 8:34 AM (EST).
   - **Event:** Whistleblower disclosure DI-12112024134 was submitted to the U.S. Office of Special Counsel (OSC) and immediately acknowledged via email. A confirmation document was also attached, providing detailed filing information.
2. **Contradictory Responses Begin:**
   - **Date:** December 16, 2024.
   - **Event:** OSC acknowledged receipt of FOIA request #FOIA-2025-063, referencing the associated whistleblower disclosure DI-12112024134. However, no substantive response was provided regarding the status of the disclosure or records requested.
3. **Denial of Records and Obstruction:**
   - **Date:** December 18, 2024.
   - **Event:** OSC claimed that disclosure DI-12112024134 "is not a valid OSC record number," directly contradicting earlier confirmations of its receipt and existence. This marked a significant escalation in the obstruction of justice.
4. **Continued Failure to Respond or Act:**
   - **Ongoing:** As of December 19, 2024, the involved individuals and agencies continue to obstruct access to records, fail to address ADA accommodation requests, and refuse to investigate or process the whistleblower disclosure.

Timeline Summary:

The actions span from the submission of the disclosure on December 11, 2024, to ongoing non-compliance and obstruction as of December 19, 2024. This timeline demonstrates a consistent pattern of negligence, obstruction, and systemic failure across multiple agencies and individuals.

4. How Did You Discover This Action?

I discovered this series of actions through direct engagement with the Office of Special Counsel (OSC) and their documented responses to my complaint and Freedom of Information Act (FOIA) request. Specifically:

1. **Initial Confirmation of Submission:**
    - On **December 11, 2024**, I submitted whistleblower disclosure DI-12112024134 to OSC via their online filing portal.
    - I received an **immediate email confirmation** acknowledging receipt, along with a detailed PDF document confirming the submission and filing number (DI-12112024134).
2. **FOIA Request and Confirmation:**
    - On **December 16, 2024**, I submitted FOIA request #FOIA-2025-063 to access records related to my whistleblower disclosure.
    - OSC confirmed receipt of my FOIA request via email, stating that it had been assigned tracking number #FOIA-2025-063 and acknowledging the subject of the request.
3. **Contradictory Denial:**
    - On **December 18, 2024**, OSC issued a contradictory response claiming that the whistleblower disclosure DI-12112024134 "is not a valid OSC record number." This denial directly conflicted with their previous confirmations of receipt and acknowledgment.
4. **Failure to Provide Substantive Responses:**
    - Repeated follow-ups to OSC, including communications with named individuals such as Barbara Wheeler Jones and Jennifer Wheeler, yielded no resolution. Their responses either ignored critical inquiries or continued to deny the existence of the submission.

Discovery Through Documentation:

The pattern of mismanagement, obstruction, and non-compliance became apparent as I analyzed the documented communications from OSC. These include:

- Email confirmations of the whistleblower submission.
- FOIA tracking and acknowledgment correspondence.
- Contradictory responses denying the existence of the disclosed filing.

This series of actions raised significant concerns about systemic failures, negligence, and potential misconduct within OSC's operations.

5. Additional Facts Supporting the Allegation

1. **Documented Evidence of Submission and Confirmation**
    - On **December 11, 2024**, I received an email from OSC confirming the submission of whistleblower disclosure DI-12112024134. The email included:
        - A PDF titled "OSCFiling-MedeirosDavid-DI-12112024134" that details the content of the disclosure.
        - Confirmation of receipt, stating that changes to the filing could only be made through OSC.
    - This acknowledgment is indisputable evidence that the filing was received and recorded by OSC.
2. **OSC's FOIA Acknowledgment Confirms Relevant Records**
    - On **December 16, 2024**, OSC confirmed receipt of FOIA request #FOIA-2025-063, explicitly referencing the subject matter and the submission.
    - This acknowledgment demonstrates that OSC was aware of and had begun processing records related to my whistleblower disclosure.
3. **Contradictory Responses Indicating Obstruction**
    - On **December 18, 2024**, OSC claimed that disclosure DI-12112024134 "is not a valid OSC record number," directly contradicting their earlier acknowledgment of receipt and detailed record creation.
    - This sudden denial raises serious concerns about intentional suppression, obstruction of justice, or gross mismanagement of whistleblower disclosures.
4. **Failure to Comply with FOIA and ADA Obligations**
    - OSC failed to provide requested records under FOIA, despite statutory requirements to do so within the prescribed timeline.
    - OSC ignored my ADA accommodation requests, including accessible document formats, simplified summaries, and email-only correspondence. This failure constitutes systemic discrimination and violates federal disability rights laws.
5. **Pattern of Non-Compliance and Evasion**
    - Follow-up communications with OSC personnel, including Acting Chief FOIA Officer **Barbara Wheeler Jones** and **Jennifer Wheeler**, yielded no clarification or resolution.
    - Their repeated failures to address the contradictions or provide valid explanations suggest intentional evasion rather than administrative error.
6. **Potential Retaliation and Systemic Misconduct**
    - As a whistleblower, I am entitled to protections under federal law. The denial of my disclosure and refusal to process my complaint undermine these protections, raising concerns of systemic retaliation or neglect.
    - These actions not only violate whistleblower protection laws but also obstruct oversight and accountability mechanisms meant to safeguard public trust.
7. **Harm to Public Safety and Accountability**
    - By obstructing my disclosure and denying access to critical records, OSC has jeopardized efforts to expose gross mismanagement, waste, and violations of federal law.

- This obstruction directly harms public oversight of government operations, particularly in the enforcement of whistleblower protections and taxpayer-funded programs.

Supporting Documentation:

- **Email confirmations** from OSC acknowledging receipt of DI-12112024134 and FOIA-2025-063.
- **PDF document** containing the complete details of DI-12112024134.
- **Correspondence with OSC personnel**, documenting the contradictory and evasive responses.

These additional facts provide a clear and compelling case of gross mismanagement, obstruction of justice, and failure to comply with federal laws and constitutional obligations.

12.07.2024

This submission constitutes an urgent and non-negotiable demand for immediate enforcement of federal and constitutional laws to rectify systemic violations and gross mismanagement in the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. The current failings jeopardize public safety, waste taxpayer resources, and violate the constitutional rights of Medicaid recipients, whistleblowers, and taxpayers. The Office of Special Counsel (OSC), in collaboration with federal oversight bodies, must act decisively to restore accountability, ensure compliance, and protect vulnerable populations.

1. Who Took the Action?

Violation of Law, Rule, or Regulation

Description:

Systematic non-compliance with federal laws governing ADA accommodations (42 U.S.C. § 12132), FOIA transparency (5 U.S.C. § 552), and Medicaid oversight (42 U.S.C. § 1396 et seq.),

resulting in direct harm to beneficiaries and whistleblowers. Supporting evidence includes denials of ADA accommodations and withheld records essential to accountability.

Federal Officials and Departments

1. **Xavier Becerra**

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   Position in Chain of Command: Head of HHS; directly responsible for Medicaid oversight and ADA enforcement at the federal level.

2. **Chiquita Brooks-LaSure**

   Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

   Position in Chain of Command: Federal official overseeing Medicaid programs, including state compliance with federal regulations.

3. **Kristen Clarke**

   Title: Assistant Attorney General, Civil Rights Division, DOJ

   Position in Chain of Command: Responsible for enforcing ADA Title II and addressing systemic violations of civil rights laws, including FOIA compliance.

4. **Gene L. Dodaro**

   Title: Comptroller General, U.S. Government Accountability Office (GAO)

   Position in Chain of Command: Oversight of federal fund allocations and audits, including Medicaid expenditures under the ABI Waiver Program.

5. **Michael E. Horowitz**

   Title: Inspector General, DOJ

   Position in Chain of Command: Responsible for investigating misconduct, including systemic violations of whistleblower protections.

6. **Christi Grimm**

   Title: Inspector General, HHS

   Position in Chain of Command: Investigates compliance issues related to Medicaid programs and ADA enforcement.

7. **Eric F. Stein**

   Title: Director, Office of Information Programs and Services, U.S. Department of State

   Position in Chain of Command: Oversees FOIA compliance for the Department of State, including ensuring proper record disclosures.

State Officials

8. **Ned Lamont**

   Title: Governor, State of Connecticut

   Position in Chain of Command: Responsible for state administration of Medicaid programs, including the ABI Waiver Program.

9. **Andrea Barton Reeves**

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   Position in Chain of Command: Administers Medicaid programs at the state level, ensuring compliance with federal regulations.

10. **Yamuna (Yam) Menon**

    Title: General Counsel/Assistant State Comptroller, Connecticut

    Position in Chain of Command: Legal authority for financial and operational oversight related to Medicaid program compliance.

11. **William Tong**

    Title: Attorney General, State of Connecticut

    Position in Chain of Command: Legal enforcement authority for state-level violations impacting Medicaid and ADA compliance.

Oversight Committees and Additional Parties

12. **James Comer**

    Title: Chair, House Committee on Oversight and Accountability

    Position in Chain of Command: Responsible for federal oversight, including whistleblower protections and Medicaid transparency.

13. **Gary Peters**

    Title: Chair, Senate Committee on Homeland Security and Governmental Affairs

    Position in Chain of Command: Oversees systemic risks in federal-state programs, including Medicaid administration.

14. **Dick Durbin**

    Title: Chair, Senate Judiciary Committee

    Position in Chain of Command: Ensures compliance with constitutional and statutory laws affecting civil rights and federal funding.

2. What Action Did They Take?

Violation of Law, Rule, or Regulation

Description:

Systematic non-compliance with federal laws governing ADA accommodations (42 U.S.C. § 12132), FOIA transparency (5 U.S.C. § 552), and Medicaid oversight (42 U.S.C. § 1396 et seq.), resulting in direct harm to beneficiaries and whistleblowers. Supporting evidence includes denials of ADA accommodations and withheld records essential to accountability.

Federal Officials and Departments

1. **Xavier Becerra**

   Action Taken:

   - Failed to enforce ADA and Medicaid compliance standards across federally funded state programs, allowing systemic violations to persist in the Connecticut ABI Waiver Program.
   - Did not act on multiple reports of non-compliance from whistleblowers and stakeholders.

2. **Chiquita Brooks-LaSure**

   Action Taken:

   - Did not ensure that CMS effectively monitored Connecticut's Medicaid program for ADA compliance, financial transparency, and operational integrity.

- Allowed state-level agencies to obstruct transparency and deny whistleblower protections without federal oversight.

3. **Kristen Clarke**

   Action Taken:

   - Failed to initiate enforcement of ADA Title II protections and investigate systemic violations of civil rights impacting individuals with disabilities.
   - Did not address FOIA non-compliance and transparency issues raised by whistleblowers.

4. **Gene L. Dodaro**

   Action Taken:

   - Did not initiate audits or reviews of Connecticut's Medicaid spending, particularly concerning allegations of misuse of funds in the ABI Waiver Program.
   - Allowed gaps in oversight to compromise federal accountability for taxpayer-funded programs.

5. **Michael E. Horowitz**

   Action Taken:

   - Did not investigate whistleblower claims or systemic failures reported within Connecticut's Medicaid administration.
   - Failed to ensure DOJ acted on reports of non-compliance with FOIA and ADA requirements.

6. **Christi Grimm**

   Action Taken:

   - Neglected to investigate complaints regarding financial mismanagement and lack of ADA compliance in the Connecticut Medicaid ABI Waiver Program.
   - Did not enforce federal oversight mechanisms to correct systemic issues despite whistleblower disclosures.

7. **Eric F. Stein**

   Action Taken:

   - Closed FOIA requests prematurely, providing insufficient justifications and failing to release requested records essential to transparency and accountability.
   - Did not uphold FOIA procedural requirements, violating federal transparency mandates.

State Officials

8. **Ned Lamont**

   Action Taken:

   - Failed to exercise executive authority to ensure state agencies complied with federal Medicaid regulations, ADA standards, and whistleblower protections.
   - Neglected to address systemic mismanagement within the ABI Waiver Program under his administration.

9. **Andrea Barton Reeves**

   Action Taken:

   - Did not implement accountability measures to address financial mismanagement, ADA non-compliance, and operational failures in the ABI Waiver Program.
   - Ignored whistleblower reports and stakeholder complaints about systemic program failures.

10. **Yamuna (Yam) Menon**

    Action Taken:

    - Denied requests for financial and operational records, obstructing transparency and public accountability.
    - Provided inadequate responses to FOIA requests, failing to meet statutory obligations.

11. **William Tong**

    Action Taken:

    - Did not investigate or prosecute state agencies for violations of federal Medicaid regulations and ADA compliance.
    - Failed to hold responsible parties accountable for systemic program failures and transparency violations.

Oversight Committees and Additional Parties

12. **James Comer**

Action Taken:

- Did not initiate oversight hearings or investigations into reported violations of Medicaid, ADA, and FOIA compliance.
- Failed to leverage congressional authority to address systemic failures impacting public health and taxpayer accountability.

13. **Gary Peters**

Action Taken:

- Neglected to investigate whistleblower disclosures and reports of systemic risks in Medicaid programs.
- Did not enforce legislative accountability mechanisms for federal oversight agencies.

14. **Dick Durbin**

Action Taken:

- Did not use Senate Judiciary Committee authority to address constitutional violations, including ADA and whistleblower protection failures.
- Failed to hold state and federal agencies accountable for violations of civil rights laws.

Impact of Actions Taken

These deliberate or negligent actions have directly contributed to:

- **Systemic Denial of ADA Accommodations:** Failure to provide accessible communication and services under federal law.
- **Transparency Failures:** Obstruction of FOIA requests and lack of accountability for taxpayer-funded programs.
- **Harm to Vulnerable Populations:** Jeopardizing health and safety for Medicaid beneficiaries by allowing non-compliance and mismanagement to persist unchecked.
- **Whistleblower Retaliation and Neglect:** Ignoring disclosures of systemic failures, leaving whistleblowers unprotected.

3. When Did This Occur?

Violation of Law, Rule, or Regulation

Description:

Systematic non-compliance with federal laws governing ADA accommodations (42 U.S.C. § 12132), FOIA transparency (5 U.S.C. § 552), and Medicaid oversight (42 U.S.C. § 1396 et seq.), resulting in direct harm to beneficiaries and whistleblowers. Supporting evidence includes denials of ADA accommodations and withheld records essential to accountability.

Timeline of Violations

1. **Initial Onset of Violations: 2013 - 2024**
    - Persistent and systemic non-compliance with FOIA requests and ADA accommodation obligations began **January 2013** and remains ongoing.
    - Patterns of failure in Medicaid program oversight were identified, including mismanagement of federal funds and failure to implement corrective actions in response to whistleblower complaints.
2. **Key Escalation Events**
    - **November 2018 - August 2022**: Reports from whistleblowers highlighted failures in Medicaid oversight, including financial mismanagement and non-compliance with ADA standards, yet no substantive federal or state actions were taken.

- **March 2024**: Formal requests for ADA accommodations were filed, but agencies failed to provide required adjustments, including accessible communication formats and simplified summaries.
- **October 2024**: Multiple FOIA requests marked as "closed" without proper statutory explanations. Agencies refused to provide requested records, obstructing public accountability and whistleblower protections.
- **November - December 2024**: Ongoing refusals to adhere to ADA accommodations, including failure to provide screen-reader-compatible formats or direct text responses, further compounded systemic barriers to accountability.

3. **Recurring Failures**
   - Federal and state entities failed to implement corrections or enforce compliance measures across Medicaid programs, despite repeated notifications of deficiencies from oversight bodies and whistleblowers.
   - Systemic delays in FOIA processing, lack of ADA accommodations, and refusal to release critical records obstructed timely resolution of violations, prolonging harm to Medicaid beneficiaries and whistleblowers.

Evidence of Timelines and Non-Compliance

- **Historical Failures (2013-2018):** Agencies exhibited chronic delays in FOIA processing, failed to uphold ADA standards, and ignored critical warnings about Medicaid oversight deficiencies.

- **Whistleblower Actions (2018-2022):** Reports of gross mismanagement and financial irregularities were consistently ignored by oversight entities, leading to continued violations of federal laws.
- **Ongoing Violations (2023-2024):** Agencies failed to meet legal obligations under FOIA and ADA, obstructing transparency and access to justice. The lack of timely interventions exacerbated risks to public accountability and vulnerable populations.

This comprehensive timeline underscores the systemic nature of these violations and emphasizes the urgency of immediate corrective actions to restore transparency, enforce compliance, and protect constitutional rights.

4. How Did You Discover This Action?

Violation of Law, Rule, or Regulation

Description:

Systematic non-compliance with federal laws governing ADA accommodations (42 U.S.C. § 12132), FOIA transparency (5 U.S.C. § 552), and Medicaid oversight (42 U.S.C. § 1396 et seq.), resulting in direct harm to beneficiaries and whistleblowers. Supporting evidence includes denials of ADA accommodations and withheld records essential to accountability.

Discovery Timeline and Process

1. **Personal Experience with ADA Non-Compliance**
    - In **March 2024**, I personally requested ADA accommodations in relation to accessing critical information under FOIA. These accommodations, including screen-reader-compatible documents, email-only communication, and simplified summaries, were explicitly denied or ignored by multiple agencies. This demonstrated a systematic failure to adhere to ADA and Section 504 of the Rehabilitation Act requirements.
2. **Analysis of FOIA Request Responses**
    - Between **2018 and 2024**, a pattern emerged across several FOIA submissions where:
        - Requests were marked as "Closed" without statutory explanations or records provided, violating 5 U.S.C. § 552.

- Denials of records lacked detailed justification under FOIA exemption codes, hindering transparency.
- Agencies failed to release information necessary for evaluating Medicaid compliance, highlighting systemic obfuscation.

3. **Whistleblower and Oversight Disclosures**
    - Reports from whistleblowers and oversight agencies, reviewed between **2020 and 2023**, revealed critical failures in Medicaid oversight. These included mismanagement of federal funds, lack of transparency, and barriers to accountability mechanisms. These disclosures were systematically disregarded by state and federal entities.
4. **Review of Public and Internal Records**
    - In **2023**, I conducted an analysis of publicly available reports and agency documents. The absence of critical records related to Medicaid provider audits, enforcement of ADA compliance, and corrective actions highlighted systemic failures. Additionally:
        - Records requested under FOIA were not provided.
        - Internal communications obtained through secondary sources revealed deliberate delays and procedural barriers.
5. **External Reports and Investigations**
    - Independent reports from advocacy organizations and state auditors, reviewed in **2022**, indicated pervasive issues, including financial mismanagement and

inadequate ADA accommodations. These findings aligned with my personal observations and whistleblower disclosures, further validating systemic violations.

6. **Direct Evidence from Correspondence and Requests**
    - Communications with agencies like the DOJ, HHS, and CMS between **2023 and 2024** explicitly documented failures to comply with statutory obligations under FOIA and ADA. Key examples include:
        - Denials of accessible documentation formats.
        - Mismanagement of Medicaid provider complaints and audit records.
        - Refusal to provide detailed explanations for procedural denials, violating federal law.

Supporting Evidence

- **FOIA Requests and Responses**: Documented delays, denials, and insufficient explanations for withheld records.
- **ADA Accommodation Failures**: Emails and correspondence explicitly rejecting or ignoring legally mandated accommodations.
- **Whistleblower Reports**: Verified disclosures of non-compliance and systemic barriers within Medicaid programs.
- **Oversight Reports**: Independent audits highlighting financial mismanagement and lack of accountability.

This discovery process demonstrates clear, ongoing violations of federal laws, emphasizing the urgent need for immediate corrective action to restore compliance, transparency, and accountability.

5. What Additional Facts Support Your Allegation?

Violation of Law, Rule, or Regulation

Description:

Systematic non-compliance with federal laws governing ADA accommodations (42 U.S.C. § 12132), FOIA transparency (5 U.S.C. § 552), and Medicaid oversight (42 U.S.C. § 1396 et seq.), resulting in direct harm to beneficiaries and whistleblowers. Supporting evidence includes denials of ADA accommodations and withheld records essential to accountability.

Detailed Supporting Facts

1. **Failure to Adhere to ADA Standards**
    - Federal and state agencies ignored legally mandated accommodations, creating systemic barriers to access:
        - **Specific Violations**:
            - Denial of screen-reader-compatible documents.
            - Failure to provide simplified summaries of complex records.
            - Refusal to use email-only communication despite explicit requests.
        - **Impact**:
            - This excluded individuals with disabilities, including myself, from equitable access to critical public information.
2. **FOIA Mismanagement**

- Agencies repeatedly failed to comply with FOIA's statutory obligations:
    - **Denials and Delays**:
        - Requests were marked "Closed" without adequate justification or explanations for withholding records.
        - Agencies provided incomplete or non-existent Vaughn Indices, violating the requirements for transparency under 5 U.S.C. § 552(b).
    - **Patterns Identified**:
        - Requests involving ADA compliance and Medicaid transparency were deprioritized or dismissed without legal grounds.

3. **Obstruction of Medicaid Oversight**
    - Agencies failed to provide records critical for assessing compliance with Medicaid regulations under 42 U.S.C. § 1396 et seq.:
        - **Financial Mismanagement**:
            - Records detailing the allocation and expenditure of Medicaid funds were withheld or claimed to not exist.
            - Independent audits suggested mismanagement of federal funds in state-level programs.
        - **Service Gaps**:
            - Lack of transparency obstructed accountability for service disruptions impacting vulnerable Medicaid recipients.

4. **Whistleblower Reports Ignored**
    - Whistleblower disclosures provided direct evidence of systemic issues:
        - **Unaddressed Allegations**:
            - Mismanagement of Medicaid funds and non-compliance with ADA standards.
            - Retaliation against individuals reporting misconduct within government agencies.
        - **Impact**:
            - Whistleblowers were denied protection under 5 U.S.C. § 2302(b)(8), further undermining transparency and accountability.
5. **Systemic Barriers to Accountability**
    - Internal and external communication failures obstructed oversight:
        - **Agency Coordination Failures**:
            - Federal and state agencies failed to collaborate effectively to resolve transparency and compliance issues.
            - Records requests routed between agencies were never fulfilled or confirmed.
        - **Lack of Oversight**:
            - Congressional oversight committees and federal agencies with jurisdiction did not take action to address systemic violations despite documented evidence.

6. **Public Interest and Broader Implications**
    - The violations documented have broader systemic impacts:
        - **Health and Safety Risks**:
            - Mismanagement of Medicaid programs jeopardizes the health and safety of recipients reliant on critical services.
            - ADA non-compliance creates accessibility barriers, further exacerbating harm to vulnerable populations.
        - **Erosion of Public Trust**:
            - Continued failures to provide transparency and accountability undermine confidence in government institutions.

Evidence Supporting These Allegations

- **FOIA Correspondence**:
    - Detailed records of unanswered or improperly handled requests, including status updates marked "Closed" without explanation.
- **ADA Accommodation Denials**:
    - Explicit email communications rejecting accommodations despite legal requirements.
- **Whistleblower Testimonies**:

    - Verified reports documenting misconduct and retaliation within the Medicaid program.

- **Audit Reports**:
    - Findings from independent audits indicating financial irregularities and gaps in Medicaid service delivery.

- **Public and Internal Records**:
    - Documentation of systemic barriers and procedural delays within federal and state agencies.

These additional facts provide a comprehensive basis for the allegations, highlighting systemic failures and violations of federal laws. They underscore the urgency for immediate corrective action to ensure compliance, transparency, and accountability.

1. Who Took the Action? - Gross Mismanagement

Description:

Persistent failure to manage federally allocated Medicaid funds within the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. Evidence includes incomplete financial audits, insufficient oversight mechanisms, and lack of coordination among federal and state agencies, jeopardizing the program's integrity and taxpayers' funds.

Key Individuals and Their Roles

1. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Federal head responsible for oversight of Medicaid programs through CMS.
    - **Role in Gross Mismanagement**:
        - Failed to provide effective leadership to ensure federal Medicaid funds were properly allocated and monitored.
        - Did not enforce compliance with federal funding requirements or mandate corrective actions for state-level non-compliance.
2. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Federal overseer of Medicaid compliance and state-level program management.

- **Role in Gross Mismanagement**:
  - Did not ensure rigorous financial oversight of Medicaid funds allocated to Connecticut's ABI Waiver Program.
  - Failed to act on whistleblower disclosures and audit findings highlighting financial mismanagement.

3. **Ned Lamont**
   - **Title**: Governor of Connecticut
   - **Position in Chain of Command**: State executive with ultimate responsibility for Medicaid implementation.
   - **Role in Gross Mismanagement**:
     - Did not address systemic failures in the administration of Medicaid funds under his jurisdiction.
     - Allowed mismanagement and inefficiencies to persist without intervention.
4. **Andrea Barton Reeves**
   - **Title**: Commissioner, Connecticut Department of Social Services (DSS)
   - **Position in Chain of Command**: State administrator overseeing Medicaid programs, including the ABI Waiver Program.
   - **Role in Gross Mismanagement**:
     - Failed to implement financial tracking systems to ensure proper use of funds.

- Did not establish oversight mechanisms for contracted service providers, leading to unchecked inefficiencies.

5. **Yamuna (Yam) Menon**
    - **Title**: General Counsel/Assistant State Comptroller, Office of the State Comptroller
    - **Position in Chain of Command**: Legal authority within the State Comptroller's Office responsible for financial accountability.
    - **Role in Gross Mismanagement**:
        - Claimed “no responsive records” exist for financial oversight of the ABI Waiver Program.
        - Obstructed transparency efforts by failing to provide financial documentation necessary for accountability.
6. **Gene L. Dodaro**
    - **Title**: Comptroller General, U.S. Government Accountability Office (GAO)
    - **Position in Chain of Command**: Federal head of the agency responsible for auditing and investigating the use of federal funds.
    - **Role in Gross Mismanagement**:
        - Did not initiate a thorough investigation into reported financial mismanagement despite whistleblower disclosures.
7. **William Tong**
    - **Title**: Attorney General, State of Connecticut

- **Position in Chain of Command**: State legal authority responsible for enforcing compliance with federal and state laws.
- **Role in Gross Mismanagement**:
  - Failed to investigate financial irregularities in the ABI Waiver Program.
  - Did not prosecute violations of federal funding and transparency requirements.

8. **Regional Administrator, CMS (Name TBD)**
   - **Title**: Regional Director overseeing Medicaid operations in Connecticut.
   - **Position in Chain of Command**: Federal regional overseer for Medicaid compliance.
   - **Role in Gross Mismanagement**:
     - Did not enforce compliance measures for state-level Medicaid administration.
9. **State Medicaid Director (Name TBD)**
   - **Title**: Director, Connecticut Medicaid Programs
   - **Position in Chain of Command**: State-level director responsible for Medicaid operations.
   - **Role in Gross Mismanagement**:
     - Failed to address known inefficiencies and financial mismanagement within the program.

- Did not escalate critical issues to federal authorities for resolution.

10. **Medicaid Fraud Control Unit (MFCU) Director (Name TBD)**
    - **Title**: Director, Connecticut Medicaid Fraud Control Unit
    - **Position in Chain of Command**: State prosecutor and investigator of Medicaid fraud.
    - **Role in Gross Mismanagement**:
        - Did not investigate or act on whistleblower reports of financial irregularities.
        - Failed to ensure accountability for misuse of Medicaid funds.

Supporting Individuals and Entities

- **State Auditors of Public Accounts (Connecticut)**: Failed to conduct comprehensive audits to detect and address systemic inefficiencies.
- **Legislative Oversight Committees**: Did not hold hearings or enforce accountability for Medicaid mismanagement.
- **Private Auditing Firms**: Overlooked irregularities during contracted reviews of Medicaid financials.

1. Regional Administrator, Centers for Medicare & Medicaid Services (CMS) Region 1

- **Name**: [Name Not Provided]
- **Title**: Regional Administrator, CMS Region 1
- **Position in Chain of Command**: Federal regional overseer for Medicaid compliance in Connecticut
- **Role in Gross Mismanagement**:
    - Did not enforce compliance measures for state-level Medicaid administration.

Note: Specific name not provided in the available sources.

2. State Medicaid Director, Connecticut

- **Name**: Kate McEvoy
- **Title**: Director, Medicaid and Health Services, Connecticut Department of Social Services
- **Position in Chain of Command**: State-level director responsible for Medicaid operations
- **Role in Gross Mismanagement**:
    - Failed to address known inefficiencies and financial mismanagement within the program.
    - Did not escalate critical issues to federal authorities for resolution.

Note: Kate McEvoy has led Connecticut's HUSKY Health/Medicaid program since 2012.

Connecticut Portal

3. Director, Medicaid Fraud Control Unit (MFCU), Connecticut

- **Name**: Christopher Godialis
- **Title**: Director, Medicaid Fraud Control Unit, Office of the Chief State's Attorney
- **Position in Chain of Command**: State prosecutor and investigator of Medicaid fraud
- **Role in Gross Mismanagement**:
    - Did not investigate or act on whistleblower reports of financial irregularities.
    - Failed to ensure accountability for misuse of Medicaid funds.

Note: Christopher Godialis is based in Rocky Hill, Connecticut.

These individuals hold key positions in overseeing Medicaid operations and fraud control in Connecticut. Their roles are critical in ensuring compliance and addressing inefficiencies within the Medicaid program.

2. What Action Did They Take? - Gross Mismanagement

Description:

Persistent failure to manage federally allocated Medicaid funds within the Connecticut Medicaid ABI Waiver Program. Evidence includes incomplete financial audits, insufficient oversight mechanisms, and lack of coordination among federal and state agencies, jeopardizing the program's integrity and taxpayers' funds.

Actions Taken by Key Individuals and Entities

1. **Xavier Becerra**
    - **Action**: As Secretary of HHS, failed to direct federal oversight or mandate corrective actions to ensure accountability for Medicaid funding allocated to Connecticut. Did not require CMS to enforce transparency or compliance measures for the ABI Waiver Program.
2. **Chiquita Brooks-LaSure**
    - **Action**: As Administrator of CMS, did not initiate or enforce audits, compliance reviews, or corrective actions for systemic financial mismanagement and lack of service delivery within the program. Ignored whistleblower reports highlighting mismanagement.
3. **Ned Lamont**
    - **Action**: As Governor of Connecticut, neglected to use executive authority to investigate or address systemic issues within the ABI Waiver Program. Allowed

state agencies to operate without adequate oversight, leading to unchecked financial inefficiencies and lapses in service provision.

4. **Andrea Barton Reeves**
    - **Action**: As Commissioner of Connecticut DSS, failed to establish financial tracking systems, enforce accountability measures, or address repeated instances of financial and operational inefficiencies. Did not ensure service providers met contractual and program standards.
5. **Yamuna (Yam) Menon**
    - **Action**: As General Counsel/Assistant State Comptroller, claimed "no responsive records" existed for financial oversight related to the ABI Waiver Program. Obstructed transparency by failing to provide critical documentation required for accountability.
6. **Gene L. Dodaro**
    - **Action**: As Comptroller General of GAO, did not initiate an independent federal investigation or audit to address whistleblower allegations and evidence of financial mismanagement. Did not leverage GAO's authority to enforce Medicaid fund oversight.
7. **William Tong**
    - **Action**: As Attorney General of Connecticut, failed to investigate or prosecute financial mismanagement and systemic violations within the ABI Waiver

Program. Did not enforce compliance with federal Medicaid regulations or state transparency laws.

8. **Regional Administrator, CMS (Name TBD)**
    - **Action**: Failed to enforce CMS's standards for Medicaid program oversight in Connecticut. Did not ensure corrective actions for financial mismanagement or address systemic operational failures.
9. **State Medicaid Director (Name TBD)**
    - **Action**: Neglected to address reports of financial mismanagement, inefficiencies, and non-compliance. Did not escalate critical issues to federal oversight entities for resolution.
10. **Medicaid Fraud Control Unit (MFCU) Director (Name TBD)**
    - **Action**: Did not investigate whistleblower allegations or pursue cases of financial fraud and abuse. Failed to hold providers or administrators accountable for mismanagement or misuse of Medicaid funds.
11. **State Auditors of Public Accounts (Connecticut)**
    - **Action**: Did not conduct thorough audits to uncover financial irregularities, address systemic inefficiencies, or ensure program compliance.
12. **Legislative Oversight Committees**
    - **Action**: Did not call for hearings, mandate accountability, or address systemic issues through legislative oversight mechanisms.
13. **Private Auditing Firms**

- **Action**: Overlooked financial discrepancies during contracted reviews, failing to detect or report systemic irregularities within the ABI Waiver Program.

Impact of Actions

- Allowed persistent misuse and inefficient allocation of Medicaid funds.
- Jeopardized the integrity of critical services for brain injury survivors dependent on the ABI Waiver Program.
- Undermined public trust in federal and state administration of taxpayer-funded healthcare programs.

This detailed account highlights the systemic failures and direct actions contributing to gross mismanagement, emphasizing the need for immediate accountability and corrective measures.

3. When Did This Occur? - Gross Mismanagement

Description:

Persistent failure to manage federally allocated Medicaid funds within the Connecticut Medicaid ABI Waiver Program. Evidence includes incomplete financial audits, insufficient oversight mechanisms, and lack of coordination among federal and state agencies, jeopardizing the program's integrity and taxpayers' funds.

Timeline of Occurrences

1. **Initial Mismanagement (2015-2024):**

   Systemic issues in Medicaid fund management began surfacing as early as 2015, marked by repeated reports of non-compliance with financial and operational oversight requirements. These issues persisted over the years without substantial corrective actions by state or federal authorities.

2. **Whistleblower Reports (2020-Present):**

   Numerous whistleblower complaints and reports from concerned stakeholders highlighted mismanagement and non-compliance in Medicaid funding. These reports, submitted to both state and federal agencies, were either ignored or inadequately addressed, exacerbating systemic inefficiencies.

3. **Failure to Address ADA Accommodations (2021-Present):**

   Specific instances of non-compliance with ADA accommodations emerged in 2021, with requests for transparency and accessible communication routinely denied, impacting program beneficiaries and whistleblowers alike.

4. **FOIA Denials and Delays (2022-Present):**

   Requests for public records under FOIA were systematically denied or delayed starting in 2022, hindering transparency and obstructing accountability efforts.

5. **Significant Lapses in Accountability (2023-2024):**

   Financial audits and oversight mechanisms revealed substantial gaps in documentation and reporting during this period, with critical records either unavailable or incomplete. This failure directly affected the program's ability to provide consistent services to Medicaid beneficiaries.

6. **Ongoing Violations (2024):**

   As of 2024, the systemic mismanagement continues unabated, with no evidence of meaningful federal or state intervention to correct these issues. This includes the failure to implement accountability measures, conduct thorough audits, or address whistleblower allegations.

Key Milestones

- **2015-2019:** Early reports of inefficiencies and mismanagement go unaddressed.
- **2020:** Whistleblower disclosures to state and federal agencies highlight systemic issues.
- **2021:** ADA accommodation failures escalate, impacting accessibility for program beneficiaries and stakeholders.
- **2022-2024:** Widespread FOIA non-compliance prevents transparency and accountability.

- **2023-2024:** Critical financial records remain incomplete, audits reveal gaps, and corrective actions are absent.

Conclusion

The timeline reflects a persistent and escalating pattern of gross mismanagement over several years, marked by failures at both state and federal levels. Immediate intervention is essential to mitigate ongoing harm to Medicaid beneficiaries and restore public trust in the administration of taxpayer-funded programs.

4. How Did You Discover This Action? - Gross Mismanagement

Description:

Persistent failure to manage federally allocated Medicaid funds within the Connecticut Medicaid ABI Waiver Program. Evidence includes incomplete financial audits, insufficient oversight mechanisms, and lack of coordination among federal and state agencies, jeopardizing the program's integrity and taxpayers' funds.

Discovery Timeline and Sources

1. **Personal Experience as a Medicaid Consumer Advocate (2015-Present):**

   Through years of direct involvement as a consumer advocate for individuals with acquired brain injuries (ABI), systemic issues in Medicaid fund allocation and program management became apparent. Reports of service disruptions, inconsistent reimbursements, and poor administrative oversight were consistently raised by program participants and providers.

2. **FOIA Requests and Denials (2022-2024):**

   Formal Freedom of Information Act (FOIA) requests were submitted to obtain records on Medicaid program operations, including provider registry information, financial audits, and compliance reports. These requests were systematically denied or delayed, revealing a lack of transparency and accountability within the system.

3. **Whistleblower Reports and Disclosures (2020-Present):**

   Whistleblower reports from within state agencies and contracted service providers

highlighted mismanagement of funds and insufficient oversight. These disclosures corroborated ongoing issues and indicated systemic failures across multiple agencies.

4. **Failed ADA Accommodations and Accessibility Barriers (2021-Present):**
   Attempts to access program-related records and services revealed ADA non-compliance, including the failure to provide accessible communication formats and reasonable accommodations for individuals with disabilities. This further obstructed transparency and accountability efforts.
5. **Incomplete Financial Audits and Reporting (2023-2024):**
   Reviews of publicly available financial audits and government reports indicated significant gaps in documentation and discrepancies in fund allocation. These findings were consistent with whistleblower disclosures and personal observations of systemic inefficiencies.
6. **Stakeholder Feedback and Advocacy Efforts (2018-Present):**
   Continuous feedback from Medicaid beneficiaries, healthcare providers, and advocacy organizations reinforced concerns about mismanagement, service inconsistencies, and the lack of corrective actions by responsible agencies.

Key Observations

- **Inaccessible Records:** Repeated FOIA denials and incomplete audit reports hindered transparency.

- **Service Disruptions:** Reports from beneficiaries and providers revealed lapses in critical Medicaid services due to poor management.
- **Whistleblower Consistency:** Multiple reports from internal and external stakeholders consistently pointed to systemic mismanagement.
- **Lack of Accountability:** Evidence of coordination failures between federal and state agencies highlighted the absence of effective oversight mechanisms.

Conclusion

The discovery of gross mismanagement was a cumulative process involving FOIA requests, whistleblower reports, stakeholder feedback, and direct observations of systemic failures. The consistent pattern of issues across multiple years and sources underscores the urgent need for comprehensive corrective actions to restore accountability and integrity to the Connecticut Medicaid ABI Waiver Program.

5. What Additional Facts Support Your Allegation? - Gross Mismanagement

Description:

Persistent failure to manage federally allocated Medicaid funds within the Connecticut Medicaid ABI Waiver Program. Evidence includes incomplete financial audits, insufficient oversight mechanisms, and lack of coordination among federal and state agencies, jeopardizing the program's integrity and taxpayers' funds.

Supporting Facts

1. **Incomplete and Delayed Financial Audits:**
    - **Fact:** Publicly available audit reports lack critical financial details, including fund allocation records and provider payment data. Annual audits mandated under Medicaid regulations (42 CFR § 431.16) are incomplete or delayed.
    - **Evidence:** Reviews of Connecticut State Auditors' reports and federal CMS audits reveal unaddressed discrepancies in Medicaid fund distribution and utilization.
2. **Lack of Accountability Measures:**
    - **Fact:** Key oversight bodies, including the Connecticut Department of Social Services (DSS) and the Office of the State Comptroller, failed to implement effective accountability mechanisms for monitoring Medicaid expenditures.
    - **Evidence:** Whistleblower disclosures and stakeholder complaints indicate that funds were mismanaged without adequate tracking systems or follow-up actions.

3. **Service Disruptions and Beneficiary Impact:**
    - **Fact:** Medicaid ABI Waiver Program participants experienced service interruptions due to delayed provider payments and administrative inefficiencies.
    - **Evidence:** Testimonies from affected beneficiaries and providers document cases of delayed reimbursements, resulting in lapses in care and service quality.
4. **Whistleblower Reports of Mismanagement:**
    - **Fact:** Multiple whistleblowers within state agencies and contracted service providers have reported systemic failures in fund management, including overpayments, underpayments, and misuse of federal Medicaid funds.
    - **Evidence:** Official whistleblower reports submitted to federal and state oversight bodies detail persistent mismanagement practices over several years.
5. **FOIA Non-Compliance:**
    - **Fact:** Systematic denials of FOIA requests for financial and operational records indicate deliberate obfuscation by state agencies.
    - **Evidence:** FOIA requests submitted between 2022 and 2024 were either denied or delayed without valid legal justification, violating 5 U.S.C. § 552.
6. **Failure to Implement Corrective Actions:**
    - **Fact:** Federal agencies, including the Centers for Medicare & Medicaid Services (CMS), failed to enforce remedial measures to address identified deficiencies.
    - **Evidence:** CMS oversight reports highlight repeated compliance failures without evidence of substantive enforcement actions or penalties.

7. **Discrepancies in Provider Records:**
    - **Fact:** Provider registry records for the ABI Waiver Program lack updated enrollment statuses, areas of specialty, and disciplinary actions.
    - **Evidence:** Reviews of publicly available registry data reveal outdated or incomplete information, raising concerns about transparency and oversight.
8. **Coordination Failures Between Agencies:**
    - **Fact:** Federal and state agencies, including CMS, DSS, and the Office of the State Comptroller, failed to coordinate effectively to ensure Medicaid compliance.
    - **Evidence:** Internal communications and agency reports point to breakdowns in inter-agency coordination, leaving systemic issues unaddressed.
9. **Impacts on Taxpayer Funds:**
    - **Fact:** Mismanagement of federal Medicaid allocations resulted in wasted taxpayer dollars.
    - **Evidence:** Financial discrepancies identified in state audits suggest improper use of funds intended for the ABI Waiver Program.
10. **Repeated Program Violations:**
    - **Fact:** The Connecticut Medicaid ABI Waiver Program has faced repeated allegations of non-compliance with Medicaid regulations (42 U.S.C. § 1396 et seq.) over the past decade.
    - **Evidence:** Historical records and legal cases involving the program highlight a pattern of systemic failures in meeting federal requirements.

Conclusion

The evidence underscores a persistent and systemic failure to manage Medicaid funds effectively within the Connecticut Medicaid ABI Waiver Program. This mismanagement compromises the program's integrity, harms beneficiaries, and wastes taxpayer resources. The lack of corrective actions and ongoing failures in transparency, accountability, and compliance necessitate immediate federal intervention.

1. Who Took the Action? - Abuse of Authority

Description:

Deliberate obstruction of transparency and ADA compliance through denials of FOIA requests and failure to provide ADA-required accommodations. Evidence highlights actions by federal and state officials that undermine whistleblower protections and public accountability, violating constitutional rights under the First, Fifth, and Fourteenth Amendments.

Federal Officials and Entities

1. **Name:** Merrick B. Garland

   Title: U.S. Attorney General

   Position in Chain of Command: Head of the U.S. Department of Justice (DOJ), overseeing all DOJ divisions, including the Civil Rights Division.

   Role: Failed to ensure DOJ compliance with FOIA, ADA accommodations, and whistleblower protections.

2. **Name:** Kristen Clarke

   Title: Assistant Attorney General, Civil Rights Division

   Position in Chain of Command: Head of the Civil Rights Division, reporting directly to the Attorney General.

   Role: Did not enforce ADA and FOIA compliance within the Civil Rights Division, undermining public accountability.

3. **Name:** Chiquita Brooks-LaSure

   Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

Position in Chain of Command: Leader of CMS, directly overseeing Medicaid program implementation.

Role: Failed to address systemic violations in Medicaid programs, including ADA compliance and whistleblower protection failures.

4. **Name:** Xavier Becerra

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   Position in Chain of Command: Federal head of HHS, overseeing all healthcare-related programs, including Medicaid.

   Role: Did not enforce oversight mechanisms to ensure Medicaid program compliance and ADA accommodations.

5. **Name:** Gene L. Dodaro

   Title: Comptroller General, U.S. Government Accountability Office (GAO)

   Position in Chain of Command: Chief of GAO, responsible for federal program audits and accountability reviews.

   Role: Failed to initiate audits or reviews addressing transparency and mismanagement in the Medicaid ABI Waiver Program.

6. **Name:** Christi Grimm

   Title: Inspector General, U.S. Department of Health and Human Services (OIG HHS)

   Position in Chain of Command: Independent federal watchdog overseeing HHS programs, including Medicaid.

   Role: Did not intervene despite whistleblower disclosures and systemic ADA violations.

State Officials and Entities

1. **Name:** Ned Lamont

   Title: Governor of Connecticut

   Position in Chain of Command: Chief executive of the State of Connecticut, overseeing all state agencies, including Medicaid.

   Role: Did not take corrective actions to address systemic failures within the Connecticut Medicaid ABI Waiver Program.

2. **Name:** Andrea Barton Reeves

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   Position in Chain of Command: Head of DSS, responsible for Medicaid program implementation at the state level.

   Role: Failed to ensure ADA compliance and transparency in the ABI Waiver Program.

3. **Name:** William Tong

   Title: Attorney General, State of Connecticut

   Position in Chain of Command: State legal authority, responsible for enforcing state and federal laws.

   Role: Did not investigate or prosecute ADA and FOIA violations reported within state agencies.

4. **Name:** Yamuna Menon

   Title: General Counsel/Assistant State Comptroller, Office of the State Comptroller

   Position in Chain of Command: Legal advisor for the State Comptroller's Office.

Role: Claimed "no responsive records" exist for key FOIA requests, obstructing transparency.

5. **Name:** Jeffrey Beckham

   Title: Secretary, Connecticut Office of Policy and Management

   Position in Chain of Command: State official responsible for budget oversight and coordination among state agencies.

   Role: Did not enforce financial accountability measures for Medicaid fund management.

6. **Name:** Manisha Juthani, MD

   Title: Commissioner, Connecticut Department of Public Health

   Position in Chain of Command: State official overseeing public health programs.

   Role: Failed to address systemic health and safety risks tied to Medicaid program failures.

Oversight Bodies and Congressional Officials

1. **Name:** James Comer

   Title: Chair, House Committee on Oversight and Accountability

   Position in Chain of Command: Federal oversight authority on government transparency and accountability.

   Role: Did not investigate systemic FOIA and ADA violations impacting Medicaid beneficiaries.

2. **Name:** Gary Peters

   Title: Chair, Senate Committee on Homeland Security and Governmental Affairs

Position in Chain of Command: Senate leader for oversight of federal agency operations.

Role: Failed to hold federal agencies accountable for Medicaid program failures.

3. **Name:** Dick Durbin

   Title: Chair, Senate Judiciary Committee

   Position in Chain of Command: Federal oversight of legal compliance in federal agencies.

   Role: Did not address whistleblower retaliation and systemic ADA violations in federal programs.

Conclusion

The individuals and entities listed above played key roles in obstructing transparency, denying ADA accommodations, and failing to protect whistleblowers, resulting in significant harm to public accountability and Medicaid beneficiaries. Their inactions highlight systemic abuse of authority requiring immediate intervention.

2. What Action Did They Take? - Abuse of Authority

Description:

Deliberate obstruction of transparency and ADA compliance through denials of FOIA requests and failure to provide ADA-required accommodations. Evidence highlights actions by federal and state officials that undermine whistleblower protections and public accountability, violating constitutional rights under the First, Fifth, and Fourteenth Amendments.

Federal Officials and Entities

1. **Merrick B. Garland**

   Action Taken:

   - Failed to ensure DOJ divisions complied with FOIA transparency standards and ADA accommodations.
   - Allowed systemic delays and lack of enforcement for whistleblower protections.
   - Did not initiate corrective measures despite clear evidence of non-compliance.

2. **Kristen Clarke**

   Action Taken:

   - Did not enforce ADA requirements or ensure FOIA accommodations were provided by the Civil Rights Division.
   - Allowed denials of requests without detailed justifications or statutory basis, violating FOIA and ADA regulations.
   - Ignored whistleblower disclosures highlighting systemic failures.

3. **Chiquita Brooks-LaSure**

   Action Taken:

   - Failed to implement oversight measures ensuring Medicaid program compliance with ADA standards.
   - Did not enforce accountability for state-level violations or escalate systemic issues impacting transparency and service delivery.
   - Neglected whistleblower reports identifying mismanagement and ADA violations in Medicaid programs.

4. **Xavier Becerra**

   Action Taken:

   - Allowed systemic inaction by HHS and its subdivisions, including CMS and OCR, in addressing ADA and FOIA compliance.
   - Failed to enforce measures ensuring federally allocated funds were managed transparently.
   - Did not address barriers to accessibility or whistleblower retaliation in federally funded programs.

5. **Gene L. Dodaro**

   Action Taken:

   - Did not initiate audits or reviews addressing systemic non-compliance with FOIA, ADA, and whistleblower protections.

- Failed to ensure GAO fulfilled its oversight responsibilities to safeguard taxpayer funds and public accountability.

6. **Christi Grimm**

   Action Taken:

   - Ignored whistleblower complaints and failed to investigate systemic ADA and FOIA violations reported within HHS-administered programs.
   - Did not enforce HHS OIG oversight responsibilities, allowing abuse of authority to persist unchecked.

State Officials and Entities

1. **Ned Lamont**

   Action Taken:

   - Did not use executive authority to address systemic failures in ADA compliance and Medicaid program transparency.
   - Allowed state agencies to deny FOIA requests and obstruct ADA-required accommodations.
   - Failed to ensure public accountability despite multiple reports of systemic violations.

2. **Andrea Barton Reeves**

   Action Taken:

- Did not enforce DSS compliance with ADA standards or ensure Medicaid transparency.
- Allowed denials of FOIA requests for Medicaid provider information essential to accountability.
- Ignored whistleblower disclosures identifying critical programmatic failures.

3. **William Tong**

   Action Taken:

   - Did not investigate ADA and FOIA violations reported within Connecticut agencies.
   - Failed to prosecute actions undermining whistleblower protections and public accountability.
   - Allowed systemic abuse of authority to persist unaddressed.

4. **Yamuna Menon**

   Action Taken:

   - Obstructed transparency by asserting "no responsive records" exist for key FOIA requests related to Medicaid program accountability.
   - Did not enforce compliance with state and federal public records laws, hindering public oversight.
   - Failed to provide accessible records as mandated under ADA standards.

5. **Manisha Juthani, MD**

   Action Taken:

- Did not intervene to address systemic health and safety risks linked to Medicaid program failures.
- Ignored ADA violations affecting access to critical health information for Medicaid beneficiaries.
- Failed to collaborate with other state agencies to ensure accountability.

6. **Jeffrey Beckham**

   Action Taken:

   - Did not enforce financial accountability for Medicaid funds allocated through the ABI Waiver Program.
   - Allowed state agencies to evade public oversight by denying FOIA requests and ADA accommodations.
   - Did not establish transparency measures to address systemic abuse.

Oversight Bodies and Congressional Officials

1. **James Comer**

   Action Taken:

   - Did not hold federal agencies accountable for ADA and FOIA violations in Medicaid programs.
   - Failed to initiate hearings or oversight measures addressing systemic abuse of authority.

- Ignored whistleblower reports identifying failures in transparency and compliance.

2. **Gary Peters**

   Action Taken:

   - Did not investigate federal agencies' failures to enforce ADA, FOIA, and whistleblower protections.
   - Neglected to ensure oversight mechanisms were implemented to prevent abuse of authority.
   - Allowed systemic failures to persist unchallenged.

3. **Dick Durbin**

   Action Taken:

   - Did not address systemic retaliation against whistleblowers reporting ADA and FOIA violations.
   - Failed to use judiciary oversight powers to mandate compliance and accountability.
   - Allowed constitutional violations to persist in federally funded programs.

Conclusion

The listed individuals and entities took deliberate actions—or failed to act—resulting in systemic abuse of authority. These actions obstruct transparency, deny ADA accommodations, and

undermine whistleblower protections, violating federal laws and constitutional rights. Immediate corrective measures are essential to restore accountability and public trust.

3. When Did This Occur? - Abuse of Authority

Description:

Deliberate obstruction of transparency and ADA compliance through denials of FOIA requests and failure to provide ADA-required accommodations. Evidence highlights actions by federal and state officials that undermine whistleblower protections and public accountability, violating constitutional rights under the First, Fifth, and Fourteenth Amendments.

Comprehensive Timeline and Details of Occurrence

1. Initial Acts of Non-Compliance

- **Start Date:** January 1, 2023
- **Description:**

  Systematic failures to comply with federal requirements began in early 2023. This included refusals to:

  - Respond to FOIA requests promptly or completely under **5 U.S.C. § 552**.
  - Honor ADA accommodation requests under **42 U.S.C. § 12132** and **29 U.S.C. § 794**.
  - Provide requested transparency regarding Medicaid ABI Waiver Program records.
- **Evidence:**
  - Ignored FOIA requests submitted to state and federal agencies for records on Medicaid provider accountability and expenditures.

- Refusal to confirm ADA-compliant communication methods, including providing records in accessible formats and summaries.

- **Notable Incidents:**
  - Initial denials lacked any justification or citation of statutory exemptions, indicating a pattern of obstruction.
  - Early whistleblower disclosures met with dismissive responses or retaliation.

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2. Escalation of Non-Compliance

- **Timeframe:** Mid-2023 to Present (December 2024)
- **Description:**

  Following the initial obstructions, agency actions escalated to include:
  - Categorical rejections of FOIA requests based on vague or unfounded grounds.
  - Refusal to comply with whistleblower protections under **5 U.S.C. § 2302(b)(8)**, including ignoring reports of systemic fraud and mismanagement.
  - Denials of ADA accommodations, further exacerbating barriers for individuals with disabilities.
- **Evidence:**
  - Multiple FOIA responses cited "No Responsive Records" despite clear evidence that relevant records were within the agency's custody.
  - Whistleblower complaints about Medicaid fund mismanagement disregarded or redirected without resolution.

- **Notable Incidents:**
    - Instances where FOIA requests for Connecticut Medicaid ABI Waiver Program records were marked "Closed" without explanation, preventing any meaningful oversight or public accountability.
    - Failures by senior officials to address escalating non-compliance even after explicit notifications.

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3. Significant Violations in 2024

- **Escalation Point:** November 8, 2024
- **Description:**

  Agencies and officials actively obstructed transparency by:
    - Marking critical FOIA cases as "Closed" without fulfilling statutory obligations to provide records or valid exemptions under **5 U.S.C. § 552(b)**.
    - Ignoring formal appeals submitted to oversight bodies, including the **Office of Government Information Services (OGIS)** and **DOJ Civil Rights Division**.
- **Evidence:**
    - Records from the U.S. Department of State affirming its refusal to provide responsive records for FOIA Case #F-2025-03145.
    - Correspondence documenting systemic failures to meet ADA accommodations, such as accessible documents, simplified summaries, and email-only communication.

- **Notable Incidents:**
    - On November 21, 2024, FOIA Case #F-2025-03145 was officially marked "Closed" without explanation, violating procedural due process.
    - Appeals submitted to **DOJ** and **HHS** were met with non-substantive responses, further delaying accountability.

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4. Ongoing and Systemic Failures

- **Timeframe:** November 2024 to Present
- **Description:**

  Despite multiple formal appeals and follow-ups, agencies and officials failed to:
    - Address systemic violations of ADA and FOIA obligations.
    - Provide records critical to public health, Medicaid oversight, and whistleblower protections.
- **Evidence:**
    - Continuous correspondence from whistleblowers and advocates detailing unresolved violations and escalating public safety concerns.
    - Agencies persistently failed to disclose names of responsible personnel or statutory justifications for record denials.
- **Notable Incidents:**
    - As of December 2024, no substantive responses or records have been provided, directly impacting Medicaid beneficiaries reliant on the ABI Waiver Program.

Conclusion

The abuse of authority occurred over a nearly two-year period, characterized by escalating violations of transparency, ADA compliance, and public accountability. The pattern of obstruction and non-compliance by federal and state officials persists despite multiple formal requests, appeals, and notifications of legal obligations. These ongoing actions represent a deliberate disregard for federal statutes, constitutional protections, and the rights of whistleblowers, taxpayers, and vulnerable populations. Immediate corrective measures are imperative to prevent further harm and restore public trust.

4. How Did You Discover This Action? - Abuse of Authority

Description:

Deliberate obstruction of transparency and ADA compliance through denials of FOIA requests and failure to provide ADA-required accommodations. Evidence highlights actions by federal and state officials that undermine whistleblower protections and public accountability, violating constitutional rights under the First, Fifth, and Fourteenth Amendments.

Comprehensive and Detailed Discovery Process

1. Direct Impact from FOIA Request Denials

- **Initial Request Experience:**

  I submitted multiple FOIA requests to federal and state agencies, including the **U.S. Department of State**, **HHS**, and **DOJ**, seeking information critical to Medicaid oversight, ADA enforcement, and whistleblower protections. Despite providing detailed records, case numbers, and accommodations for my disabilities, the requests were either ignored, improperly denied, or marked as "Closed" without substantive response.

- **Examples of FOIA Denials:**

  - **Case #F-2025-03145**: The U.S. Department of State claimed no responsive records existed despite clear evidence that such records were under their purview.
  - Agencies failed to cite valid FOIA exemptions under **5 U.S.C. § 552(b)**, instead providing vague or irrelevant justifications, obstructing access to crucial records.

2. ADA Accommodation Violations and Barriers

- **Failure to Honor ADA Requests:**

  My FOIA requests included explicit ADA accommodation requirements, such as:

  - Providing email-only communication.
  - Delivering accessible, screen-reader-compatible PDFs.
  - Including simplified summaries for complex documents.
  - Embedding response text directly in email bodies.

- **Observed Violations:**

  Agencies consistently ignored these accommodations, violating **42 U.S.C. § 12132** (ADA Title II) and **29 U.S.C. § 794** (Section 504 of the Rehabilitation Act). For example:

  - Responses required navigating inaccessible portals.
  - Key documents were provided in formats incompatible with assistive technologies.
  - Denials lacked accompanying justifications or detailed summaries.

3. Escalation by Whistleblower Reports

- **Whistleblower Disclosures:**

  As a whistleblower and advocate, I received corroborating reports from other stakeholders, including:

  - Medicaid providers frustrated by the lack of oversight and financial accountability in the ABI Waiver Program.
  - Beneficiaries who faced service disruptions due to mismanagement.

- State and federal employees who witnessed internal failures but feared retaliation under inadequate whistleblower protections.

- **Corroborated Failures:**

  Reports highlighted deliberate non-compliance, systemic fraud, and barriers to transparency that aligned with my own experiences, underscoring the depth of abuse.

4. Documented Patterns of Obstruction

- **Repeated Lack of Transparency:**

  Agencies demonstrated a recurring pattern of:

  - Providing non-substantive or contradictory responses to FOIA and whistleblower inquiries.
  - Closing cases without addressing the core issues or fulfilling requests.
  - Avoiding accountability by failing to name responsible personnel or disclose internal communications.

- **Notable Incidents:**

  - Communications with the **Office of Information Access Liaison (State Department)** revealed procedural deficiencies, including the absence of legally mandated justifications for withheld records.
  - Follow-up appeals to **DOJ OIG**, **CMS**, and **GAO** were met with either silence or vague acknowledgments without resolution.

5. Evidence from Public Oversight Failures

- **Public Documentation Gaps:**

  Publicly available records and audits failed to address the systemic issues reported, confirming that agencies were not maintaining adequate documentation or following compliance protocols.

  - For example, Medicaid oversight records lacked evidence of any recent audits or investigations into ABI Waiver Program administration.

- **Transparency Barriers:**

  Attempts to access public financial records through state and federal portals repeatedly failed due to incomplete or outdated systems.

6. Monitoring of Agency Communications

- **Inconsistent Messaging:**

  Monitoring agency responses revealed discrepancies between public statements and actions:

  - Agencies publicly claimed transparency while denying valid FOIA requests.
  - Internal communications obtained from whistleblower disclosures showed deliberate attempts to avoid addressing ADA violations and systemic failures.

7. Escalation to Advocacy and Oversight Bodies

- **Interventions by Oversight Entities:**

  Efforts to engage advocacy groups and federal oversight bodies, such as the **Office of Government Information Services (OGIS)** and **DOJ Civil Rights Division**, further

revealed systemic barriers. These entities acknowledged deficiencies but failed to provide timely or effective intervention.

Conclusion

The discovery of these abuses of authority emerged through a combination of personal experiences, corroborated whistleblower disclosures, documented agency failures, and persistent transparency barriers. The systemic nature of these violations reflects deliberate obstruction by responsible officials, requiring immediate corrective action to restore compliance with federal laws and constitutional protections.

5. What Additional Facts Support Your Allegation? - Abuse of Authority

Description:

Deliberate obstruction of transparency and ADA compliance through denials of FOIA requests and failure to provide ADA-required accommodations. Evidence highlights actions by federal and state officials that undermine whistleblower protections and public accountability, violating constitutional rights under the First, Fifth, and Fourteenth Amendments.

Comprehensive and Detailed Additional Facts

1. Pattern of FOIA Denials Without Legal Justification

- **Improperly Closed Requests:**

  Numerous FOIA requests, including **Case #F-2025-03145**, were marked as "Closed" without substantive responses or valid exemptions under **5 U.S.C. § 552(b)**. Agencies consistently failed to:

  - Provide a **Vaughn Index** or detailed explanation for redactions or denials.
  - Cite specific legal grounds for withholding requested records.

- **Obstructive Practices:**

  Agencies imposed barriers such as:

  - Redirecting requests to inaccessible external portals.
  - Requiring the use of password-protected links incompatible with ADA accommodations.
  - Refusing to identify responsible personnel or decision-makers in responses.

2. Systematic ADA Accommodation Violations

- **Failure to Provide Reasonable Accommodations:**

  Despite explicit ADA requests based on cognitive impairments resulting from a traumatic brain injury, agencies repeatedly:

  - Failed to use **email-only communication** as requested.
  - Denied requests to embed text directly in the email body for screen-reader compatibility.
  - Provided documents in inaccessible formats, violating **42 U.S.C. § 12132** (ADA Title II) and **29 U.S.C. § 794** (Section 504 of the Rehabilitation Act).

- **Evidence of Non-Compliance:**

  - Multiple correspondences lacked accessible formatting, rendering the information unusable for individuals with disabilities.
  - Requests for simplified summaries of complex records were ignored, creating further barriers to understanding.

3. Whistleblower Disclosures Highlighting Agency Failures

- **Corroborating Testimonies:**

  Whistleblowers within federal and state agencies reported systemic efforts to avoid accountability, including:

  - Suppressing records related to Medicaid oversight and ADA compliance.
  - Failing to address internal reports of non-compliance with federal transparency and anti-discrimination laws.

- **Retaliation Risks:**

  Whistleblowers expressed concerns about retaliation, citing inadequate protections under **5 U.S.C. § 2302(b)(8)** (Whistleblower Protection Act).

4. Lack of Oversight and Accountability

- **State and Federal Coordination Failures:**

  Agencies failed to collaborate effectively to address known issues within the Medicaid ABI Waiver Program. For example:

  - The **Connecticut Department of Social Services (DSS)** and **Office of the State Comptroller** failed to provide requested financial records to federal oversight entities.
  - Federal agencies, including **CMS** and **OCR**, did not enforce corrective actions or audits to address these gaps.

- **Absence of Oversight Reports:**

  Publicly available audits and compliance reviews failed to address systemic transparency barriers, raising questions about the thoroughness of oversight mechanisms.

5. Procedural Deficiencies in FOIA Processing

- **Delayed or Incomplete Responses:**

  Agencies consistently exceeded statutory deadlines under **5 U.S.C. § 552(a)(6)(A)** without providing updates or estimated completion dates. This prolonged the lack of access to critical information.

- **Failure to Identify Decision-Makers:**

  Communications omitted the names, titles, and roles of individuals responsible for processing FOIA requests, violating procedural fairness and transparency standards.

6. Constitutional Violations

- **First Amendment – Right to Public Information:**

  FOIA denials obstructed the constitutional right to access government information essential for public accountability (DOJ v. Reporters Committee for Freedom of the Press, 1989).

- **Fifth Amendment – Due Process:**

  The lack of transparency and failure to address ADA accommodations constituted a denial of due process rights (Mathews v. Eldridge, 1976).

- **Fourteenth Amendment – Equal Protection:**

  Discriminatory practices against individuals with disabilities violated equal protection guarantees, particularly in the context of federally funded programs (Tennessee v. Lane, 2004).

7. Documented Financial Mismanagement

- **Failure to Track Medicaid Funds:**

  Agencies demonstrated inadequate tracking and reporting of Medicaid allocations for the ABI Waiver Program, jeopardizing the program's sustainability and beneficiaries' access to services.

- **Evidence of Fraudulent Practices:**

  Internal communications revealed discrepancies between reported and actual fund utilization, suggesting potential misuse of taxpayer dollars.

8. Evidence of Deliberate Obstruction

- **Attempts to Avoid Accountability:**

  Internal records obtained through whistleblower disclosures indicated efforts to suppress evidence of non-compliance, including:

  - Delaying responses to FOIA requests to avoid public scrutiny.
  - Failing to maintain accurate records of ADA compliance or Medicaid audits.

- **Resistance to Independent Oversight:**

  Federal agencies did not adequately support independent reviews or third-party audits, undermining accountability efforts.

9. Broader Public Impact

- **Harm to Vulnerable Populations:**

  The lack of transparency and ADA compliance directly harmed individuals reliant on Medicaid services, particularly brain injury survivors dependent on the ABI Waiver Program.

- **Erosion of Public Trust:**

  Systematic failures in transparency and accountability eroded public confidence in the integrity of federal and state programs.

Conclusion

The additional facts provided illustrate a pervasive pattern of abuse of authority across multiple agencies, resulting in significant harm to beneficiaries, taxpayers, and whistleblowers. These actions reflect systemic violations of federal laws and constitutional protections, demanding immediate corrective action to restore transparency, accountability, and compliance.

Gross Waste of Funds

Description:

Improper use of Medicaid funds due to inefficiencies, overpayments to service providers, and failure to track expenditures effectively. Evidence demonstrates a systemic lack of financial accountability, leading to the misuse of taxpayer dollars.

Individuals and Entities Responsible

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command:** Federal executive responsible for Medicaid oversight under CMS.
    - **Role in the Mismanagement:**
        - Failed to implement robust oversight mechanisms to monitor state-level Medicaid spending.
        - Did not initiate audits despite evidence of inefficiencies.
2. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command:** Federal administrator for Medicaid compliance and funding.
    - **Role in the Mismanagement:**

- Neglected to enforce Medicaid financial tracking standards in Connecticut.
- Failed to demand accurate expenditure data and address known discrepancies.

3. **Ned Lamont**
    - **Title:** Governor of Connecticut
    - **Position in Chain of Command:** Chief executive overseeing Medicaid program implementation and accountability.
    - **Role in the Mismanagement:**
        - Did not investigate or rectify systemic inefficiencies in the ABI Waiver Program.
        - Failed to allocate state resources for proper financial oversight.
4. **Andrea Barton Reeves**
    - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
    - **Position in Chain of Command:** State administrator responsible for Medicaid programs.
    - **Role in the Mismanagement:**
        - Allowed systemic inefficiencies, including overpayments and unverified claims.
        - Did not establish sufficient financial tracking mechanisms.

5. **Yamuna (Yam) Menon**
    - **Title:** General Counsel/Assistant State Comptroller, Connecticut
    - **Position in Chain of Command:** Legal authority for state financial accountability.
    - **Role in the Mismanagement:**
        - Failed to enforce transparency and compliance in Medicaid fund allocation.
        - Neglected to conduct audits to identify mismanagement.
6. **William Tong**
    - **Title:** Attorney General, State of Connecticut
    - **Position in Chain of Command:** State legal authority for enforcing compliance with laws.
    - **Role in the Mismanagement:**
        - Did not investigate or prosecute financial irregularities.
        - Ignored whistleblower disclosures and public complaints.
7. **Everett L. Handford**
    - **Title:** Regional Director, HHS Region 1
    - **Position in Chain of Command:** Federal representative for Medicaid operations in Connecticut.
    - **Role in the Mismanagement:**

- Neglected to conduct audits or enforce Medicaid oversight standards.

8. **Marjorie Sozanski**
    - **Title:** Director, Connecticut Medicaid Fraud Control Unit (MFCU)
    - **Position in Chain of Command:** State investigator for Medicaid fraud and abuse.
    - **Role in the Mismanagement:**
        - Did not investigate fraudulent practices or financial mismanagement in the ABI Waiver Program.
9. **John C. Geragosian and Robert M. Kane**
    - **Title:** State Auditors, Connecticut Auditors of Public Accounts
    - **Position in Chain of Command:** Independent oversight body for Medicaid expenditures.
    - **Role in the Mismanagement:**
        - Failed to conduct thorough audits or address discrepancies in financial reporting.
10. **Jeffrey Beckham**
    - **Title:** Secretary, Connecticut Office of Policy and Management (OPM)
    - **Position in Chain of Command:** Senior state official responsible for budgetary oversight.
    - **Role in the Mismanagement:**

- Allowed mismanagement to persist without intervention.
- Did not coordinate with federal agencies to resolve irregularities.

11. **CMS Medicaid Program Integrity Director**
    - **Title:** Federal official responsible for Medicaid compliance.
    - **Role in the Mismanagement:**
        - Failed to enforce federal accountability standards in Connecticut's Medicaid programs.
        - Did not escalate issues of inefficiency to higher authorities.
12. **Private Auditing Firms**
    - **Title:** Independent Auditors Contracted by Connecticut DSS
    - **Position in Chain of Command:** Contractors reviewing Medicaid expenditures.
    - **Role in the Mismanagement:**
        - Overlooked systemic inefficiencies during audits.
13. **Medicaid Service Providers and Contractors**
    - **Title:** Vendors delivering services under the ABI Waiver Program.
    - **Role in the Mismanagement:**
        - Submitted improper billing claims and engaged in inefficient practices.

Conclusion

The listed individuals and entities collectively failed in their responsibility to manage Medicaid funds effectively, resulting in gross financial waste and a breach of public trust. Immediate corrective actions, transparency, and accountability are required to safeguard taxpayer dollars and restore the integrity of the ABI Waiver Program.

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Conclusion

The listed individuals and entities collectively failed in their responsibility to manage Medicaid funds effectively, resulting in gross financial waste and a breach of public trust. Immediate corrective actions, transparency, and accountability are required to safeguard taxpayer dollars and restore the integrity of the ABI Waiver Program.

2. What Action Did They Take? - Gross Waste of Funds

Description:

Improper use of Medicaid funds due to inefficiencies, overpayments to service providers, and failure to track expenditures effectively. Evidence demonstrates systemic lack of financial accountability, resulting in significant misuse of taxpayer dollars.

Detailed Actions Taken by Key Individuals and Entities

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Actions Taken:**
        - Failed to implement federal oversight mechanisms to prevent improper fund usage at the state level.
        - Did not mandate audits or issue directives for immediate corrective action despite reports of financial irregularities in Medicaid programs.
2. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Actions Taken:**
        - Neglected to enforce Medicaid financial compliance and reporting standards in Connecticut.
        - Failed to require Connecticut DSS to reconcile discrepancies in expenditures and address improper payments to providers.

3. **Ned Lamont**
    - **Title:** Governor of Connecticut
    - **Actions Taken:**
        - Allowed systemic inefficiencies and financial mismanagement to persist under his administration.
        - Did not provide adequate state-level oversight or allocate resources to prevent improper Medicaid fund utilization.
4. **Andrea Barton Reeves**
    - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
    - **Actions Taken:**
        - Allowed overpayments and unverified billing by service providers.
        - Failed to implement transparent financial tracking systems or address known inefficiencies within the ABI Waiver Program.
5. **Yamuna (Yam) Menon**
    - **Title:** General Counsel/Assistant State Comptroller, Connecticut
    - **Actions Taken:**
        - Did not ensure financial accountability or enforce compliance with Medicaid fund allocation requirements.
        - Failed to conduct audits to address discrepancies in financial reporting.
6. **William Tong**

- **Title:** Attorney General, State of Connecticut
- **Actions Taken:**
  - Did not investigate or pursue legal actions against parties involved in the misuse of Medicaid funds.
  - Ignored whistleblower complaints and reports of systemic financial mismanagement.

7. **Everett L. Handford**
   - **Title:** Regional Director, HHS Region 1
   - **Actions Taken:**
     - Failed to conduct regional audits or investigations to ensure compliance with Medicaid financial standards.
     - Neglected to enforce accountability measures for state agencies managing Medicaid funds.
8. **Marjorie Sozanski**
   - **Title:** Director, Connecticut Medicaid Fraud Control Unit (MFCU)
   - **Actions Taken:**
     - Did not investigate fraudulent claims or financial mismanagement within the ABI Waiver Program.
     - Allowed improper billing practices to persist unchecked.
9. **John C. Geragosian and Robert M. Kane**

- **Title:** State Auditors, Connecticut Auditors of Public Accounts
- **Actions Taken:**
  - Failed to identify or address systemic inefficiencies in Medicaid fund utilization during audits.
  - Did not publish detailed findings on the mismanagement of ABI Waiver Program funds.

10. **Jeffrey Beckham**
    - **Title:** Secretary, Connecticut Office of Policy and Management (OPM)
    - **Actions Taken:**
      - Allowed mismanagement to persist without implementing intervention or oversight measures.
      - Did not coordinate with federal agencies to address financial irregularities in the program.

11. **CMS Medicaid Program Integrity Director**
    - **Title:** Director of Medicaid Program Integrity, CMS
    - **Actions Taken:**
      - Did not escalate known issues of financial inefficiency to higher federal authorities.
      - Failed to enforce Medicaid compliance standards in Connecticut.

12. **Private Auditing Firms**

- **Title:** Independent Auditors Contracted by Connecticut DSS
- **Actions Taken:**
  - Overlooked irregularities and systemic inefficiencies during audits.
  - Did not report findings that could have prompted corrective action.

13. **Medicaid Service Providers and Contractors**
    - **Title:** Medicaid Service Providers and Vendors
    - **Actions Taken:**
      - Submitted improper billing claims and failed to deliver services efficiently.
      - Did not report systemic issues to DSS or federal oversight agencies.

Conclusion

The actions—or inactions—of these individuals and entities contributed directly to the gross waste of Medicaid funds. Their collective failure to establish accountability, enforce compliance, and address inefficiencies allowed taxpayer dollars to be misused, undermining the integrity of the Medicaid ABI Waiver Program. Immediate intervention is required to restore accountability and prevent further misuse of federal and state resources.

3. When Did This Occur? - Gross Waste of Funds

Description:

Improper use of Medicaid funds due to inefficiencies, overpayments to service providers, and failure to track expenditures effectively. Evidence shows that the lack of financial accountability resulted in significant misuse of taxpayer dollars.

Detailed Timeline of Events and Actions

Phase 1: Initial Failures to Establish Accountability Mechanisms (2013–2017)

1. **Timeline:**
    - Financial mismanagement within the Connecticut Medicaid ABI Waiver Program began as early as 2013, following changes to Medicaid fund allocation policies and lack of internal checks.
2. **Evidence:**
    - **Auditor Reports:** Early internal DSS reviews identified missing provider documentation, including unverified claims and missing invoices.
    - **Whistleblower Attempts:** Several internal whistleblowers flagged the lack of standardized financial oversight protocols during this period.
3. **Impact:**
    - Opportunities for early intervention were missed, enabling systemic inefficiencies and overpayments to become embedded in program operations.

Phase 2: Escalation of Financial Irregularities and Provider Abuses (2017–2020)

1. **Timeline:**
    - Over these years, multiple warning signs of systemic waste emerged, such as unexplained increases in program costs and repeated failures in provider audits.
2. **Evidence:**
    - **Medicaid Provider Overpayments:** Records indicate that several providers received payments that exceeded contracted amounts without sufficient justification.
    - **No Reconciliations:** The lack of reconciliation processes to confirm that paid services were rendered further enabled overpayments.
    - **Investigative Inaction:** MFCU failed to investigate allegations of provider fraud, citing "insufficient resources."
3. **Impact:**
    - Unchecked irregularities further eroded program integrity, with federal funds continuously being mismanaged despite clear signs of dysfunction.

Phase 3: Federal Oversight Failures and Disregard for Transparency (2018–2021)

1. **Timeline:**
    - Despite federal requirements for accountability, oversight agencies such as CMS and HHS Region 1 failed to act decisively during this period.
2. **Evidence:**

- **CMS Medicaid Integrity Audits:** CMS did not conduct thorough audits for Connecticut's Medicaid programs during this time, despite mounting complaints from advocacy organizations.
- **FOIA Denials:** Numerous requests for transparency into Medicaid fund utilization were delayed or denied, violating FOIA statutes and further obscuring accountability.
- **Federal Notices of Non-Compliance Ignored:** Connecticut DSS received federal notices citing deficiencies in Medicaid program oversight but did not address the issues effectively.

3. **Impact:**
   - Federal inaction allowed systemic financial waste to persist, with millions of taxpayer dollars being misallocated or improperly claimed.

Phase 4: ADA and Fiscal Accountability Failures Amplified (2021–2023)

1. **Timeline:**
   - During this period, whistleblowers and advocacy groups filed formal complaints to both state and federal agencies regarding fiscal mismanagement and non-compliance with ADA accessibility standards.
2. **Evidence:**

- **Barriers to Access:** Medicaid beneficiaries reported significant delays in receiving services due to unallocated funds, mismanagement, and lack of program transparency.
- **Documented Waste:** Auditors flagged repeated instances of unclaimed or improperly allocated funds, yet no significant corrective measures were taken.
- **ADA Non-Compliance:** State and federal agencies failed to provide ADA-compliant communication methods, hindering stakeholders' ability to understand or address fiscal irregularities.

3. **Impact:**
   - Public trust in the Medicaid ABI Waiver Program eroded significantly, with beneficiaries directly harmed by delays and mismanagement.

Phase 5: Immediate and Ongoing Failures (2024–Present)

1. **Timeline:**
   - Most recently, fiscal year 2024 highlights the ongoing gross waste of funds due to entrenched inefficiencies and negligence at both state and federal levels.
2. **Evidence:**
   - **Current Discrepancies:** Recent whistleblower reports detail the ongoing overpayment of Medicaid providers and failure to recover funds improperly allocated.

- **Persistent Non-Compliance:** DSS and other agencies have yet to implement meaningful reforms to address these issues.
- **Whistleblower Retaliation:** Individuals attempting to expose these inefficiencies continue to face retaliation, further obstructing oversight efforts.

3. **Impact:**
   - Systemic waste continues to drain public resources while Medicaid recipients suffer from delays and inadequate services.

Conclusion

The gross waste of Medicaid funds within the Connecticut ABI Waiver Program is not a one-time failure but a systemic issue spanning more than a decade. This timeline highlights consistent inaction and neglect from key federal and state agencies, resulting in significant taxpayer losses and harm to vulnerable populations dependent on Medicaid services. Immediate corrective action is essential to address these ongoing violations and restore public trust in the integrity of Medicaid programs.

4. How Did You Discover This Action? - Gross Waste of Funds

Description:

Improper use of Medicaid funds due to inefficiencies, overpayments to service providers, and failure to track expenditures effectively. Evidence shows that the lack of financial accountability resulted in significant misuse of taxpayer dollars.

Comprehensive and Detailed Discovery Timeline

Phase 1: Initial Observations and Emerging Red Flags (2013–2017)

1. Inconsistent Financial Records:

- During a review of publicly available Medicaid expenditure data and state-level reports, inconsistencies emerged between allocated federal Medicaid funds and reported program expenditures.
- Certain categories of expenditures were either unaccounted for or significantly inflated without supporting documentation.

2. Provider Complaints and Anecdotal Evidence:

- Direct communication from service providers indicated delays in payments, while others reported unexplained overpayments.
- Providers shared concerns that the Department of Social Services (DSS) lacked adequate mechanisms to verify service claims.

3. Internal Whistleblower Disclosures:

- Several DSS employees confidentially disclosed concerns about the absence of a standardized auditing process to track Medicaid funds.
- These disclosures highlighted that mismanagement stemmed from systemic inefficiencies and a lack of oversight.

Phase 2: Escalation of Irregularities and Whistleblower Reports (2018–2020)

1. Access to Internal Reports and State Audit Summaries:

- Access to internal summaries revealed substantial gaps in financial audits conducted by DSS and the Connecticut Office of Policy and Management (OPM).
- Audit summaries lacked reconciliation data, with certain financial anomalies labeled as "pending review" for years without resolution.

2. Freedom of Information Act (FOIA) Requests:

- Formal FOIA requests for detailed financial records and program audits yielded insufficient responses or outright denials, raising further concerns about transparency.
- Redacted documents failed to provide clarity regarding the disposition of unspent Medicaid funds.

3. Advocacy and Beneficiary Reports:

- Advocacy organizations working with Medicaid beneficiaries documented recurring service delays attributed to unexplained funding shortages.
- Beneficiaries reported disruptions in critical services, such as in-home support and rehabilitative care, which providers cited as stemming from inconsistent fund allocation.

Phase 3: Federal Oversight and FOIA Disclosures (2021–2023)

1. Responses from Federal Agencies (CMS and HHS):

- Responses to FOIA requests from the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS) revealed a lack of federal oversight into Connecticut's Medicaid expenditures.
- CMS officials acknowledged receiving "high-level concerns" about Connecticut's ABI Waiver Program but failed to provide detailed compliance reports.

2. Whistleblower Allegations:

- Additional whistleblower disclosures directly implicated Connecticut DSS and private auditing firms in failing to detect or report financial irregularities.
- Whistleblowers described a "culture of inaction," where internal reports were ignored or suppressed to avoid federal scrutiny.

3. Public Records Analysis:

- Analysis of publicly available state budget records identified unexplained discrepancies in Medicaid expenditure categories, particularly those related to provider reimbursements.
- Significant allocations labeled as "miscellaneous expenses" lacked justification or supporting documentation.

Phase 4: Systematic Barriers to Transparency (2023–Present)

1. Denied FOIA Requests:

- Multiple FOIA requests submitted to Connecticut DSS, CMS, and related agencies were denied or returned as "no responsive records."
- This obstruction hindered the ability to identify specific instances of financial mismanagement or fraud.

2. Cross-Agency Communication Breakdown:

- Internal communications obtained through whistleblower reports revealed a lack of coordination between DSS, OPM, and the State Comptroller's Office in addressing flagged financial issues.

3. Advocacy Organization Investigations:

- Advocacy organizations conducted independent investigations into Medicaid fund allocation, discovering patterns of overpayments and service delays.
- Findings were shared with oversight agencies, but no immediate action was taken to rectify the issues.

How Discovery Led to Further Investigation

1. **Pattern Recognition:**
    - A comprehensive review of the evidence revealed recurring issues, including missing audits, unverified provider claims, and unexplained fund reallocation.
    - These patterns suggested systemic mismanagement rather than isolated errors.
2. **Independent Whistleblower Disclosures:**

- Whistleblowers corroborated findings with internal communications and evidence of systemic failures within DSS and its contracted auditors.

3. **ADA and FOIA Violations:**
   - Repeated denials of FOIA requests and failure to provide ADA accommodations for accessible communication highlighted deliberate obstructions to transparency and accountability.

Conclusion

The discovery of gross waste of funds within the Connecticut Medicaid ABI Waiver Program stems from extensive evidence, including internal whistleblower disclosures, FOIA-requested records, public budget reviews, and advocacy investigations. The systemic nature of these issues reflects deliberate negligence and a failure by state and federal agencies to enforce financial accountability and transparency, warranting immediate corrective action.

5. What Additional Facts Support Your Allegation? - Gross Waste of Funds

Description:

Improper use of Medicaid funds due to inefficiencies, overpayments to service providers, and failure to track expenditures effectively. Evidence shows that the lack of financial accountability resulted in significant misuse of taxpayer dollars.

Comprehensive and Detailed Supporting Facts

A. Audit Deficiencies and Financial Mismanagement

1. **Absence of Comprehensive Audits**
    - The Connecticut Department of Social Services (DSS) failed to conduct or provide complete and accurate audits of Medicaid expenditures within the Acquired Brain Injury (ABI) Waiver Program.
    - State Auditors of Public Accounts did not identify or resolve discrepancies in provider claims, leaving millions of dollars unaccounted for.
    - Annual reports lacked reconciliation between allocated federal Medicaid funds and actual program expenditures.
2. **Overpayments and Unverified Claims**
    - Evidence from whistleblower reports indicates overpayments to service providers who submitted unverified or incomplete claims.
    - Medicaid service providers billed for services outside their contractual scope, and no mechanism was in place to flag or investigate these discrepancies.

3. **Improper Fund Allocations**
    - Significant funds were categorized under vague or generic labels such as "miscellaneous expenditures," without supporting documentation or explanation.
    - Disproportionate increases in administrative costs were recorded with no corresponding improvements in program delivery.

B. Federal and State Oversight Failures

1. **Inadequate Federal Oversight by CMS**
    - The Centers for Medicare & Medicaid Services (CMS) did not enforce financial accountability measures for state-level Medicaid operations in Connecticut.
    - Despite receiving high-level complaints about inefficiencies and waste, CMS failed to initiate audits or corrective actions.
2. **Neglect by the Office of Policy and Management (OPM)**
    - The Connecticut Office of Policy and Management allowed systemic inefficiencies to persist without coordinating with DSS or other oversight bodies to implement corrective measures.
3. **HHS Region 1 Negligence**
    - The HHS Regional Director did not ensure that DSS complied with Medicaid program integrity standards, contributing to unchecked financial waste.

C. Whistleblower and Advocacy Disclosures

1. **Whistleblower Testimonies**
    - Internal DSS whistleblowers reported systemic mismanagement, including deliberate efforts to suppress findings of financial discrepancies to avoid federal scrutiny.
    - Whistleblower disclosures documented gaps in financial reporting, including missing expenditure details and unverified provider reimbursements.
2. **Advocacy Organization Investigations**
    - Nonprofit organizations investigating Medicaid program inefficiencies found patterns of financial irregularities, including delayed reimbursements and gaps in service delivery tied to unaccounted funds.

D. FOIA Obstruction and Transparency Failures

1. **FOIA Denials and Delays**
    - Multiple FOIA requests for detailed financial records and audits were denied, with agencies citing "no responsive records" despite clear evidence of mismanagement.
    - Delays in responding to FOIA requests further obstructed efforts to uncover the scope of financial waste.
2. **Lack of Accessible Records**

- Even when records were provided, they were heavily redacted or incomplete, failing to address critical questions regarding fund utilization and oversight responsibilities.

E. Programmatic Impact on Beneficiaries and Providers

1. **Service Disruptions for Beneficiaries**
   - Medicaid beneficiaries experienced delays in receiving critical services due to inconsistencies in fund allocation and program delivery.
   - Brain injury survivors dependent on the ABI Waiver Program faced interruptions in in-home support and rehabilitative care.
2. **Burden on Service Providers**
   - Providers reported delayed payments and excessive administrative burdens caused by inadequate financial tracking and reimbursement systems.
   - Some providers were forced to discontinue services, reducing access for Medicaid recipients.

F. Evidence of Collusion and Neglect by Contracted Auditors

1. **Auditor Failures**
   - Private auditing firms contracted by DSS failed to flag financial irregularities or report inefficiencies in their findings.

- Evidence suggests that auditors overlooked systemic issues or were not provided with the necessary data to conduct thorough reviews.

2. **Contractor Neglect**
   - Medicaid service providers and contractors engaged in improper billing practices, including duplicate claims and billing for unauthorized services.
   - No meaningful oversight was implemented to ensure that contracted entities complied with financial and operational standards.

G. Broader Implications for Public Trust and Taxpayer Funds

1. **Erosion of Public Confidence**
   - The mismanagement of Medicaid funds undermines public trust in government accountability and the equitable use of taxpayer dollars.
2. **Potential Legal Violations**
   - Non-compliance with federal statutes, including Medicaid regulations (42 U.S.C. § 1396 et seq.), FOIA (5 U.S.C. § 552), and ADA (42 U.S.C. § 12132), indicates potential violations that warrant immediate federal intervention.

Conclusion

The additional facts presented demonstrate a systemic failure across federal, state, and contracted entities to ensure the proper use of Medicaid funds. These failures have directly contributed to the misuse of taxpayer dollars, disrupted services for vulnerable populations, and perpetuated a

lack of accountability. Immediate corrective measures, transparency, and oversight are essential to restore program integrity and prevent further harm.

Comprehensive List of Individuals and Entities Responsible for Danger to Public Health

1. Federal Oversight

a. Xavier Becerra

- **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
- **Position in Chain of Command:** Federal head of HHS, overseeing all Medicaid-related programs, including state-administered waivers like the ABI Waiver Program.
- **Role in the Mismanagement:**
    - Did not establish federal intervention mechanisms to address systemic failures in Connecticut's ABI Waiver Program.
    - Failed to ensure Medicaid funds were used effectively to protect public health.

b. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** Federal administrator responsible for ensuring compliance with Medicaid standards nationwide.
- **Role in the Mismanagement:**
    - Did not enforce federal guidelines to ensure programmatic compliance by Connecticut's Medicaid program administrators.
    - Failed to take remedial action despite multiple reports of non-compliance affecting vulnerable beneficiaries.

c. Everett L. Handford

- **Title:** Regional Director, HHS Region 1
- **Position in Chain of Command:** Federal representative overseeing Medicaid operations in New England, including Connecticut.
- **Role in the Mismanagement:**
    - Neglected to require compliance with federal health and safety standards in Connecticut's ABI Waiver Program.
    - Did not intervene to address deficiencies in service delivery that jeopardized public health.

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2. State Leadership

a. Ned Lamont

- **Title:** Governor of Connecticut
- **Position in Chain of Command:** Chief executive of Connecticut, responsible for state-administered Medicaid programs.
- **Role in the Mismanagement:**
    - Did not use executive authority to investigate and rectify systemic failures in the ABI Waiver Program.
    - Failed to allocate resources to ensure the health and safety of Medicaid beneficiaries.

b. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command:** State administrator of Medicaid programs, including the ABI Waiver Program.
- **Role in the Mismanagement:**
    - Did not implement operational changes to ensure critical care delivery to brain injury survivors.
    - Overlooked program failures that placed beneficiaries at risk.

c. William Tong

- **Title:** Attorney General, State of Connecticut
- **Position in Chain of Command:** State's legal authority tasked with ensuring compliance with state and federal laws.
- **Role in the Mismanagement:**
    - Did not investigate or take legal action to address complaints of systemic non-compliance with Medicaid standards.

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3. State Medicaid Leadership

a. Jeffrey Beckham

- **Title:** Secretary, Connecticut Office of Policy and Management (OPM)
- **Position in Chain of Command:** Senior state official overseeing Connecticut's budget and financial operations.

- **Role in the Mismanagement:**
    - Allowed resource mismanagement and failed to coordinate oversight efforts to protect public health.

b. Yamuna (Yam) Menon

- **Title:** General Counsel/Assistant State Comptroller, Connecticut
- **Position in Chain of Command:** Legal authority within the State Comptroller's Office responsible for Medicaid fund accountability.
- **Role in the Mismanagement:**
    - Failed to ensure financial transparency and accountability to prevent risks to public health.

c. Medicaid Fraud Control Unit (MFCU) Director: Marjorie Sozanski

- **Title:** Director, Connecticut MFCU
- **Position in Chain of Command:** State-level investigator tasked with addressing Medicaid fraud and abuse.
- **Role in the Mismanagement:**
    - Did not investigate service failures or fraudulent practices that jeopardized Medicaid recipients' health and safety.

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4. Legislative Oversight

a. Connecticut General Assembly Human Services Committee

- **Position in Chain of Command:** Provides legislative oversight of DSS programs.
- **Role in the Mismanagement:**
    - Did not hold hearings or conduct inquiries into systemic programmatic failures within the ABI Waiver Program.

b. State Auditors of Public Accounts (John C. Geragosian and Robert M. Kane)

- **Title:** State Auditors, Connecticut Auditors of Public Accounts
- **Position in Chain of Command:** Independent oversight body for public accounts.
- **Role in the Mismanagement:**
    - Failed to identify and report systemic inefficiencies affecting public health in Medicaid-funded programs.

Summary

The individuals and entities listed above collectively contributed to systemic failures in the ABI Waiver Program, endangering the health and safety of brain injury survivors. This mismanagement demands immediate corrective action and accountability to safeguard vulnerable populations.

2. What Action Did They Take? – Danger to Public Health

Description:

The mismanagement of the Connecticut Medicaid ABI Waiver Program by federal, state, and contracted entities has directly jeopardized the health and safety of brain injury survivors. These failures include non-compliance with Medicaid regulations, lack of ADA accommodations, and insufficient oversight, all of which have resulted in inadequate care and service disruptions for vulnerable populations. Below is a comprehensive detailing of the actions and omissions that contributed to this systemic failure.

Federal Oversight Failures

1. Xavier Becerra

- **Action Taken:**
    - Did not establish or enforce oversight mechanisms within HHS to monitor Connecticut's Medicaid ABI Waiver Program.
    - Allowed gaps in program accountability that led to service failures for brain injury survivors.
    - Failed to mandate corrective actions despite reports of systemic violations affecting public health.

2. Chiquita Brooks-LaSure

- **Action Taken:**

- Did not enforce federal Medicaid standards requiring states to ensure continuity of care for beneficiaries.
- Allowed Connecticut DSS to operate the ABI Waiver Program without addressing critical failures in compliance and service delivery.
- Neglected to conduct federal-level audits or impose penalties for non-compliance, leaving programmatic failures unchecked.

3. Everett L. Handford

- **Action Taken:**
  - Failed to require corrective actions from Connecticut state agencies under his purview as HHS Region 1 Director.
  - Did not intervene to address complaints or public health risks reported by beneficiaries and whistleblowers.
  - Neglected to provide direct oversight or escalate systemic issues to CMS leadership.

State Leadership Failures

4. Ned Lamont

- **Action Taken:**
  - Did not use executive authority to initiate investigations or reforms to address deficiencies in the ABI Waiver Program.

- Allowed inadequate funding and mismanagement to persist, compromising essential healthcare services.
- Failed to establish an inter-agency task force to address widespread non-compliance and service disruptions.

5. Andrea Barton Reeves

- **Action Taken:**
  - Did not implement operational or compliance reforms within DSS to ensure adequate service delivery under the ABI Waiver Program.
  - Allowed unverified service providers and contractors to continue operating without accountability, resulting in gaps in care.
  - Overlooked systemic complaints from Medicaid beneficiaries regarding lapses in healthcare services.

6. William Tong

- **Action Taken:**
  - Failed to investigate legal violations tied to mismanagement and public health risks within the ABI Waiver Program.
  - Did not initiate lawsuits or legal actions to compel programmatic compliance with state and federal laws.
  - Ignored whistleblower complaints highlighting imminent risks to vulnerable populations.

State Medicaid Leadership Failures

7. Jeffrey Beckham

- **Action Taken:**
    - Did not address budgetary discrepancies or enforce accountability measures to prevent service failures.
    - Neglected to ensure that Medicaid funds were appropriately allocated to critical health services.
    - Allowed systemic inefficiencies to persist without remedial action.

8. Yamuna (Yam) Menon

- **Action Taken:**
    - Failed to enforce legal and financial accountability measures to protect public health.
    - Did not take action to ensure that financial mismanagement did not impact service delivery to brain injury survivors.
    - Overlooked reporting failures from contracted providers, exacerbating systemic issues.

9. Marjorie Sozanski

- **Action Taken:**
    - Did not investigate fraudulent practices or billing irregularities within the ABI Waiver Program.

- Failed to address complaints from beneficiaries and whistleblowers regarding service gaps.
- Did not escalate programmatic failures to federal authorities despite evident risks to public health.

Legislative and Oversight Failures

10. State Auditors of Public Accounts (John C. Geragosian and Robert M. Kane)

- **Action Taken:**
  - Failed to conduct comprehensive audits of Medicaid funds allocated to the ABI Waiver Program.
  - Did not identify or report on systemic inefficiencies affecting public health outcomes.
  - Allowed gaps in financial reporting and accountability to persist without addressing their impact on healthcare delivery.

11. Connecticut General Assembly Human Services Committee

- **Action Taken:**
  - Did not hold public hearings to address reported public health risks within the ABI Waiver Program.
  - Failed to exercise legislative authority to compel DSS to implement reforms or address deficiencies in service delivery.

Contractor and Provider Failures

12. Private Auditing Firms

- **Action Taken:**
    - Overlooked systemic inefficiencies and irregularities during audits of Medicaid expenditures.
    - Did not provide actionable recommendations to address financial mismanagement impacting healthcare services.

13. Medicaid Service Providers and Vendors

- **Action Taken:**
    - Submitted improper billing claims for services not rendered or delivered inadequately.
    - Did not report systemic issues or failures to DSS or federal oversight agencies.
    - Contributed to service disruptions by failing to meet contractual and regulatory obligations.

Conclusion

The actions and omissions of federal, state, and contracted entities demonstrate gross negligence and deliberate indifference to the health and safety of Medicaid beneficiaries. These failures demand immediate accountability and systemic reforms to protect public health and restore program integrity.

3. When Did This Occur? – Danger to Public Health

Description:

The mismanagement of the Connecticut Medicaid ABI Waiver Program has persisted over a decade, marked by systemic failures, lapses in oversight, and non-compliance with federal laws. These failures have directly endangered the health and safety of brain injury survivors reliant on Medicaid services. Below is a comprehensive and detailed timeline highlighting key events and patterns of negligence contributing to the ongoing public health crisis.

Detailed Timeline of Events

1. Program Establishment and Initial Oversight Failures (2010–2015):

- **Program Creation and Goals:**

  The Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program was created to provide essential services for individuals with brain injuries, enabling them to live independently in the community.

- **Early Indicators of Non-Compliance:**

  - Lack of foundational oversight mechanisms to ensure compliance with Medicaid standards, including the verification of service provider qualifications.
  - Complaints of service inconsistencies emerged, with beneficiaries reporting significant delays in accessing care.
  - Initial state audits, if conducted, failed to address these issues or establish corrective actions.

- **Federal Oversight Gaps:**
    - CMS and HHS Region 1 did not implement robust monitoring protocols for the program despite clear obligations under Medicaid law (42 U.S.C. § 1396).
    - Transparency in program operations, including service allocations and expenditures, was lacking, violating FOIA standards (5 U.S.C. § 552).

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2. Growing Complaints and Escalating Failures (2016–2020):

- **Service Delivery Interruptions:**
    - Reports of beneficiaries being denied critical services, such as cognitive rehabilitation, transportation, and case management, became more frequent.
    - Service providers consistently reported delayed reimbursements, leading to disruptions in care.
- **Whistleblower Allegations:**
    - Whistleblowers began filing complaints highlighting ADA violations, financial mismanagement, and misuse of Medicaid funds.
    - Allegations included non-compliance with ADA standards (42 U.S.C. § 12132), particularly regarding accessibility barriers for individuals with cognitive impairments.
- **State-Level Negligence:**
    - Connecticut DSS failed to take corrective actions despite clear evidence of systemic inefficiencies.

- Audits conducted by the State Comptroller and Auditors of Public Accounts either did not occur or were superficial, failing to identify discrepancies in fund allocations or service delivery.

- **Federal Inaction:**
  - CMS and HHS Region 1 were notified of the escalating issues but failed to enforce remedial measures or mandate compliance with federal Medicaid regulations.

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3. Exacerbation of Issues During the COVID-19 Pandemic (2020–2022):

- **Impact of the Pandemic:**
  - The COVID-19 pandemic amplified existing deficiencies, leaving beneficiaries without access to critical healthcare services and resources.
  - Remote communication platforms, hastily implemented during the pandemic, were not ADA-compliant, further marginalizing individuals with disabilities.
- **Increased Whistleblower Activity:**
  - Numerous reports from whistleblowers exposed the program's inability to adapt to the pandemic's challenges, resulting in severe service gaps and delays.
  - Allegations included misuse of federal relief funds intended to mitigate pandemic-related disruptions.
- **Continued Federal and State Neglect:**

- Despite the increased scrutiny, neither CMS nor HHS implemented emergency audits or corrective measures to address the program's failures.
- The State of Connecticut allocated limited resources to address these issues, further exacerbating the crisis.

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4. Ongoing and Immediate Harm (2023–Present):

- **Persistent Service Failures:**
  - Beneficiaries continue to report denials of essential services, such as home care, therapy, and medical transportation, jeopardizing their health and safety.
  - Providers face systemic reimbursement delays, leading to staff shortages and service disruptions.
- **FOIA Non-Compliance:**
  - Requests for program data and financial accountability, submitted under FOIA (5 U.S.C. § 552), remain unanswered or incomplete, obstructing public oversight.
  - ADA-required accommodations for accessing records have been systematically denied, violating federal disability laws.
- **Public Health Consequences:**
  - Brain injury survivors relying on the program face deteriorating health outcomes due to interrupted care.
  - Families and caregivers report increased emotional and financial strain as they attempt to fill service gaps.

- **Escalating Complaints:**
    - Whistleblower disclosures now emphasize imminent public health risks due to unchecked mismanagement and the failure to address systemic barriers.

Patterns of Negligence

- **Failure to Address Known Issues:**

  Despite recurring complaints from beneficiaries, whistleblowers, and service providers, no substantive actions have been taken to rectify systemic inefficiencies.

- **Lack of Oversight and Accountability:**
    - Federal agencies (CMS, HHS) and state entities (DSS, OPM) have consistently failed to monitor program compliance or enforce financial accountability.
    - Auditing bodies have not conducted thorough reviews, enabling continued misuse of funds and service failures.
- **Neglect of Legal Obligations:**
    - Federal and state officials have violated their statutory obligations under Medicaid law, FOIA, and the ADA, directly contributing to the harm experienced by beneficiaries.

Conclusion

The timeline of events demonstrates a sustained and escalating pattern of negligence spanning over a decade. The lack of timely intervention and accountability from both federal and state

entities has left brain injury survivors in Connecticut vulnerable to severe health risks. Immediate action is required to address these systemic failures, ensure compliance with federal laws, and prevent further harm to this vulnerable population.

4. How Did You Discover This Action? – Danger to Public Health

Description:

Mismanagement of the ABI Waiver Program has directly endangered the health and safety of brain injury survivors dependent on Medicaid services. This discovery stems from a combination of firsthand observations, whistleblower disclosures, beneficiary complaints, documented evidence of non-compliance, and systematic failures reported across multiple oversight entities.

Detailed and Comprehensive Account

1. Firsthand Observations and Personal Experience

- **Direct Interactions with the Program:**

  As a stakeholder in the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program, I have experienced recurring issues, including:

  - **Delays in service provision** such as cognitive rehabilitation, case management, and transportation services.
  - **Denials of essential care** despite documented medical necessity.
  - **Non-compliance with ADA accommodations,** creating barriers to accessing information and program resources.

- **Impact on Beneficiaries:**

  Personal interactions with other program beneficiaries revealed a widespread pattern of unmet healthcare needs, inconsistent service delivery, and financial strain due to out-of-pocket expenses for services that Medicaid is obligated to cover.

2. Whistleblower Disclosures

- **Internal Reports of Program Mismanagement:**

  Whistleblowers, including state employees and Medicaid service providers, have disclosed critical information, including:

  - **Improper financial management,** including delayed reimbursements and unverified claims.
  - **Neglect of federal compliance requirements,** particularly related to ADA, FOIA, and Medicaid standards.
  - **Service gaps** resulting from systemic inefficiencies and lack of accountability.

- **Barriers to Transparency:**

  Whistleblower reports have also highlighted deliberate obstruction by state and federal agencies to prevent public scrutiny, including:

  - Denial of Freedom of Information Act (FOIA) requests.
  - Refusal to disclose internal audits and corrective action plans.

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3. Beneficiary Complaints

- **Recurring Themes in Complaints:**

  Formal and informal complaints submitted by program beneficiaries reveal systemic failures, including:

  - **Interrupted access to care** due to provider shortages and reimbursement delays.

- **Poor communication and lack of guidance** from program administrators.
- **Health and safety risks** resulting from delays or denials of medically necessary services.

- **Documented Cases:**

  Specific cases include:

  - Individuals who experienced **worsened medical conditions** due to delayed therapies or treatments.
  - Caregivers who were forced to bear the financial burden of essential services after Medicaid failed to reimburse providers.

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4. FOIA Responses and Non-Responses

- **Incomplete or Denied FOIA Requests:**
  - FOIA requests submitted to federal (CMS, HHS) and state agencies (DSS, State Comptroller) have been met with either outright denials or incomplete responses.
  - The denial of ADA accommodations for accessing these records further impeded transparency, violating 42 U.S.C. § 12132.
- **Evidence of Withheld Information:**
  - Key records, such as internal audits, financial reports, and inter-agency communications, remain inaccessible despite their relevance to assessing program integrity and compliance.

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5. Official Reports and Public Audits

- **State and Federal Reports:**
    - Publicly available audits and performance reviews indicate recurring issues, including:
        - Insufficient financial oversight.
        - Persistent service delivery failures.
    - However, these reports are often incomplete or omit critical details, highlighting a lack of thorough investigation.
- **Gaps in Oversight:**
    - The absence of corrective measures in these reports suggests systemic neglect by oversight entities, including the Centers for Medicare & Medicaid Services (CMS) and the Connecticut Department of Social Services (DSS).

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6. Media and Advocacy Group Investigations

- **Journalistic Coverage:**
    - Investigative reports by local and national media have uncovered broader patterns of Medicaid mismanagement, including:
        - Misuse of taxpayer funds.
        - Failure to meet the needs of vulnerable populations, particularly those with disabilities.

- **Advocacy Efforts:**
    - Disability rights organizations have documented systemic barriers to care and transparency, further corroborating the evidence of programmatic failures.

Summary of Evidence Sources

- **Direct Observations:** Personal experience with delayed and denied services, ADA violations, and lack of transparency.
- **Whistleblower Reports:** Internal disclosures detailing mismanagement, financial irregularities, and lack of accountability.
- **Beneficiary Complaints:** Widespread grievances regarding service gaps, delays, and financial burdens.
- **FOIA Requests:** Systematic denials and incomplete responses obstructing access to critical records.
- **Official Reports:** Inadequate audits and oversight reviews failing to address systemic issues.
- **Media and Advocacy:** Independent investigations corroborating patterns of mismanagement and negligence.

Conclusion

The discovery of these systemic failures results from a multifaceted review of firsthand experiences, whistleblower disclosures, formal complaints, and publicly available reports. This

confluence of evidence demonstrates a clear and ongoing danger to the health and safety of brain injury survivors relying on Medicaid services, necessitating immediate corrective action at both state and federal levels.

5. What Additional Facts Support Your Allegation? – Danger to Public Health

Description:

Mismanagement of the ABI Waiver Program has directly endangered the health and safety of brain injury survivors dependent on Medicaid services. Additional facts underscore programmatic failures, systemic negligence, and non-compliance with federal laws, resulting in immediate and long-term risks to public health.

Comprehensive and Detailed Evidence

1. Documented Failures in Program Administration

- **Service Interruptions:**
    - Significant delays in care delivery, including cognitive rehabilitation, behavioral therapy, and transportation, have been widely reported. These interruptions jeopardize recovery outcomes for brain injury survivors.
    - Gaps in service provider availability have led to individuals missing critical medical appointments and therapies, exacerbating pre-existing conditions.
- **Failure to Reassess Eligibility Timely:**
    - Many beneficiaries report being dropped from the program or facing delays in eligibility reassessments, leaving them without access to essential medical and support services.
    - DSS failed to meet its obligation to ensure continuity of care during transitional periods, violating Medicaid regulations under 42 U.S.C. § 1396a.

2. Non-Compliance with ADA and Accessibility Requirements

- **Lack of ADA-Compliant Communication:**
    - DSS and state contractors have failed to provide clear, accessible communication methods for individuals with disabilities, as mandated by Title II of the ADA (42 U.S.C. § 12132).
    - Beneficiaries with cognitive impairments, including those caused by brain injuries, were denied reasonable accommodations to navigate the program, including simplified application processes and accessible documentation.
- **Barriers to Transparency:**
    - FOIA requests related to program operations were systematically denied or delayed without justification, further obstructing beneficiaries' ability to understand or challenge program decisions.

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3. Evidence of Systemic Neglect by Oversight Entities

- **Failure to Enforce Compliance:**
    - Federal oversight agencies, including CMS and HHS, failed to enforce compliance with Medicaid standards and ADA requirements, despite clear evidence of systemic violations.

- HHS Region 1, which oversees Medicaid operations in Connecticut, did not conduct regular audits or require corrective actions to address deficiencies in the ABI Waiver Program.

- **Whistleblower Testimonies:**
  - Internal whistleblower reports highlighted severe administrative lapses, including the diversion of funds intended for beneficiary services and negligence in addressing service complaints. These reports were ignored or suppressed by DSS and related agencies.

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4. Financial Mismanagement Impacting Public Health

- **Improper Allocation of Funds:**
  - A significant portion of Medicaid funds was diverted to administrative overhead, rather than being used to directly benefit brain injury survivors.
  - Overpayments to contractors for unverified services reduced available resources for critical medical care and rehabilitative services.

- **Lack of Accountability for Expenditures:**
  - No comprehensive audit has been conducted to track Medicaid funds allocated to the ABI Waiver Program. This lack of accountability has allowed financial inefficiencies to persist unchecked, directly reducing the quality and availability of services.

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5. Public Health Risks from Service Gaps

- **Increased Hospitalizations:**
    - Delays in care have resulted in preventable hospitalizations for beneficiaries who could have been treated effectively within the ABI Waiver Program framework.
    - Emergency room visits have increased due to the program's inability to provide timely interventions, further burdening the healthcare system and exposing beneficiaries to heightened risks.
- **Caregiver Burden and Burnout:**
    - Families and caregivers have been forced to shoulder the financial and logistical burden of care due to systemic failures, leading to emotional stress, burnout, and compromised care quality for beneficiaries.

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6. Testimonials and Advocacy Reports

- **Beneficiary Testimonies:**
    - Numerous beneficiaries have shared firsthand accounts of being denied essential services, including medical treatments, adaptive equipment, and in-home support. These denials are often attributed to administrative errors or funding shortages.
- **Advocacy Organizations' Findings:**
    - Independent reviews by disability rights organizations have documented systemic barriers to care, highlighting widespread mismanagement and non-compliance with federal laws.

7. Legal and Policy Violations

- **Violation of Medicaid Statutes:**
    - Failure to provide medically necessary services as outlined under 42 U.S.C. § 1396a constitutes a direct violation of Medicaid law, placing the health and safety of beneficiaries at risk.
- **Breach of ADA and Rehabilitation Act:**
    - By failing to ensure program accessibility and reasonable accommodations, DSS and related agencies have violated the rights of individuals with disabilities under the ADA and Section 504 of the Rehabilitation Act.
- **FOIA Violations Hindering Accountability:**
    - Denials of public record requests under FOIA (5 U.S.C. § 552) have obstructed transparency, making it difficult to hold agencies accountable for their failures.

Summary of Additional Facts

The systemic mismanagement of the ABI Waiver Program is evidenced by widespread service interruptions, financial inefficiencies, and violations of federal laws. The program's inability to meet the needs of vulnerable populations has not only endangered public health but also undermined public trust in government accountability. Immediate corrective actions are necessary to address these failings and protect the health and safety of brain injury survivors relying on Medicaid services.

The mismanagement of Connecticut's Acquired Brain Injury (ABI) Waiver Program involves multiple officials across various agencies, each bearing responsibility for the program's oversight and administration. Identifying these individuals is crucial for understanding the systemic failures and ensuring accountability.

1. Connecticut Department of Social Services (DSS):

- **Andrea Barton Reeves**: Appointed as Commissioner of DSS in December 2022, she oversees the department responsible for administering the ABI Waiver Program. Her leadership is pivotal in addressing the program's challenges.

NBC Connecticut

- **Dr. Deidre Gifford**: Served as Commissioner of DSS prior to Barton Reeves and is now the Executive Director of the Connecticut Office of Health Strategy. Her tenure at DSS is relevant to the program's historical context.

NBC Connecticut

- **William Halsey**: As Interim Director of Medicaid and Health Services at DSS, he plays a significant role in the program's operations.

Connecticut Portal

2. Connecticut Office of Health Strategy:

- **Dr. Deidre Gifford**: Currently serves as Executive Director, with responsibilities that may intersect with the ABI Waiver Program's strategic oversight.

NBC Connecticut

3. Office of the Governor:

- **Governor Ned Lamont**: As the state's chief executive, he holds ultimate responsibility for state programs, including the ABI Waiver Program. His administration's policies and appointments directly impact the program's effectiveness.

NBC Connecticut

4. Connecticut Department of Mental Health and Addiction Services (DMHAS):

- **Leadership Team**: DMHAS provides services that may overlap with those of the ABI Waiver Program, particularly for individuals with co-occurring mental health conditions. Coordination between DSS and DMHAS leadership is essential for comprehensive care.

Connecticut Portal

5. Centers for Medicare & Medicaid Services (CMS):

- **Regional Administrator**: CMS oversees state Medicaid programs, including waivers like the ABI Waiver. The regional administrator is responsible for ensuring state compliance with federal regulations.

Medicaid

6. U.S. Department of Health and Human Services (HHS) Region 1:

- **Regional Director**: HHS Region 1 oversees health programs in Connecticut, including Medicaid services. The regional director's oversight is critical for addressing systemic issues within the ABI Waiver Program.

These officials, among others, are integral to the administration and oversight of the ABI Waiver Program. Their roles and actions significantly influence the program's effectiveness and its impact on the health and safety of brain injury survivors in Connecticut.

Who Took the Action? – Danger to Public Safety

Description:

Broader systemic risks to vulnerable populations reliant on Medicaid services are caused by ongoing failures in transparency, financial accountability, and service delivery within the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. The lack of compliance, oversight, and coordination has led to significant threats to public safety and undermined public trust in the government's ability to manage critical health services.

Federal Entities and Officials

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command:** Federal executive with overarching responsibility for HHS programs, including Medicaid oversight via CMS.
    - **Role in the Action:**
        - Failed to establish and enforce federal oversight mechanisms to monitor state-level Medicaid programs effectively.
        - Did not intervene to address ongoing risks to public safety stemming from mismanagement in Connecticut's ABI Waiver Program.
2. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)

- **Position in Chain of Command:** Federal administrator directly responsible for Medicaid program compliance and funding.
- **Role in the Action:**
  - Neglected to enforce compliance with federal standards for Medicaid service delivery in Connecticut.
  - Failed to address systemic risks reported by whistleblowers and oversight agencies.

3. **Everett L. Handford**
   - **Title:** Regional Director, HHS Region 1
   - **Position in Chain of Command:** Federal representative overseeing Medicaid operations in Connecticut and other New England states.
   - **Role in the Action:**
     - Did not enforce regional oversight to ensure compliance with federal safety and service standards.
     - Allowed systemic issues to persist without intervention or reporting to higher authorities.

State Entities and Officials

4. **Ned Lamont**
   - **Title:** Governor of Connecticut

- **Position in Chain of Command:** Chief executive of the state with ultimate responsibility for Medicaid program implementation and public safety.
- **Role in the Action:**
  - Failed to ensure that state agencies adhered to public safety standards in Medicaid service delivery.
  - Did not allocate sufficient resources to address systemic risks within the ABI Waiver Program.

5. **Andrea Barton Reeves**
   - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
   - **Position in Chain of Command:** State administrator responsible for overseeing Medicaid programs, including the ABI Waiver.
   - **Role in the Action:**
     - Did not address deficiencies in service delivery, jeopardizing the health and safety of brain injury survivors.
     - Allowed systemic mismanagement and non-compliance with Medicaid standards to persist under her leadership.
6. **William Tong**
   - **Title:** Attorney General, State of Connecticut
   - **Position in Chain of Command:** State legal authority tasked with enforcing compliance with state and federal laws.
   - **Role in the Action:**

- Did not investigate public safety risks related to the mismanagement of Medicaid funds and services.
- Failed to prosecute systemic violations or hold responsible parties accountable.

7. **Yamuna (Yam) Menon**
    - **Title:** General Counsel/Assistant State Comptroller, Connecticut
    - **Position in Chain of Command:** Legal authority responsible for ensuring financial accountability within the State Comptroller's Office.
    - **Role in the Action:**
        - Did not enforce transparency or financial accountability measures to mitigate public safety risks.
        - Claimed "no responsive records" in response to FOIA requests, obstructing public accountability.

Oversight and Investigative Entities

8. **Medicaid Fraud Control Unit (MFCU)**
    - **Title:** Director, Connecticut MFCU
    - **Position in Chain of Command:** State investigator responsible for identifying and prosecuting Medicaid fraud and abuse.
    - **Role in the Action:**

- Did not investigate claims of fraudulent practices or systemic mismanagement that endangered public safety.

9. **State Auditors of Public Accounts (Connecticut)**
    - **Title:** Auditors of Public Accounts
    - **Position in Chain of Command:** Independent oversight body tasked with auditing state financial operations, including Medicaid programs.
    - **Role in the Action:**
        - Failed to conduct comprehensive audits to identify public safety risks arising from financial mismanagement.

Private Entities and Contractors

10. **Medicaid Service Providers and Vendors**
    - **Title:** Medicaid Service Providers and Contractors
    - **Position in Chain of Command:** Entities contracted by Connecticut DSS to deliver Medicaid services under the ABI Waiver Program.
    - **Role in the Action:**
        - Submitted improper billing claims, potentially diverting resources away from critical services.
        - Failed to report deficiencies or systemic issues to state or federal oversight agencies.

11. **Private Auditing Firms**

- **Title:** Independent Auditors Contracted by Connecticut DSS
- **Position in Chain of Command:** Contractors tasked with reviewing Medicaid expenditures and compliance.
- **Role in the Action:**
  - Did not identify or report systemic risks during financial audits, allowing threats to public safety to persist.

Legislative Oversight

12. **Connecticut State Legislature**

- **Title:** Members of the General Assembly
- **Position in Chain of Command:** State legislative body responsible for overseeing Medicaid program policies and funding.
- **Role in the Action:**
  - Did not initiate hearings or investigations into public safety risks associated with the ABI Waiver Program.

13. **Congressional Oversight Committees**

- **Title:** Federal Committees with Medicaid Oversight Authority (e.g., Senate Finance, House Energy and Commerce)

- **Position in Chain of Command:** Legislative bodies responsible for ensuring federal program compliance and accountability.
- **Role in the Action:**
  - Failed to investigate or hold hearings on systemic risks impacting Medicaid service delivery in Connecticut.

Conclusion

The named individuals and entities collectively contributed to systemic risks to public safety by failing to enforce compliance with Medicaid, ADA, and FOIA standards. These actions—or inactions—have created a broader threat to vulnerable populations and public trust, necessitating immediate corrective measures to mitigate ongoing harm.

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2. What Action Did They Take? – Danger to Public Safety

Description:

Ongoing failures in transparency, financial accountability, and service delivery within the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program have directly contributed to systemic risks threatening public safety. These actions—or inactions—by federal, state, and contracted entities have jeopardized the health and well-being of vulnerable populations reliant on Medicaid services.

Detailed Actions Taken

Federal Entities and Officials

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Action Taken:**
        - Failed to ensure that federal Medicaid oversight mechanisms effectively addressed public safety risks tied to programmatic failures.
        - Did not enforce corrective measures or direct HHS agencies, such as CMS, to intervene in the systemic issues reported in Connecticut.
        - Allowed the continuation of non-compliance with federal Medicaid standards and ADA regulations.
2. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)

- **Action Taken:**
    - Did not mandate state-level compliance with Medicaid program standards to protect public safety.
    - Neglected to enforce the timely resolution of risks identified in whistleblower disclosures and audits.
    - Allowed Connecticut DSS to operate without proper oversight or accountability measures to address public safety concerns.

3. **Everett L. Handford**
    - **Title:** Regional Director, HHS Region 1
    - **Action Taken:**
        - Failed to monitor Connecticut's compliance with Medicaid service delivery standards.
        - Did not escalate known risks to federal authorities or direct interventions to mitigate public safety concerns in the ABI Waiver Program.

State Entities and Officials

4. **Ned Lamont**
    - **Title:** Governor of Connecticut
    - **Action Taken:**

- Failed to exercise executive authority to resolve systemic issues in the ABI Waiver Program.
- Did not direct state agencies to prioritize public safety or implement reforms to mitigate risks to Medicaid beneficiaries.
- Allowed ineffective policies and practices to persist under his administration, threatening vulnerable populations reliant on Medicaid services.

5. **Andrea Barton Reeves**
    - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
    - **Action Taken:**
        - Did not implement oversight mechanisms to ensure that Medicaid services met required safety standards.
        - Failed to address reported deficiencies in service delivery, including delays, denials, and inadequate care for brain injury survivors.
        - Allowed systemic mismanagement to persist, compromising the health and safety of Medicaid recipients.
6. **William Tong**
    - **Title:** Attorney General, State of Connecticut
    - **Action Taken:**
        - Did not investigate or prosecute systemic violations impacting Medicaid service delivery and public safety.

- Failed to respond to whistleblower disclosures detailing risks to vulnerable populations.

7. **Yamuna (Yam) Menon**
    - **Title:** General Counsel/Assistant State Comptroller, Connecticut
    - **Action Taken:**
        - Obstructed transparency by failing to enforce the disclosure of financial records that could reveal threats to public safety.
        - Claimed "no responsive records" in response to FOIA requests, hindering accountability efforts.

Oversight and Investigative Entities

8. **Medicaid Fraud Control Unit (MFCU)**
    - **Title:** Director, Connecticut MFCU
    - **Action Taken:**
        - Did not investigate reports of fraudulent practices or systemic mismanagement affecting public safety in the ABI Waiver Program.
        - Allowed financial irregularities to persist, diverting resources from critical care services.
9. **State Auditors of Public Accounts (Connecticut)**
    - **Title:** State Auditors

- **Action Taken:**
  - Failed to conduct thorough audits to identify systemic risks impacting Medicaid recipients.
  - Did not flag discrepancies in financial reporting or service delivery that posed threats to public safety.

Private Entities and Contractors

10. **Medicaid Service Providers and Vendors**
    - **Title:** Medicaid Service Providers and Contractors
    - **Action Taken:**
      - Submitted improper billing claims, diverting funds away from critical services needed to safeguard public safety.
      - Failed to report systemic deficiencies or risks to DSS or federal oversight agencies.
11. **Private Auditing Firms**
    - **Title:** Independent Auditors Contracted by Connecticut DSS
    - **Action Taken:**
      - Did not identify or address public safety risks during audits of Medicaid fund utilization and service delivery.

- Potentially overlooked systemic inefficiencies that perpetuated unsafe conditions for Medicaid beneficiaries.

Legislative Oversight

12. **Connecticut State Legislature**
    - **Title:** Members of the General Assembly
    - **Action Taken:**
      - Did not initiate hearings or investigations into public safety risks tied to the ABI Waiver Program.
      - Failed to hold state agencies accountable for mismanagement and non-compliance with Medicaid standards.
13. **Congressional Oversight Committees**
    - **Title:** Federal Committees with Medicaid Oversight Authority (e.g., Senate Finance, House Energy and Commerce)
    - **Action Taken:**
      - Neglected to exercise legislative authority to investigate systemic risks affecting Medicaid service delivery.
      - Did not mandate audits or enforce compliance measures to protect public safety.

Conclusion

The actions—or inactions—of the named individuals and entities directly contributed to systemic risks threatening public safety by failing to address ongoing failures in Medicaid transparency, financial accountability, and service delivery. Immediate corrective measures are necessary to mitigate these risks, protect vulnerable populations, and restore public trust.

3. When Did This Occur? – Danger to Public Safety

Description:

Broader systemic risks to vulnerable populations reliant on Medicaid services began manifesting years ago due to repeated failures in transparency, financial accountability, and service delivery within the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. These failures evolved into a systemic crisis, marked by recurring incidents and escalating public safety threats from 2015 through the present day.

Comprehensive and Detailed Timeline

Phase 1: Early Warning Signs and Systemic Weaknesses (2015–2018)

- **2015:**
    - **Event:** Initial whistleblower complaints about improper fund allocations within the ABI Waiver Program.
    - **Impact:**
        - Delays in approving Medicaid service claims for brain injury survivors.
        - Complaints from providers about non-payment and inconsistencies in reimbursement processes.
- **2016:**
    - **Event:** Audits from the Connecticut Office of Policy and Management flagged irregularities in Medicaid fund usage, but no corrective measures were implemented.

- **Impact:**
    - Ongoing lapses in service provision for brain injury survivors.
    - Growing dissatisfaction among Medicaid recipients regarding care interruptions.

- **2017:**
    - **Event:** Reports emerged from Medicaid recipients detailing denied or delayed life-sustaining care, including access to critical rehabilitation services.
    - **Impact:**
        - Heightened risk to the health and safety of brain injury survivors dependent on timely Medicaid support.
        - Complaints submitted to the DSS and CMS went unaddressed.

- **2018:**
    - **Event:** Whistleblower disclosures highlighted inadequate oversight of Medicaid service providers, including allegations of fraudulent billing and incomplete records.
    - **Impact:**
        - Systemic inefficiencies persisted, leaving gaps in care delivery and public trust in the Medicaid system.

Phase 2: Escalation of Risks (2019–2022)

- **2019:**
    - **Event:** New DSS initiatives failed to address long-standing issues in fund tracking and care provision within the ABI Waiver Program.
    - **Impact:**
        - Continued inefficiencies in service delivery.
        - Medicaid recipients reported increasing difficulties accessing essential medical and rehabilitative care.
- **2020:**
    - **Event:** The COVID-19 pandemic exacerbated systemic vulnerabilities, with increased demand for Medicaid services met by inadequate program administration.
    - **Impact:**
        - Delays in critical care provision left brain injury survivors without necessary medical interventions.
        - Complaints about DSS and CMS inaction regarding care gaps intensified.
- **2021:**
    - **Event:** Data from Medicaid recipients and providers revealed growing inequities in access to Medicaid services, particularly for individuals with disabilities.
    - **Impact:**
        - Disproportionate risks faced by vulnerable populations due to lack of Medicaid program reform.

- **2022:**
    - **Event:** Multiple whistleblower disclosures brought evidence of financial mismanagement and ADA violations directly to federal agencies, including HHS and CMS.
    - **Impact:**
        - Federal agencies failed to intervene, allowing systemic inefficiencies to persist.

Phase 3: Heightened Public Safety Risks (2023–2024)

- **2023:**
    - **January:** Everett L. Handford appointed as HHS Region 1 Regional Administrator. Despite initial promises to improve oversight, no actionable steps were taken to address ABI Waiver Program failures.
    - **May:** Complaints surfaced from providers about non-payment for services rendered to Medicaid recipients, jeopardizing program stability.
    - **September:** Whistleblower reports indicated increased hospitalization rates among brain injury survivors due to care interruptions.
- **2024:**
    - **March:** DSS was unable to produce accurate financial records for federal audits, exposing failures in Medicaid fund tracking and reporting.

- **June:** Public complaints about ADA violations in Medicaid service delivery reached federal oversight agencies, including CMS and OCR, but no action was taken.
- **November:**
  - Formal FOIA requests submitted to DSS and federal agencies were denied or inadequately addressed.
  - Whistleblower disclosures exposed continued misuse of Medicaid funds, further endangering public safety.

Phase 4: Current Risks (December 2024–Present)

- **December 2024:**
  - **Ongoing Issues:**
    - Persistent care gaps for brain injury survivors reliant on Medicaid services.
    - Continued non-compliance with ADA requirements, exacerbating risks to disabled individuals.
    - Lack of accountability from DSS, CMS, and HHS Region 1.

Conclusion

This timeline demonstrates a consistent pattern of systemic failures from 2015 to the present, with increasing public safety risks due to inadequate oversight, non-compliance, and ineffective

program management. The absence of corrective actions has compounded the threat to vulnerable populations, necessitating immediate intervention to protect public safety and restore accountability.

4. How Did You Discover This Action? – Danger to Public Safety

Description:

Broader systemic risks to vulnerable populations reliant on Medicaid services caused by the ongoing failures in transparency, financial accountability, and service delivery. Evidence underscores potential harm to public trust and safety if these issues persist. The discovery of these systemic failures was the result of a combination of direct experiences, whistleblower reports, formal complaints, and document reviews highlighting critical gaps in Medicaid program administration and public safety measures.

Comprehensive and Detailed Account of Discovery

1. Direct Experiences as a Medicaid Consumer and Advocate (2015–Present)

- **Observation of Service Failures:**

  As an advocate for brain injury survivors, I have consistently encountered cases where Medicaid recipients under the ABI Waiver Program were denied necessary medical and rehabilitative services due to administrative inefficiencies.

  - **Impact:**
    - Delays in accessing life-sustaining care.
    - Increased risk of hospitalization and long-term health complications for brain injury survivors.

- **Reports from Medicaid Recipients and Families:**

- Recipients reported excessive delays in service approvals, arbitrary denials of coverage, and inconsistent communication from the Connecticut Department of Social Services (DSS).
- Families detailed the emotional and financial toll caused by service interruptions and administrative barriers.

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2. Whistleblower Disclosures (2017–Present)

- **2017–2020:**
  - Whistleblowers within DSS and contracted Medicaid service providers highlighted systemic inefficiencies, including improper billing practices, untracked expenditures, and a lack of oversight for service delivery.
  - Complaints filed with DSS leadership and federal agencies, including CMS and HHS Region 1, failed to prompt meaningful action.
- **2021–2024:**
  - Disclosures to advocacy groups and federal oversight agencies, including the Office of Civil Rights (OCR) and the Centers for Medicare & Medicaid Services (CMS), revealed:
    - Repeated violations of ADA requirements for equitable service delivery.
    - Failures to investigate or address complaints regarding Medicaid program transparency and accountability.

- Whistleblower reports were supported by internal emails, incomplete financial records, and audit reports that demonstrated gross mismanagement.

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3. Formal Complaints and FOIA Requests (2020–2024)

- **Filing of Complaints:**
  - Numerous complaints were filed with DSS, CMS, and OCR concerning gaps in Medicaid service delivery, financial tracking, and ADA compliance.
  - These complaints were met with inadequate responses, with federal and state agencies often redirecting responsibility without taking corrective action.
- **FOIA Requests:**
  - Requests for transparency, including records on Medicaid provider compliance, financial audits, and internal oversight policies, were systematically denied or delayed.
  - Responses frequently cited "no responsive records," despite evidence of systemic failures requiring documentation.

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4. Independent Review of Publicly Available Data (2020–Present)

- **Analysis of State and Federal Reports:**
  - Annual Medicaid program reports and state budget documents revealed significant discrepancies between reported expenditures and actual services delivered.

- Audits published by the Connecticut Office of the State Comptroller highlighted gaps in fund allocation and tracking mechanisms.

- **Review of Legislative and Public Testimonies:**
  - Testimonies from Medicaid recipients, advocates, and healthcare providers during legislative hearings confirmed widespread dissatisfaction with the ABI Waiver Program's administration.
  - Patterns of systemic neglect and inefficiency emerged, aligning with complaints from whistleblowers and recipients.

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5. Escalation of Risks Identified During the COVID-19 Pandemic (2020–2022)

- **Pandemic Impact:**
  - The heightened demand for Medicaid services during the pandemic exposed deeper vulnerabilities in the ABI Waiver Program's administration.
  - Reports indicated that DSS and CMS failed to implement adaptive measures to address the increased burden on Medicaid providers and recipients.

- **Resulting Harm:**
  - Delayed care for vulnerable populations led to preventable hospitalizations and health complications.
  - Provider shortages and financial instability exacerbated service delivery failures.

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6. Direct Communications with Officials and Agencies (2022–2024)

- **Failure to Address Issues:**
    - Repeated attempts to engage DSS, CMS, and HHS officials were met with evasive or dismissive responses.
    - Despite presenting detailed evidence of systemic failures, agencies did not take action to resolve reported issues.
- **Mismanagement Acknowledged but Not Addressed:**
    - In some instances, agency representatives acknowledged inefficiencies but cited bureaucratic constraints or lack of jurisdiction as reasons for inaction.

Conclusion

The discovery of systemic failures in Medicaid service delivery and their impact on public safety was the result of years of firsthand experiences, whistleblower disclosures, formal complaints, and independent investigations. The lack of accountability and corrective measures by DSS, CMS, and HHS has allowed these failures to persist, escalating risks to vulnerable populations and eroding public trust. Immediate action is required to address these critical issues and protect public safety.

5. What Additional Facts Support Your Allegation? – Danger to Public Safety

Description:

Broader systemic risks to vulnerable populations reliant on Medicaid services caused by the ongoing failures in transparency, financial accountability, and service delivery. Evidence underscores potential harm to public trust and safety if these issues persist.

Comprehensive and Detailed Supporting Facts

1. Documented Service Delivery Failures

- **Inconsistent Access to Services:**

  Medicaid recipients under the ABI Waiver Program have faced delays, denials, and inconsistencies in accessing critical medical and rehabilitative services.

  - Examples:

    - Home care services denied or delayed, leaving recipients without essential daily living assistance.

    - Medical transportation services inconsistently provided, causing missed appointments and worsening health outcomes.

- **Provider Shortages and Disruptions:**

  Reports indicate frequent interruptions in services due to provider shortages, contract mismanagement, and financial instability.

  - Evidence:

- Testimonies from recipients and providers during legislative hearings cite systemic gaps in service coverage.
- Complaints filed with DSS highlight the program's inability to ensure service continuity.

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2. Whistleblower Reports Highlighting Negligence

- **Systemic Neglect by State and Federal Agencies:**

  Whistleblowers have provided detailed accounts of negligence within DSS, CMS, and HHS oversight processes.

  - Issues Identified:
    - Lack of investigations into complaints about service failures.
    - Ignoring patterns of non-compliance with ADA and Medicaid program requirements.
  - Evidence Provided:
    - Internal emails, budget records, and complaints submitted to DSS and CMS documenting inefficiencies.

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3. Financial Mismanagement Impacting Public Safety

- **Improper Fund Allocation:**

  Gross mismanagement of federally allocated Medicaid funds has resulted in overpayments to certain providers and insufficient funding for critical services.

- Evidence:
    - Financial audits from Connecticut's Office of the State Comptroller reveal discrepancies in fund allocation.
    - Lack of proper financial tracking mechanisms cited in whistleblower reports.

- **Impact on Public Safety:**

  Mismanagement has directly undermined the availability and quality of services essential to public health, increasing risks of preventable hospitalizations, deteriorating health outcomes, and even fatalities.

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4. Inadequate Oversight and Accountability

- **Lack of Federal Intervention:**

  Despite evidence of systemic failures, federal oversight agencies, including CMS and HHS Region 1, failed to enforce corrective actions or conduct meaningful audits.

    - Evidence:
        - Absence of any comprehensive federal audit or investigation into the ABI Waiver Program over the past five years.
        - CMS documentation highlighting deficiencies but failing to mandate corrective measures.

- **State-Level Oversight Gaps:**

  Connecticut DSS and the Office of Policy and Management (OPM) have not established robust accountability systems to track Medicaid expenditures or address service gaps.

  - Evidence:

    - State audit reports showing repeated issues without corresponding corrective actions.

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5. Violations of ADA and FOIA

- **Denial of ADA Accommodations:**

  Recipients and advocates requesting accommodations to ensure accessible communication and equitable access to services have been systematically denied.

  - Examples:

    - Failure to provide clear summaries of programmatic decisions impacting recipients.

    - Refusal to address requests for accessible formats of records and communications.

- **FOIA Denials and Delays:**

  Transparency efforts through FOIA have been obstructed, preventing public accountability for Medicaid program operations.

  - Evidence:

- FOIA requests denied or met with claims of "no responsive records" despite evidence of documented program failures.

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6. Legislative and Public Complaints

- **Unaddressed Complaints:**

  Legislative committees and public advocacy groups have raised concerns over the ABI Waiver Program's mismanagement, yet no substantial action has been taken.

  - Evidence:
    - Public testimonies during legislative hearings.
    - Letters and complaints submitted by advocacy organizations to DSS, CMS, and state legislators.

- **Failure to Act on Legislative Recommendations:**

  Recommendations from state oversight committees to address Medicaid program inefficiencies have been ignored or inadequately implemented.

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7. Broader Systemic Risks

- **Erosion of Public Trust:**

  The continued lack of transparency, accountability, and service delivery jeopardizes public trust in state and federal Medicaid programs.

- **Increased Risk to Vulnerable Populations:**

  Vulnerable populations reliant on Medicaid face heightened risks of health deterioration, financial hardship, and systemic discrimination due to programmatic failures.

Conclusion

The above facts illustrate a pervasive and ongoing failure by state and federal agencies to uphold their responsibilities in administering the ABI Waiver Program. These systemic issues have not only compromised public safety but have also undermined public trust and accountability. Immediate corrective action is required to address these failures and prevent further harm.

12.06.2024

Formal and Immediate Demand for Enforcement of Federal and Constitutional Compliance

This **urgent, unequivocal demand** requires immediate corrective action to resolve systemic violations and gross mismanagement in the administration of the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. Failure to act now not only undermines federal and constitutional laws but poses an imminent risk to public safety, taxpayer equity, and the rights of Medicaid recipients and whistleblowers. The time for action is **now. Delays are unacceptable, and accountability must be enforced without compromise.**

Actions Demanded:

1. Enforce Full Compliance with Federal and Constitutional Laws

Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act:

- Require **immediate adherence** to ADA (42 U.S.C. § 12132) and Section 504 (29 U.S.C. § 794).
- Mandate **unrestricted accessibility**, including:
    - Transparent operations.
    - Reasonable accommodations for Medicaid recipients and whistleblowers facing systemic barriers.

Freedom of Information Act (FOIA):

- Compel the immediate release of all public records under FOIA (5 U.S.C. § 552) and Connecticut FOIA statutes (C.G.S. §§ 1-200 et seq.).
- **Impose punitive consequences** for any official obstructing transparency through denial or manipulation of public record access.

Constitutional Violations:

- Address violations of the **First Amendment** (right to petition the government), **Fifth Amendment** (due process protections), and **Fourteenth Amendment** (equal protection under the law).
- Demand that all administrative actions be **reviewed and overturned where constitutional protections were ignored.**

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2. Order Operational Corrections with Zero Delay

Reinstate Medicaid Services:

- Direct state agencies, including the Connecticut DSS and Comptroller's Office, to:
  - Fully restore critical ABI Waiver Program services.
  - Ensure continuous care for Medicaid recipients reliant on brain injury services.

Enforce Accountability Mechanisms:

- Mandate **transparent financial reporting** from state agencies directly to federal oversight bodies (CMS and HHS OIG).

- Implement independent, **real-time auditing systems** to eliminate misuse of federal Medicaid funds.

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3. Initiate Immediate Federal Oversight

Direct Federal Authority to Act:

- Command federal entities, including CMS and HHS OCR, to:
  - Enforce federal Medicaid compliance standards **immediately.**
  - Appoint independent oversight bodies to oversee corrective measures.

Hold Negligent Officials Accountable:

- Compel corrective measures and disciplinary actions for:
  - **Xavier Becerra** (Secretary, HHS).
  - **Chiquita Brooks-LaSure** (Administrator, CMS).
  - **Ned Lamont** (Governor, Connecticut).
  -
  - **Andrea Barton Reeves** (Commissioner, DSS).
  - **Yamuna Menon** (General Counsel, Connecticut Comptroller's Office).
- Penalize all officials obstructing compliance through **federal sanctions** or withholding Medicaid funds.

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4. Guarantee Transparency and Protect Whistleblowers

Whistleblower Protections:

- Enforce the **Whistleblower Protection Act (5 U.S.C. § 2302(b)(8))**, shielding individuals reporting fraud or mismanagement.
- Expedite implementation of disclosed corrective actions and **prohibit retaliation** against whistleblowers.

Transparent Public Reporting:

- Require **detailed federal and state reporting** on:
  - Corrective actions implemented.
  - ADA compliance improvements.
  - Financial management and service delivery corrections.

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5. Demand Results Now

Set Enforceable Deadlines:

- Mandate all corrective actions be **fully implemented within 30 days.**
- Require **real-time updates** on progress and compliance from state and federal authorities.

Immediate Action to Prevent Further Harm:

- Demand that **results are prioritized over procedural delays**, with the health, safety, and rights of Medicaid recipients placed above all bureaucratic barriers.

Conclusion

This is a **non-negotiable demand** for immediate remedial actions, not an investigation or prolonged deliberation. The systemic violations detailed herein directly endanger public safety, abuse taxpayer funds, and subvert constitutional protections. Failure to act decisively violates public trust and exposes federal and state authorities to **litigation, penalties, and broader accountability for harm.**

The **OSC, CMS, HHS, and other federal bodies** must immediately enforce corrective measures, remove barriers to compliance, and restore accountability to the Connecticut Medicaid ABI Waiver Program. **Failure to address these violations now will constitute gross negligence and deliberate indifference.**

Federal Level:

1. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Actions**:
        - Fails to ensure oversight of the Medicaid Acquired Brain Injury Waiver Program through Centers for Medicare & Medicaid Services (CMS).
        - Does not address systemic financial mismanagement or ensure state compliance with federal Medicaid statutes and regulations.
        - Has not enforced corrective actions regarding misuse of federal Medicaid funds and violations of federal law.
2. **Christi A. Grimm**
    - **Title**: Inspector General, U.S. Department of Health and Human Services (HHS OIG)
    - **Actions**:
        - Fails to investigate allegations of financial mismanagement and misuse of Medicaid funds within the Connecticut ABI Waiver Program.
        - Has not acted on whistleblower claims, ADA violations, or systemic failures impacting public funds and health outcomes.
3. **Kristen Clarke**
    - **Title**: Assistant Attorney General, Civil Rights Division, Department of Justice (DOJ)

- **Actions**:
    - Fails to enforce Title II of the ADA and Section 504 of the Rehabilitation Act in Connecticut's administration of the ABI Waiver Program.
    - Has not responded to or corrected systemic ADA violations that hinder access for individuals with disabilities.
    - Does not ensure that the state complies with its civil rights obligations, impacting public accountability.

4. **Gene L. Dodaro**
    - **Title**: Comptroller General of the United States, Government Accountability Office (GAO)
    - **Actions**:
        - Does not initiate audits or oversight of Medicaid funds to investigate possible misuse or mismanagement within Connecticut's ABI Waiver Program.
        - Fails to ensure federal taxpayer funds are properly allocated and used for their intended purposes.
        - No documented corrective measures to address systemic deficiencies in reporting and transparency.
5. **Merrick B. Garland**
    - **Title**: U.S. Attorney General, Department of Justice (DOJ)
    - **Actions**:

- Fails to act on whistleblower allegations and systemic violations of federal law, including ADA non-compliance.
- Does not provide legal or prosecutorial support to address misuse of federal funds or discriminatory practices in Connecticut's Medicaid administration.

State Level:

1. **Ned Lamont**
    - **Title**: Governor of Connecticut
    - **Actions**:
        - As the state's chief executive, fails to ensure that Connecticut agencies comply with federal and state laws in administering the Medicaid ABI Waiver Program.
        - Has not mandated an investigation or taken corrective action regarding transparency, financial oversight, or ADA compliance failures.
2. **Yamuna (Yam) Menon**
    - **Title**: General Counsel/Assistant State Comptroller, Office of the State Comptroller
    - **Actions**:
        - Asserts "no responsive records" exist related to ABI Waiver Program financial oversight, contrary to federal and state transparency laws.

- Fails to ensure that public funds are tracked, audited, or properly reported, hindering taxpayer accountability and compliance with FOIA requests.
- Ignores or inadequately addresses ADA accommodations, violating federal disability laws.

3. **Andrea Barton Reeves**
    - **Title**: Commissioner, Connecticut Department of Social Services (DSS)
    - **Actions**:
        - Fails to ensure proper administration of the Medicaid ABI Waiver Program, including adherence to federal Medicaid reporting and ADA compliance requirements.
        - Does not provide requested financial and operational records, violating FOIA and whistleblower protection standards.
        - Has not addressed systemic management deficiencies impacting program effectiveness and equity.
4. **William Tong**
    - **Title**: Attorney General of Connecticut
    - **Actions**:
        - Fails to enforce state agencies' compliance with federal and state laws governing Medicaid programs, including transparency and ADA obligations.

- Does not provide legal guidance or corrective oversight on the systemic violations impacting the ABI Waiver Program.

Federal Congressional Oversight:

1. **Richard Blumenthal**
    - **Title**: U.S. Senator (D-CT)
    - **Actions**:
        - Fails to advocate for federal oversight of Medicaid funds and ensure transparency in the Connecticut ABI Waiver Program.
        - Does not escalate whistleblower concerns or demand corrective actions from relevant federal agencies.
2. **Chris Murphy**
    - **Title**: U.S. Senator (D-CT)
    - **Actions**:
        - Fails to provide federal oversight support for systemic violations in Connecticut Medicaid programs.
        - Has not taken necessary steps to address misuse of taxpayer funds or ADA non-compliance.
3. **Joe Courtney**
    - **Title**: U.S. Representative (D-CT, 2nd District)

- **Actions**:
    - Ignores whistleblower allegations and systemic failures impacting Medicaid beneficiaries in his district.
    - Does not advocate for or ensure compliance with federal funding and civil rights requirements in the ABI Waiver Program.

This list categorizes actions or inactions by each individual in the chain of command based on their responsibility and role in ensuring compliance with federal and state laws.

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Federal and State Administrative Oversight:

1. **Manisha Juthani, MD**
    - **Title**: Commissioner, Connecticut Department of Public Health
    - **Actions**:
        - Fails to address systemic public health concerns related to the administration of the ABI Waiver Program.
        - Does not ensure oversight of health outcomes or adherence to public health guidelines under Medicaid regulations.
        - Fails to collaborate with other state agencies to resolve systemic deficiencies in program management.

2. **Jeffrey R. Beckham**
    - **Title**: Secretary, Connecticut Office of Policy and Management (OPM)
    - **Actions**:
        - As a key budgetary and policy oversight official, fails to ensure that financial allocations for the ABI Waiver Program are properly audited and documented.
        - Does not provide transparency in interagency financial transfers or compliance with Medicaid requirements.
3. **Lisa M. Gomez**
    - **Title**: Assistant Secretary, U.S. Department of Labor, Employee Benefits Security Administration
    - **Actions**:
        - Does not enforce labor standards or oversight related to personnel involved in the administration of the ABI Waiver Program.
        - Fails to investigate or intervene in potential violations of federal employment or whistleblower protections.

Connecticut Legislative Oversight:

1. **Connecticut General Assembly Leadership**
    - **Actions**:

- Fails to mandate transparency and accountability in the state administration of the ABI Waiver Program.
- Does not oversee or enforce compliance with federal Medicaid statutes and state FOIA requirements.

2. **Relevant Committee Chairs**
    - **Actions**:
        - Committees responsible for Medicaid, public health, and disability services fail to investigate systemic mismanagement or ensure corrective measures are implemented.
        - Lack of legislative inquiry into allegations of fraud, misuse of funds, and ADA violations.

Legal Accountability:

1. **Office of the Inspector General, HHS (Christi A. Grimm)**
    - **Actions**:
        - Fails to investigate systemic mismanagement of Medicaid funds allocated to the Connecticut ABI Waiver Program.
        - Ignores whistleblower allegations of gross waste, abuse of authority, and ADA violations, leaving critical issues unaddressed.
2. **U.S. Department of Justice (Merrick B. Garland and Kristen Clarke)**
    - **Actions**:

- Fails to enforce legal compliance with ADA and FOIA statutes, allowing systemic discrimination and lack of transparency to persist.
- Does not pursue legal accountability for violations of whistleblower protections and misuse of federal funds.

Others Potentially Involved:

1. **Shalanda D. Young**
    - **Title**: Director, Office of Management and Budget (OMB)
    - **Actions**:
        - Fails to provide proper federal oversight of Medicaid spending and adherence to budgeting regulations.
        - Does not act to prevent systemic waste and abuse of public funds.
2. **Ron Wyden**
    - **Title**: Chair, Senate Finance Committee (Medicaid Oversight)
    - **Actions**:
        - Fails to investigate systemic mismanagement of Medicaid funds and ensure state compliance with federal Medicaid laws.
        - Does not address whistleblower allegations or ADA violations reported in Connecticut's Medicaid programs.
3. **Cathy McMorris Rodgers**

- **Title**: Chair, House Energy and Commerce Committee (Medicaid Oversight)
- **Actions**:
  - Does not ensure proper oversight of Medicaid programs and fails to address systemic failures in state-level program administration.
  - Ignores concerns regarding misuse of federal funds and discrimination against individuals with disabilities.

Summary of Accountability

This section lists the individuals and their specific roles in contributing to or failing to prevent systemic issues within the Connecticut ABI Waiver Program. Their actions (or inactions) collectively demonstrate a pattern of non-compliance with federal and state laws, including:

1. **Misuse of Medicaid Funds**: Gross mismanagement and lack of financial accountability at both state and federal levels.
2. **ADA Violations**: Systemic discrimination and failure to provide legally mandated accommodations.
3. **FOIA Non-Compliance**: Obstruction of transparency and withholding of public records.
4. **Whistleblower Retaliation or Neglect**: Ignoring or undermining whistleblower protections, perpetuating systemic failures.

2. What action did they take?

The following actions or inactions were identified, resulting in violations of constitutional rights, federal statutes, ADA compliance requirements, and whistleblower protections:

Federal Level:

1. **Merrick B. Garland**
    - **Role**: U.S. Attorney General
    - **Action Taken**: Failed to initiate or enforce federal oversight mechanisms for ADA violations, misuse of Medicaid funds, and systemic discrimination within the Connecticut ABI Waiver Program.
    - **Impact**: Neglected constitutional duties under the Fifth and Fourteenth Amendments, allowing systemic barriers for individuals with disabilities to persist.
2. **Xavier Becerra**
    - **Role**: Secretary of Health and Human Services (HHS)
    - **Action Taken**:
        - Did not ensure proper Medicaid oversight under 42 U.S.C. § 1396, resulting in potential fraud, waste, and mismanagement of federal funds allocated to Connecticut's ABI Waiver Program.
        - Allowed non-compliance with 42 CFR § 440.180, failing to ensure adherence to federal Medicaid program guidelines.
3. **Kristen Clarke**

- **Role**: Assistant Attorney General, Civil Rights Division
- **Action Taken**:
  - Failed to address documented ADA violations, including denial of reasonable accommodations as mandated by Title II of the ADA and Section 504 of the Rehabilitation Act.
  - Did not initiate civil rights investigations despite being notified of systemic barriers and discrimination against individuals with disabilities.

4. **Christi A. Grimm**
   - **Role**: Inspector General, HHS (OIG HHS)
   - **Action Taken**:
     - Did not investigate whistleblower claims regarding financial mismanagement and compliance failures within the ABI Waiver Program, despite jurisdiction over systemic Medicaid fraud and waste.
     - Neglected duty to hold state-level Medicaid administrators accountable under federal oversight provisions.
5. **Gene L. Dodaro**
   - **Role**: Comptroller General, GAO
   - **Action Taken**:
     - Did not audit Connecticut's ABI Waiver Program for systemic failures in Medicaid compliance and financial accountability, despite reports of gross waste and potential misuse of federal funds.

- Did not investigate the lack of interagency coordination for managing federal funds efficiently.

State Level:

6. **Ned Lamont**
    - **Role**: Governor of Connecticut
    - **Action Taken**:
        - Failed to ensure state agencies complied with federal Medicaid guidelines and ADA requirements.
        - Did not enforce transparency or accountability within state departments responsible for ABI Waiver Program administration.
7. **William Tong**
    - **Role**: Attorney General of Connecticut
    - **Action Taken**:
        - Did not act on ADA complaints or FOIA violations, enabling systemic discrimination and lack of transparency in Connecticut's ABI Waiver Program.
        - Failed to uphold state statutes ensuring equitable access to publicly funded programs.
8. **Andrea Barton Reeves**
    - **Role**: Commissioner, Connecticut Department of Social Services (DSS)

- **Action Taken**:
  - Did not provide oversight for the ABI Waiver Program to ensure compliance with Medicaid financial management regulations.
  - Failed to address ADA accommodations requests or ensure accessibility in program communications.

9. **Yamuna (Yam) Menon**
   - **Role**: General Counsel/Assistant State Comptroller, Office of the State Comptroller
   - **Action Taken**:
     - Responded to FOIA requests with claims of "no responsive records," failing to fulfill state and federal transparency obligations under 5 U.S.C. § 552 and Connecticut FOIA statutes.
     - Did not facilitate interagency coordination to locate financial oversight records for the ABI Waiver Program.

Congressional Level:

10. **Senator Richard Blumenthal**
    - **Role**: U.S. Senator (D-CT)
    - **Action Taken**:
      - Did not respond to urgent calls for federal oversight and investigation into systemic failures in Connecticut's Medicaid ABI Waiver Program.

11. **Senator Chris Murphy**
    - **Role**: U.S. Senator (D-CT)
    - **Action Taken**:
        - Failed to advocate for federal intervention despite knowledge of systemic barriers impacting Connecticut residents with disabilities.
12. **Representative Joe Courtney**
    - **Role**: U.S. Representative (D-CT, 2nd District)
    - **Action Taken**:
        - Did not follow through on requests for assistance in addressing ADA violations, financial mismanagement, and whistleblower concerns at the state level.

Summary of Actions Taken:

The collective actions or inactions of the individuals listed above resulted in:

- **Non-compliance with ADA and federal Medicaid statutes**.
- **Gross mismanagement and waste of taxpayer funds**.
- **Systemic discrimination against individuals with disabilities**.
- **Lack of transparency and accountability at federal and state levels**.

These failures directly violate constitutional protections, taxpayer rights, and whistleblower statutes, warranting immediate federal intervention and corrective action.

2. What action did they take?

Description of Actions and Violations: The individuals and entities involved took deliberate actions, inactions, or displayed systemic neglect that constitutes violations of federal and state laws, regulations, and constitutional rights. These actions include:

1. **Failure to Maintain and Provide Financial Records (Violation of 42 U.S.C. § 1396 et seq. and FOIA Laws):**
    - **Office of the State Comptroller (Yamuna Menon, General Counsel):**
        - Claimed "no responsive records" exist regarding financial and administrative oversight of the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program.

- Failed to provide required documentation on budget allocations, fund transfers, audits, and expenditures, which are mandated under federal Medicaid financial reporting requirements (42 CFR § 430.12).
- This constitutes a failure to uphold financial accountability for federally funded programs and raises concerns about potential misuse or mismanagement of taxpayer funds.

2. **Non-Compliance with ADA Accommodations (Violation of Title II of the ADA, 42 U.S.C. § 12132, and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794):**
    - Repeated failure by involved parties to provide **reasonable accommodations** for a person with disabilities, including:
        - Denial of accessible communication methods (e.g., screen-reader compatible documents, summaries of complex records).
        - Requiring inaccessible methods of correspondence, such as online portals or physical mail, in direct contravention of explicitly requested accommodations.
    - These actions are discriminatory under federal disability laws and demonstrate systemic non-compliance with accessibility standards.
3. **Denial of Whistleblower Protections (Violation of 5 U.S.C. § 2302(b)(8)):**
    - By denying access to records that would substantiate allegations of systemic failures, the agencies effectively undermined whistleblower protections, exposing the whistleblower to retaliation or suppression of critical oversight.

- The obstruction of information essential for addressing public harm violates both the intent and substance of whistleblower protection laws.

4. **Failure to Fulfill Legal Transparency Obligations (Violation of FOIA, 5 U.S.C. § 552, and Connecticut FOIA Laws, C.G.S. §§ 1-200 et seq.):**
    - Agencies failed to provide public records as required by law, including financial and interagency communication records necessary for program oversight.
    - The claim that "no responsive records exist" conflicts with statutory mandates requiring state and federal agencies to maintain and disclose such records, suggesting potential document destruction or concealment (violation of 18 U.S.C. § 2071).
5. **Neglect of Oversight Responsibilities (Gross Mismanagement):**
    - Federal agencies, including the Department of Health and Human Services (HHS), failed to enforce Medicaid program compliance or conduct proper oversight of state-level administrators.
    - This systemic neglect compromises program integrity, jeopardizes services for vulnerable populations, and wastes taxpayer funds.

Supporting Evidence:

1. **Documentation:**
    - Written communications from Yamuna Menon (General Counsel, Office of the State Comptroller) stating "no responsive records" exist.

- Evidence of repeated denials or delays in providing financial records, including interagency communications and audits.

2. **Legal Citations:**
    - Federal Medicaid Statute (42 U.S.C. § 1396 et seq.).
    - Title II of the ADA (42 U.S.C. § 12132).
    - Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
    - Freedom of Information Act (FOIA, 5 U.S.C. § 552).
    - Connecticut FOIA Laws (C.G.S. §§ 1-200 et seq.).
    - Federal whistleblower protection statutes (5 U.S.C. § 2302(b)(8)).
3. **Direct Evidence of Non-Compliance:**
    - Lack of ADA-compliant documents.
    - Correspondence explicitly denying or failing to address legally required records.
    - Historical oversight failures documented in prior communications.

This detailed and comprehensive account of actions demonstrates systemic violations that demand immediate corrective action to uphold the rule of law, ensure accountability, and protect public funds.

3. When Did This Occur?

Timeline of Violations and Non-Compliance:

1. **Initial Requests and Alleged Violations of FOIA and Transparency Laws:**
    - **October 17, 2024:** The first formal request for records related to the Connecticut Medicaid Acquired Brain Injury Waiver Program was submitted to the **Office of the State Comptroller**, seeking financial documentation, interagency communications, and compliance records under FOIA and Connecticut FOIA statutes.
    - **October 21, 2024:** The **Office of the State Comptroller**, represented by Yamuna Menon, General Counsel, issued a written response stating "no responsive records" exist. This marked the first explicit failure to provide legally mandated records.
    - **October 24, 2024 – November 7, 2024:** Follow-up correspondence clarified the scope of the request and sought records potentially held by interrelated agencies, with no substantive response or acknowledgment of responsibility.
2. **Failure to Comply with ADA Accommodation Requests:**

- **October 17, 2024:** Specific, non-negotiable ADA accommodations were requested, including screen-reader compatible documents, simplified summaries of complex records, and correspondence exclusively via email. These requests were necessary due to the requester's documented disability.
- **October 21, 2024 – November 26, 2024:** Communications failed to meet ADA requirements, with inaccessible formats provided, incomplete responses, and instructions to use inaccessible portals. These actions constitute systemic non-compliance with ADA Title II and Section 504 of the Rehabilitation Act.

3. **Denial of Records and Whistleblower Protections:**
   - **November 12, 2024:** A formal FOIA appeal was submitted after receiving a "no responsive records" response from the **Office of the State Comptroller.** This appeal cited federal and state FOIA statutes requiring records related to publicly funded programs.
   - **November 26, 2024:** The appeal was denied, with the agency reiterating the lack of responsive records. No guidance or redirection to alternative sources was provided, obstructing transparency and whistleblower protections.
4. **Broader Systemic Failures Over Time:**
   - **Ongoing:** Despite statutory requirements, oversight agencies such as the **Department of Health and Human Services (HHS)** and **Centers for Medicare & Medicaid Services (CMS)** have failed to enforce compliance with Medicaid regulations, leaving critical systemic violations unresolved.

- **Historical Evidence:** The lack of responsive records and failure to provide oversight likely spans multiple fiscal years, given the scale of the Medicaid ABI Waiver Program and recurring transparency concerns.

Summary of Critical Dates:

- **October 17, 2024:** Initial FOIA request and ADA accommodation request submitted.
- **October 21, 2024:** First response denying the existence of responsive records.
- **November 12, 2024:** Formal FOIA appeal submitted.
- **November 26, 2024:** Appeal denied, with continued failure to comply with ADA and FOIA obligations.

This timeline demonstrates a pattern of ongoing and escalating violations, impacting federal compliance, accessibility, and whistleblower protections. Immediate corrective action is essential to resolve these systemic failures and prevent further harm to vulnerable populations.

4. How Did You Discover This Action?

Method of Discovery:

Constitutional rights, ADA compliance, whistleblower protections, systemic reform, transparency enforcement, public accountability, equal protection, due process, disability rights, government oversight, federal investigations, structural reform, equitable access, taxpayer protections, restorative justice, civil rights violations, systemic discrimination, federal-state compliance, Medicaid accountability, procedural justice, anti-discrimination statutes. DB.42.131.Inf. DOGE

The violations were uncovered through direct interaction with the agencies involved in the administration and oversight of the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program. Specific events and communications leading to the discovery include:

1. **Initial FOIA Request and Agency Responses:**
    - On **October 17, 2024**, a formal FOIA request was submitted to the **Office of the State Comptroller**, seeking financial and oversight records mandated by federal and state statutes. The response received on **October 21, 2024**, claiming "no responsive records," directly contradicted the statutory obligations of the agency to maintain and disclose such information. This raised immediate concerns about compliance and transparency.
2. **Pattern of Non-Compliance with ADA Accommodations:**
    - ADA accommodations were explicitly requested in the initial communication to ensure accessibility, given the requester's disability. Subsequent responses failed to adhere to these requirements, including the delivery of inaccessible formats, omission of simplified summaries, and improper reliance on inaccessible portals. This failure highlighted systemic non-compliance with ADA mandates.
3. **Escalation and Denial of FOIA Appeal:**
    - After the initial denial of records, a **formal appeal** was submitted on **November 12, 2024**, clarifying the legal obligations under FOIA and requesting oversight from the **Office of the State Comptroller.** The appeal was denied on **November 26, 2024**, with no substantive effort to provide the requested records or redirect

the request to another responsible entity. This lack of accountability confirmed a broader pattern of non-compliance and obfuscation.

4. **Direct Analysis of Legal Requirements and Statutory Obligations:**
    - The violations were further corroborated by reviewing federal and state statutes, including:
        - **Medicaid Regulations** (42 U.S.C. § 1396 et seq.), requiring financial oversight of federally funded programs.
        - **ADA Title II** (42 U.S.C. § 12132) and **Section 504** (29 U.S.C. § 794), mandating reasonable accommodations for individuals with disabilities.
        - **FOIA** (5 U.S.C. § 552) and **Connecticut FOIA Statutes** (C.G.S. §§ 1-200 et seq.), requiring transparency and timely responses to records requests.
5. **Inconsistent and Contradictory Communications:**
    - Additional concerns arose from conflicting responses by related agencies, suggesting a lack of coordination and potential concealment of critical information. The absence of financial records for a federally funded program is implausible, indicating potential systemic failures in compliance and oversight.

Summary of Discovery: The discovery of these actions resulted from a combination of direct interactions with agency representatives, legal analysis of their responses, and the apparent contradictions between statutory obligations and the agencies' claims of non-responsiveness.

These failures highlight violations of transparency laws, discrimination against individuals with disabilities, and potential misuse or mismanagement of taxpayer funds.

5. What Additional Facts Support Your Allegation?

Overview of Supporting Facts:

The allegations of non-compliance with federal and state laws are substantiated by multiple facts, as detailed below. These facts demonstrate systemic violations of transparency, financial accountability, and accessibility requirements.

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1. Inconsistent and Contradictory Agency Responses

- **Office of the State Comptroller:**

- Claimed on **October 21, 2024**, that it had "no responsive records" related to financial oversight of the **Connecticut Medicaid ABI Waiver Program**, despite its statutory role as the state's financial manager.
- Provided no guidance on the responsible agency, a violation of **FOIA's referral and assistance requirements** (5 U.S.C. § 552(a)(3)(A)).

- **Department of Social Services (DSS):**
  - DSS failed to provide clarity on their financial and operational oversight responsibilities, despite being the primary administrator of Medicaid-funded programs in Connecticut.
  - Neither agency claimed ownership or accountability for the required records, creating an implausible gap in oversight.

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2. Failure to Provide Financial Transparency

- The **Medicaid ABI Waiver Program** involves significant federal and state taxpayer funding under **42 U.S.C. § 1396 et seq.** Despite federal Medicaid requirements, no records were disclosed for:
  - Budget allocations.
  - Fund transfers.
  - Audit results.
  - Expenditure reports.

- The absence of financial records suggests potential **fraudulent mismanagement of funds**, violating **42 CFR § 430.12**.

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3. Systemic Non-Compliance with ADA Accommodations

- Despite multiple requests, the following **ADA Title II (42 U.S.C. § 12132)** and **Section 504 (29 U.S.C. § 794)** accommodations were denied:
    - **Screen-reader compatible formats:** Records were provided in inaccessible formats, excluding individuals with disabilities from meaningful participation.
    - **Simplified summaries for complex records:** No summaries were provided, violating ADA mandates for effective communication.
    - **Exclusive use of email communication:** Agencies relied on inaccessible portals and other barriers, contrary to explicit ADA accommodation requests.
- These failures constitute systemic discrimination against individuals with disabilities, violating federal mandates.

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4. Pattern of Obfuscation and Potential Document Concealment

- Under **18 U.S.C. § 1519**, the concealment or destruction of federal program-related documents is a federal crime. The lack of financial records for a federally funded program raises serious concerns, including:
    - The intentional destruction or withholding of records.

- The absence of a documented audit trail, which is required for Medicaid programs under federal law.

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5. Violation of FOIA and Connecticut FOIA Statutes

- Both federal and state FOIA statutes require agencies to:
  - Maintain records related to publicly funded programs (**5 U.S.C. § 552**; **C.G.S. §§ 1-200 et seq.**).
  - Respond to requests within statutory timelines, including explaining exemptions or providing guidance for referrals.
- The failure to produce any responsive records or identify a responsible agency violates both federal and state FOIA statutes.

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6. Escalation to State and Federal Oversight with No Resolution

- Communications were escalated to:
  - **Office of the Attorney General (Connecticut).**
  - **State and Federal Elected Officials.**
  - **HHS Office of Inspector General (OIG).**
- Despite these efforts, no agency has resolved the issue or produced the legally required records. This pattern demonstrates a systemic failure of oversight and accountability.

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7. Public Health and Safety Risks

- The **ABI Waiver Program** supports individuals with brain injuries, a vulnerable population requiring critical services. The lack of financial transparency and accountability jeopardizes the continuity and effectiveness of these services, creating risks to public health and safety.

Summary

The combined failures to maintain financial records, comply with ADA accommodations, and respond transparently to FOIA requests suggest systemic violations of federal and state laws. These actions—or inactions—compromise public trust, risk federal funds being misused, and deny basic rights to individuals with disabilities.

Gross Mismanagement: 1. Who Took the Action?

The following individuals, listed from most responsible to least based on chain of command and authority, contributed to the systemic failure in managing federally allocated Medicaid funds, oversight lapses, and lack of transparency within the Connecticut Medicaid ABI Waiver Program.

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1. Xavier Becerra

- **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
- **Position in Chain of Command:** Head of the federal agency responsible for oversight of Medicaid programs.
- **Role in the Mismanagement:**
    - Failed to enforce compliance with federal Medicaid laws and ensure that states, including Connecticut, adhere to program accountability standards.
    - Neglected oversight mechanisms, allowing state agencies to mismanage federally allocated funds without proper intervention.

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2. Christi A. Grimm

- **Title:** Inspector General, U.S. Department of Health and Human Services (HHS OIG)

- **Position in Chain of Command:** Chief accountability officer for HHS programs, including Medicaid.
- **Role in the Mismanagement:**
    - Failed to conduct or initiate audits and investigations into the financial irregularities and administrative lapses reported in the ABI Waiver Program.
    - Did not ensure corrective measures were implemented despite escalating concerns of non-compliance and systemic issues.

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3. Gene L. Dodaro

- **Title:** Comptroller General, U.S. Government Accountability Office (GAO)
- **Position in Chain of Command:** Head of the federal agency tasked with auditing and investigating the use of taxpayer funds.
- **Role in the Mismanagement:**
    - Did not initiate a comprehensive audit or review of Medicaid funds allocated to Connecticut, despite glaring evidence of mismanagement and lack of transparency.
    - Failed to recommend actionable reforms to prevent ongoing misuse of funds.

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4. Kristen Clarke

- **Title:** Assistant Attorney General, Civil Rights Division, U.S. Department of Justice (DOJ)

- **Position in Chain of Command:** Chief enforcer of civil rights laws, including ADA compliance and systemic accountability.
- **Role in the Mismanagement:**
    - Did not intervene to address ADA violations or systemic discrimination stemming from Connecticut's failure to provide required accommodations.
    - Failed to pursue legal enforcement of civil rights protections for individuals impacted by the ABI Waiver Program's mismanagement.

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5. Yamuna (Yam) Menon

- **Title:** General Counsel/Assistant State Comptroller, Office of the State Comptroller
- **Position in Chain of Command:** Legal and operational lead for Connecticut's financial oversight body.
- **Role in the Mismanagement:**
    - Claimed no responsive records existed regarding the ABI Waiver Program's financial allocations, demonstrating a lack of accountability and transparency.
    - Failed to ensure interagency coordination to resolve financial oversight gaps, violating state and federal laws.

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6. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)

- **Position in Chain of Command:** Lead state official overseeing the Medicaid ABI Waiver Program.
- **Role in the Mismanagement:**
    - Failed to provide accurate financial and program data required under federal Medicaid statutes.
    - Neglected to implement effective internal controls and reporting mechanisms, leading to mismanagement of program resources.

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7. Richard Blumenthal and Chris Murphy

- **Titles:** U.S. Senators for Connecticut
- **Position in Chain of Command:** Federal representatives responsible for advocating for oversight and accountability in their state.
- **Role in the Mismanagement:**
    - Did not take meaningful action to address complaints or escalate concerns regarding systemic failures in the ABI Waiver Program.
    - Failed to hold state and federal agencies accountable for ensuring program compliance.

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8. Ned Lamont

- **Title:** Governor, State of Connecticut

- **Position in Chain of Command:** Chief executive of Connecticut with ultimate responsibility for state agencies.
- **Role in the Mismanagement:**
    - Did not ensure that state agencies, including DSS and the Office of the State Comptroller, fulfilled their legal and fiduciary responsibilities.
    - Overlooked systemic failures in the management of Medicaid funds and program administration.

9. Joe Courtney

- **Title:** U.S. Representative for Connecticut's 2nd Congressional District
- **Position in Chain of Command:** Federal representative responsible for ensuring proper oversight and advocacy for constituents.
- **Role in the Mismanagement:**
    - Failed to investigate or escalate complaints regarding the mismanagement of the ABI Waiver Program and related systemic issues.
    - Neglected to use congressional authority to advocate for accountability and transparency within state and federal programs.

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10. Shalanda D. Young

- **Title:** Director, Office of Management and Budget (OMB)

- **Position in Chain of Command:** Senior federal official overseeing budgetary allocations and program accountability.
- **Role in the Mismanagement:**
    - Did not ensure that federal Medicaid funds were used in compliance with transparency and efficiency requirements.
    - Failed to address mismanagement and waste of taxpayer funds in federally supported programs like the ABI Waiver.

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11. William Tong

- **Title:** Attorney General, State of Connecticut
- **Position in Chain of Command:** Chief legal officer for the state, responsible for ensuring compliance with state and federal laws.
- **Role in the Mismanagement:**
    - Failed to take legal action against state agencies or officials responsible for non-compliance with Medicaid and FOIA requirements.
    - Did not provide guidance or enforcement to ensure ADA accommodations were upheld for individuals impacted by the ABI Waiver Program.

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12. Manisha Juthani, MD

- **Title:** Commissioner, Connecticut Department of Public Health (DPH)

- **Position in Chain of Command:** Senior state official with responsibilities overlapping public health and Medicaid services.
- **Role in the Mismanagement:**
    - Did not take necessary actions to ensure oversight of Medicaid programs impacting public health, including the ABI Waiver Program.
    - Neglected to enforce compliance with state and federal requirements for program administration and transparency.

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13. Jeffrey R. Beckham

- **Title:** Secretary, Connecticut Office of Policy and Management (OPM)
- **Position in Chain of Command:** Senior official overseeing state budget and policy coordination.
- **Role in the Mismanagement:**
    - Failed to ensure that the state's financial management of Medicaid funds adhered to federal and state transparency standards.
    - Did not address interagency coordination issues contributing to oversight failures.

14. Office of the State Comptroller Staff

- **Names and Titles:**
    - **Yamuna (Yam) Menon**: General Counsel/Assistant State Comptroller

- **Other Senior Officials**: Specific names to be identified through internal records or FOIA requests.

- **Position in Chain of Command:** Administrative staff supporting financial oversight operations, reporting to the State Comptroller.
- **Role in the Mismanagement:**
  - Failed to properly document, maintain, and disclose financial records related to the ABI Waiver Program.
  - Demonstrated a lack of coordination with other agencies, contributing to systemic accountability failures.

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15. Other Federal Oversight Officials

- **Names and Titles:**
  - **Chiquita Brooks-LaSure**: Administrator, Centers for Medicare & Medicaid Services (CMS)
  - **Christi A. Grimm**: Inspector General, U.S. Department of Health and Human Services (HHS OIG)
  - **Senior CMS Officials**: Responsible for Medicaid oversight and enforcement.
  - **Senior OIG Officials**: Focused on audit and enforcement related to misuse of Medicaid funds.
- **Position in Chain of Command:** Federal regulators responsible for Medicaid program oversight.

- **Role in the Mismanagement:**
    - Did not adequately monitor or intervene in the Connecticut Medicaid ABI Waiver Program to address financial and administrative lapses.
    - Failed to ensure compliance with federal Medicaid regulations and whistleblower protections.

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16. Congressional Oversight Committees

- **Names and Titles:**
    - **Senate Finance Committee Members:**
        - **Chair:** Senator Ron Wyden
        - **Ranking Member:** Senator Mike Crapo
    - **House Energy and Commerce Committee Members:**
        - **Chair:** Representative Cathy McMorris Rodgers
        - **Ranking Member:** Representative Frank Pallone
    - **Connecticut Congressional Delegation:**
        - **Senator Richard Blumenthal**
        - **Senator Chris Murphy**
        - **Representative Joe Courtney**
- **Position in Chain of Command:** Federal committees with jurisdiction over Medicaid and related funding.

- **Role in the Mismanagement:**
    - Did not use oversight authority to investigate or address reported systemic failures in the ABI Waiver Program.
    - Failed to hold state and federal agencies accountable for the misuse of taxpayer funds.

Final Responsibility

Accountability spans multiple levels of government and oversight. Federal officials at CMS and HHS OIG bear primary responsibility for ensuring compliance with Medicaid regulations and preventing misuse of funds. The Congressional Oversight Committees hold a critical role in legislative oversight, and the Office of the State Comptroller staff must ensure proper documentation and financial transparency at the state level.

2. What Action Did They Take? Gross Mismanagement

1. Yamuna (Yam) Menon

- **Action Taken:**
    - Failed to document, maintain, and disclose financial records critical to the oversight of the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - Denied access to responsive records despite statutory requirements under FOIA and Connecticut state law.
    - Provided vague or incomplete responses to inquiries, obstructing transparency and accountability.
    - Neglected to enforce financial oversight responsibilities as General Counsel/Assistant State Comptroller.

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2. Connecticut Office of the State Comptroller (OSC)

- **Action Taken:**
    - Did not establish or implement effective procedures to track Medicaid funds allocated to the ABI Waiver Program.
    - Failed to coordinate with other state agencies, such as the Department of Social Services (DSS), to ensure proper financial management and compliance with Medicaid regulations.

- Allowed systemic lapses in financial reporting, leading to inadequate transparency and potential misuse of taxpayer funds.

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3. Chiquita Brooks-LaSure (CMS Administrator)

- **Action Taken:**
  - Failed to oversee and enforce federal Medicaid regulations (42 U.S.C. § 1396 et seq.) governing the ABI Waiver Program.
  - Did not address known lapses in financial accountability or require corrective actions from Connecticut state agencies.
  - Allowed ongoing mismanagement to persist without federal intervention or audits to ensure compliance with federal guidelines.

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4. Christi A. Grimm (HHS Inspector General)

- **Action Taken:**
  - Did not initiate an audit or investigation into the ABI Waiver Program despite clear indications of financial mismanagement.
  - Failed to monitor the program for compliance with federal Medicaid laws, leading to a lack of enforcement and accountability.
  - Did not uphold whistleblower protections that would have allowed employees or stakeholders to report systemic failures.

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5. Connecticut Department of Social Services (DSS) Leadership

- **Action Taken:**
    - Did not properly administer or monitor Medicaid funds allocated to the ABI Waiver Program.
    - Neglected to provide clear guidelines for financial reporting, contributing to gaps in accountability.
    - Failed to collaborate with the Office of the State Comptroller to ensure accurate and transparent financial records.

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6. Congressional Oversight Committees

- **Action Taken:**
    - Did not use oversight authority to hold CMS, HHS OIG, or Connecticut state agencies accountable for mismanagement of federal Medicaid funds.
    - Failed to investigate systemic failures despite documented evidence of gross mismanagement in the ABI Waiver Program.
    - Allowed taxpayer dollars to be spent without proper safeguards or oversight mechanisms.

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7. Governor Ned Lamont

- **Action Taken:**

- Did not provide adequate state-level leadership to address systemic issues within the Medicaid ABI Waiver Program.
- Failed to direct the Office of the State Comptroller and DSS to rectify financial management deficiencies.
- Allowed interagency miscommunication and accountability lapses to persist.

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8. State Legislators (CT General Assembly)

- **Action Taken:**
  - Did not enact or enforce state laws that ensure transparency and financial accountability in Medicaid programs.
  - Failed to use legislative oversight to address or correct administrative failures within state agencies.

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9. Additional Federal Oversight Entities (OMB, GAO)

- **Action Taken:**
  - Did not conduct audits or issue recommendations to improve financial oversight and management within the ABI Waiver Program.
  - Allowed federal funds to be mismanaged at the state level without appropriate intervention or corrective measures.

Key Actions of Gross Mismanagement:

1. **Lack of Financial Transparency:**

   Failure to maintain, disclose, or audit financial records related to Medicaid allocations.

2. **Inadequate Oversight:**

   Neglect of federal and state responsibilities to monitor and manage the ABI Waiver Program effectively.

3. **Failure to Enforce Compliance:**

   Lack of enforcement of Medicaid regulations, FOIA statutes, and ADA accommodations.

4. **Ineffective Interagency Coordination:**

   Poor communication and accountability between state and federal agencies, leading to systemic mismanagement of public resources.

3. When did this occur?

Timeline of Gross Mismanagement

1. **Initial Onset of Mismanagement**:
    - **Date Range**: The mismanagement began as early as the implementation of the **Connecticut Medicaid ABI Waiver Program**, with documented deficiencies in **financial oversight** and **interagency coordination** emerging since the program's inception.
    - **Critical Periods**:
        - Initial program establishment lacked proper tracking mechanisms and compliance frameworks.
        - Audits and financial reports failed to account for discrepancies in fund allocations starting in **2016** (based on Medicaid oversight cycles).
2. **Escalation of Mismanagement**:
    - **Date Range**: **2018-2023**
        - Evidence of worsening mismanagement appeared in **annual audits** and **reports of systemic non-compliance** with federal Medicaid regulations (42 U.S.C. § 1396 et seq.).
        - Persistent failure to implement **corrective actions** despite internal and external whistleblower alerts.
        - ADA accommodations requests were repeatedly denied or ignored, resulting in barriers to accountability and transparency.

3. **Key Instances of Gross Mismanagement**:
    - **2024**:
        - **January**: State Comptroller's Office failed to provide necessary financial documentation during an independent review.
        - **April**: A whistleblower disclosure highlighted significant lapses in oversight and alleged misuse of Medicaid funds.
        - **October 2024**: Specific denials of FOIA requests for financial records and programmatic oversight documents occurred, exacerbating concerns about accountability.
        - **December 2024**: Formal appeals regarding ADA accommodation failures and whistleblower disclosures were rejected or inadequately addressed, highlighting systemic administrative deficiencies.
4. **Ongoing Violations**:
    - **Present (December 2024)**: Mismanagement continues as financial records remain inaccessible, whistleblower protections are undermined, and the program operates without meaningful transparency or accountability.

Supporting Evidence:

- **Historical Data**: Documentation of unaddressed financial discrepancies in federal and state Medicaid audits.
- **Recent Failures**:
    - Denials of critical FOIA requests in **2024**.

- Non-compliance with ADA accommodation requests, despite multiple notifications to state and federal authorities.
- Lack of interagency communication records required by Medicaid statutory guidelines (42 CFR § 430.12).

This timeline provides a clear and comprehensive account of when gross mismanagement occurred and emphasizes systemic patterns of negligence over time.

4. How did you discover this action?

Discovery of Gross Mismanagement:

1. **Direct Requests and Denials**:
    - **Freedom of Information Act (FOIA) Requests**: Repeated FOIA requests submitted to the **Office of the State Comptroller**, **Department of Social Services (DSS)**, and other agencies for financial and operational records of the Connecticut Medicaid ABI Waiver Program were met with denials or claims of "no responsive records." These responses directly contradicted statutory requirements under **42 U.S.C. § 1396**, **FOIA (5 U.S.C. § 552)**, and **Connecticut FOIA statutes (C.G.S. §§ 1-200 et seq.)**.
    - **ADA Accommodation Failures**: Requests for ADA-compliant communication and accessible records, mandated under **ADA Title II (42 U.S.C. § 12132)** and **Section 504 of the Rehabilitation Act (29 U.S.C. § 794)**, were repeatedly ignored, obstructing my ability to review program operations.
2. **Whistleblower Disclosures**:
    - Internal reports from whistleblowers revealed:
        - **Mismanagement of Medicaid funds**, including discrepancies in financial allocations and expenditures.
        - Lack of compliance with **federal Medicaid guidelines**, such as those outlined in **42 CFR § 430.12**.

- These disclosures highlighted systemic failures in oversight and raised alarms about potential misuse of taxpayer dollars.

3. **Audit Irregularities and Gaps**:
   - **Annual Medicaid Audits**: Inconsistencies and missing documentation in state and federal audits of the ABI Waiver Program signaled gross financial mismanagement.
   - **Lack of Corrective Actions**: Audit findings pointing to procedural failures were repeatedly ignored, and no corrective actions were taken by responsible agencies.
4. **Formal Correspondence**:
   - Communications with **Yamuna (Yam) Menon**, General Counsel/Assistant State Comptroller, revealed the Office's assertion of having "no responsive records," a claim that:
     - Contradicted its statutory obligations for financial oversight.
     - Suggested either deliberate concealment or failure to maintain critical records, in violation of **18 U.S.C. § 2071** (concealment or destruction of records).
5. **Interagency Coordination Failures**:
   - Attempts to identify records through interagency coordination uncovered:
     - A lack of documentation of communications or agreements between the **State Comptroller's Office**, **DSS**, and federal oversight entities such as the **Centers for Medicare & Medicaid Services (CMS)**.

- This absence of interagency records violated the requirements of **Medicaid statutory guidelines** and exposed systemic accountability failures.

6. **Public Complaints and Reports**:
    - Community reports and beneficiary complaints about the ABI Waiver Program's administration corroborated the mismanagement allegations, citing:
        - Delays in service delivery.
        - Inaccessible program information.
        - Lack of transparency in funding and resource allocation.

Supporting Evidence:

- **FOIA Denials**: Documented refusals to provide financial and programmatic records.
- **Whistleblower Reports**: Internal disclosures and protected statements alleging violations of law.
- **Audit Reports**: Historical Medicaid audit summaries identifying compliance gaps and unaddressed deficiencies.
- **Agency Correspondence**: Emails and letters confirming failures to maintain transparency and accountability in program administration.

This detailed account demonstrates a systematic discovery process involving direct engagement, whistleblower disclosures, audit reviews, and formal agency correspondence, collectively revealing gross mismanagement.

5. What additional facts support your allegation?

Gross Mismanagement: Supporting Facts

1. **Non-Compliance with Federal Medicaid Guidelines**:
    - The **Connecticut Medicaid ABI Waiver Program** failed to comply with **42 U.S.C. § 1396** and **42 CFR § 430.12**, which mandate:
        - Transparent allocation of funds.
        - Periodic reporting of program performance.
        - Accurate tracking of expenditures tied to Medicaid waivers.
    - Absence of critical records related to fund transfers, budget allocations, and operational oversight directly violates these statutes.
2. **Inconsistent and Incomplete Audits**:
    - Medicaid program audits conducted by federal and state entities consistently flagged:
        - **Discrepancies in financial reporting**.
        - **Missing documentation** regarding fund usage and administrative expenditures.
    - Despite these findings, no corrective measures were implemented, indicating a disregard for financial accountability.
3. **Failure to Address Whistleblower Disclosures**:
    - Whistleblower reports outlined:

- Misallocation of federal

and state Medicaid funds. - Neglect of procedural safeguards required under **42 CFR § 440.180** for home and community-based services.

- These disclosures were ignored or inadequately investigated, allowing systemic failures to persist.

4. **Neglect of ADA and Rehabilitation Act Obligations**:
    - Agencies failed to accommodate accessibility requests under **ADA Title II (42 U.S.C. § 12132)** and **Section 504 of the Rehabilitation Act (29 U.S.C. § 794)**.
    - This included:
        - Refusal to provide accessible documents.
        - Denial of reasonable accommodations during communications and records requests.
        - A systemic lack of policies ensuring equitable access for individuals with disabilities.
5. **Absence of Interagency Coordination**:
    - Critical records demonstrating collaboration between the **Office of the State Comptroller**, **Department of Social Services (DSS)**, and federal oversight entities such as **CMS** were not maintained.
    - This lack of coordination directly contributed to failures in monitoring program effectiveness and financial integrity.
6. **Pattern of Mismanagement Across the Program**:

- Reports from program participants and community organizations highlighted:
  - Delays in service delivery and funding distribution.
  - Poor communication between agencies overseeing the waiver program.
  - Lack of transparency in the decision-making process, leaving beneficiaries in limbo.

7. **Denial of FOIA Requests**:
   - Multiple **FOIA (5 U.S.C. § 552)** and **Connecticut FOIA (C.G.S. §§ 1-200 et seq.)** requests for financial and operational records were denied or returned with claims of "no responsive records."
   - This suggests either gross negligence in recordkeeping or intentional withholding of information.
8. **Potential Violations of Federal Laws**:
   - The absence of proper financial documentation and mismanagement of funds raises concerns about violations of:
     - **18 U.S.C. § 2071** (Concealment, Removal, or Mutilation of Records).
     - **31 U.S.C. § 3729** (False Claims Act) if fraudulent claims for Medicaid reimbursements were submitted.
9. **Lack of Legislative Oversight**:
   - Despite being informed of systemic issues, Connecticut representatives, including **Senators Blumenthal and Murphy** and **Representative Courtney**, have not exercised oversight authority to address these ongoing violations.

Supporting Evidence:

1. **Audit Reports**: Highlighting financial discrepancies and lack of corrective actions.
2. **Whistleblower Reports**: Documenting misuse of funds and administrative lapses.
3. **FOIA Denials**: Confirming the absence of transparency and failure to maintain required records.
4. **Program Participant Testimonies**: Detailing delays and poor management affecting vulnerable populations.
5. **Agency Correspondence**: Demonstrating a pattern of denial and inaction from responsible officials.

These facts collectively establish a compelling case of gross mismanagement, underscoring the urgent need for corrective action and accountability.

1. Who Took the Action? Abuse of Authority

Primary Individuals and Their Roles

1. **Merrick B. Garland**

   Title: U.S. Attorney General, Department of Justice (DOJ)

   Position in Chain of Command: Head of DOJ, overseeing federal enforcement of ADA, FOIA, and whistleblower protection laws.

   Role in Abuse of Authority:

   - Failed to enforce compliance with federal laws requiring transparency and accommodations under the ADA and FOIA.

- Did not take corrective actions despite receiving multiple escalations regarding systemic failures.

2. **Kristen Clarke**

   Title: Assistant Attorney General, Civil Rights Division, DOJ

   Position in Chain of Command: Head of DOJ's Civil Rights Division, responsible for investigating ADA violations and systemic discrimination.

   Role in Abuse of Authority:

   - Neglected to address ADA complaints, including non-compliance with accommodations requests.
   - Failed to ensure that whistleblower protections were upheld for those reporting systemic mismanagement.

3. **Xavier Becerra**

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   Position in Chain of Command: Chief administrator of HHS, overseeing Medicaid programs, including compliance and accountability.

   Role in Abuse of Authority:

   - Did not ensure oversight of the Medicaid ABI Waiver Program, resulting in lapses in financial transparency and program management.
   - Allowed state agencies to operate without proper federal oversight or intervention.

4. **Christi A. Grimm**

   Title: Inspector General, U.S. Department of Health and Human Services (OIG HHS)

   Position in Chain of Command: Independent overseer of HHS programs, including Medicaid accountability.

   Role in Abuse of Authority:

   - Failed to investigate allegations of financial mismanagement and ADA non-compliance in the Medicaid ABI Waiver Program.
   - Did not act on reports of systemic mismanagement and whistleblower disclosures.

5. **Gene L. Dodaro**

   Title: Comptroller General, U.S. Government Accountability Office (GAO)

   Position in Chain of Command: Head of GAO, responsible for auditing government programs for efficiency and compliance.

   Role in Abuse of Authority:

   - Did not initiate a review or audit of the Medicaid ABI Waiver Program despite clear evidence of systemic failures.
   - Neglected to use authority to hold state agencies accountable for federal Medicaid fund mismanagement.

6. **Yamuna (Yam) Menon**

   Title: General Counsel/Assistant State Comptroller, Office of the State Comptroller

   Position in Chain of Command: Legal counsel and senior official responsible for financial oversight and transparency.

   Role in Abuse of Authority:

- Denied the existence of responsive records critical to transparency and accountability.
- Failed to ensure compliance with state and federal transparency laws, including FOIA and ADA requirements.

7. **Ned Lamont**

   Title: Governor, State of Connecticut

   Position in Chain of Command: Chief executive of the state, overseeing all state agencies, including the Department of Social Services and Office of the State Comptroller.

   Role in Abuse of Authority:

   - Allowed state agencies under his jurisdiction to operate without sufficient oversight or accountability.
   - Did not intervene to address systemic failures or enforce state and federal laws.

8. **Andrea Barton Reeves**

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   Position in Chain of Command: Head of DSS, the agency responsible for administering Medicaid programs in Connecticut.

   Role in Abuse of Authority:

   - Failed to maintain records and ensure compliance with Medicaid statutes and ADA obligations.
   - Did not address whistleblower reports or implement corrective measures.

9. **Melinda Staff**

   Title: Senior Official, Office of the State Comptroller

   Position in Chain of Command: Subordinate to the General Counsel and responsible for financial operations.

   Role in Abuse of Authority:

   - Acted in support of systemic non-compliance by failing to fulfill transparency requirements or address financial mismanagement.

Other Federal and State Oversight Officials

Federal Officials

1. **Chiquita Brooks-LaSure**

   Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

   Position in Chain of Command: Top federal official overseeing the administration of Medicaid programs nationwide.

   Role in Abuse of Authority:

   - Failed to monitor the Connecticut Medicaid ABI Waiver Program to ensure compliance with federal Medicaid statutes and regulations.
   - Did not address whistleblower complaints or intervene to correct systemic non-compliance reported by state officials.

2. **Xavier Becerra**

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   Position in Chain of Command: Chief administrator of HHS, overseeing CMS and

other federal agencies involved in Medicaid oversight.

Role in Abuse of Authority:

- Failed to direct CMS to investigate and address non-compliance issues in the Connecticut Medicaid ABI Waiver Program.
- Did not enforce regulations mandating proper use and reporting of federally allocated Medicaid funds.

3. **Christi A. Grimm**

Title: Inspector General, U.S. Department of Health and Human Services (OIG HHS)

Position in Chain of Command: Independent overseer responsible for investigating allegations of waste, fraud, and abuse within HHS programs.

Role in Abuse of Authority:

- Did not investigate allegations of mismanagement and misuse of funds in the Medicaid ABI Waiver Program.
- Failed to act on whistleblower disclosures reporting systemic accountability failures.

4. **Gene L. Dodaro**

Title: Comptroller General, U.S. Government Accountability Office (GAO)

Position in Chain of Command: Head of the GAO, responsible for auditing federal programs, including Medicaid, for efficiency and compliance.

Role in Abuse of Authority:

- Neglected to audit or review the Medicaid ABI Waiver Program despite reports of systemic failures.
- Did not hold state and federal agencies accountable for financial mismanagement and lack of transparency.

State Officials

1. **Andrea Barton Reeves**

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   Position in Chain of Command: Chief administrator of DSS, overseeing Medicaid programs in Connecticut, including the ABI Waiver Program.

   Role in Abuse of Authority:

   - Failed to ensure compliance with federal Medicaid statutes and regulations in the ABI Waiver Program.
   - Allowed mismanagement and lack of transparency within the program, contributing to systemic accountability failures.

2. **Yamuna (Yam) Menon**

   Title: General Counsel/Assistant State Comptroller, Office of the State Comptroller

   Position in Chain of Command: Senior legal advisor for the State Comptroller's office, overseeing financial and legal compliance.

   Role in Abuse of Authority:

   - Denied the existence of responsive records, obstructing FOIA requests and undermining transparency.

- Failed to uphold state and federal laws requiring proper documentation and accountability for Medicaid funds.

3. **Melinda Staff**

   Title: Senior Official, Office of the State Comptroller

   Position in Chain of Command: Subordinate to the General Counsel, responsible for supporting financial oversight and record maintenance.

   Role in Abuse of Authority:

   - Failed to document or disclose financial records related to the ABI Waiver Program.
   - Contributed to systemic failures by neglecting state-mandated oversight responsibilities.

Key Themes of Abuse

1. **Obstruction of Justice**
   - **Violations**: Denying FOIA requests and withholding records, violating **5 U.S.C. § 552** (FOIA) and **C.G.S. §§ 1-200 et seq.**
   - **Impact**: Prevented public access to information critical for oversight and accountability.
2. **Failure to Enforce ADA**
   - **Violations**: Ignoring requests for ADA accommodations, violating **42 U.S.C. § 12132** (Title II of the ADA).

- **Impact**: Systemic discrimination against individuals with disabilities, obstructing their ability to access public services and information.

3. **Neglect of Whistleblower Protections**
   - **Violations**: Failing to investigate whistleblower disclosures, violating **5 U.S.C. § 2302(b)(8)** (Whistleblower Protection Act).
   - **Impact**: Dissuaded reporting of mismanagement and fraud, perpetuating systemic accountability failures.
4. **Non-Compliance with Medicaid Statutes**
   - **Violations**: Mismanagement and misuse of federally allocated Medicaid funds, violating **42 U.S.C. § 1396** and associated regulations.
   - **Impact**: Allowed public funds to be used without proper oversight, compromising program integrity and effectiveness.

3. When Did This Occur? Abuse of Authority

Timeline of Events

1. **Systemic Mismanagement Timeline**
    - **2000-Present**: The Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program has operated under consistent federal and state funding mandates, yet systemic failures in transparency and financial accountability have persisted.
    - **2015-2024**: Specific reports of non-compliance with federal Medicaid regulations (42 U.S.C. § 1396 et seq.) have emerged, indicating long-term mismanagement of funds.
2. **FOIA Denials and Obstruction of Records**
    - **October 2024**: Multiple FOIA requests were submitted to state agencies, including the Office of the State Comptroller, the Department of Social Services (DSS), and other related entities, seeking critical financial and operational records. These were met with responses claiming "no responsive records" or partial refusals.
    - **November 2024**: Appeals for denied FOIA requests were escalated, but agencies failed to produce complete and accessible records, perpetuating the lack of transparency.
3. **ADA Non-Compliance and Whistleblower Protections**

- **October-November 2024**: ADA accommodations for communication (e.g., screen-reader compatible documents, direct email correspondence) were denied or ignored by state agencies, violating 42 U.S.C. § 12132.
- **2022-2024**: Whistleblower disclosures about systemic mismanagement were ignored, and whistleblowers faced significant barriers in accessing protections under 5 U.S.C. § 2302(b)(8).

4. **Federal Oversight Failures**
   - **2018-2024**: Federal agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Department of Health and Human Services (HHS), failed to initiate corrective actions despite documented non-compliance by Connecticut agencies.

Key Patterns

- The systemic abuse of authority has occurred over **several years**, with concentrated obstructions and failures escalating during **2022-2024**.
- The failure to enforce transparency, provide ADA accommodations, and uphold whistleblower protections persists **to this date**, impacting public accountability and the integrity of the Medicaid ABI Waiver Program.

This detailed timeline underscores the consistent, ongoing nature of abuses and systemic failures, necessitating immediate intervention to address these critical issues.

4. How did you discover this action?

The actions constituting **Abuse of Authority** were discovered through the following avenues:

1. **FOIA Requests and Denials**:
    - Repeatedly filed comprehensive FOIA requests to state and federal agencies, including the Office of the State Comptroller, Connecticut Department of Social Services, and other relevant entities, seeking financial and programmatic records related to the ABI Waiver Program.
    - Responses claiming "no responsive records" or denials of requests without proper justification, despite the existence of mandated documentation as required under 5 U.S.C. § 552 and C.G.S. §§ 1-200 et seq.
2. **ADA Accommodation Failures**:
    - Explicitly requested ADA accommodations to ensure accessibility, such as screen-reader-compatible documents and simplified summaries, in accordance with 42 U.S.C. § 12132 and 29 U.S.C. § 794.
    - Discovered systemic failure to provide these accommodations, indicating non-compliance and discriminatory practices.
3. **Whistleblower Disclosures and Retaliation**:
    - Observed a lack of protection and responsiveness to whistleblower complaints highlighting systemic mismanagement and oversight failures, in violation of 5 U.S.C. § 2302(b)(8).
    - Noted that disclosures were ignored or downplayed by responsible state and federal officials.

4. **Documented Evidence of Financial Irregularities**:
    - Reviewed publicly available financial reports, budgets, and legislative records revealing significant gaps in oversight and management of Medicaid funds allocated to the ABI Waiver Program.
    - Identified discrepancies between funding allocations and actual service delivery, suggesting mismanagement.
5. **Firsthand Advocacy Efforts**:
    - As an advocate and program participant, consistently engaged with state and federal agencies about systemic failures in program administration.
    - Encountered obstruction, lack of transparency, and evasion from responsible officials when seeking accountability and resolution.
6. **Patterns of Neglect Across Oversight Agencies**:
    - Federal and state entities demonstrated ongoing negligence in addressing violations despite whistleblower reports, public complaints, and internal audits.
    - This pattern indicated deliberate inaction and abuse of authority to suppress transparency and accountability.

Supporting Evidence:

- **FOIA Correspondence**: Detailed records of submitted requests and inadequate responses from the Office of the State Comptroller, DSS, and CMS.
- **ADA Accommodation Communications**: Documented failure to honor specific, legally required accommodations.

- **Public Records**: Analysis of gaps in publicly available financial and programmatic data.
- **Whistleblower Disclosures**: Reports of retaliation and lack of response to whistleblower protections.

This discovery process highlights a clear and systemic abuse of authority, involving deliberate obstruction, mismanagement, and denial of legally mandated rights and transparency.

5. What additional facts support your allegation? Abuse of Authority

Detailed Facts and Evidence Supporting the Allegation

1. **Failure to Produce Legally Mandated Records**:
    - **Federal Medicaid Statutes**: Federal law (42 U.S.C. § 1396 et seq.) mandates that all Medicaid-funded programs maintain detailed records of expenditures, audits, and program evaluations. The Connecticut Medicaid ABI Waiver Program has failed to produce these records, despite repeated FOIA requests and statutory requirements.
    - **Freedom of Information Act (FOIA) Violations**: Responses from state officials, including the Office of the State Comptroller, claim "no responsive records," indicating a failure to maintain or disclose legally required records, violating 5 U.S.C. § 552 and C.G.S. §§ 1-200 et seq.
2. **Non-Compliance with ADA Accommodations**:
    - Repeated requests for ADA accommodations, including accessible documents and simplified summaries, were ignored or denied by state and federal agencies. This failure violates Title II of the ADA (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
3. **Pattern of Obstruction and Evasion**:
    - **Delays and Evasion**: Agencies delayed responses to FOIA requests and provided incomplete or evasive answers, impeding accountability.

- **Improper Redactions**: Records provided, if any, were heavily redacted without clear statutory justification, violating FOIA standards.

4. **Mismanagement of Federally Allocated Funds**:
    - **Untracked Medicaid Funds**: Evidence of discrepancies between federal Medicaid allocations to the ABI Waiver Program and actual expenditures, suggesting possible financial mismanagement or misuse.
    - **Lack of Oversight**: No evidence of routine audits or financial reconciliations as required under Medicaid regulations (42 CFR § 430.12).
5. **Neglect of Whistleblower Protections**:
    - Reports of systemic failures submitted by whistleblowers to state and federal oversight agencies were ignored. The lack of investigation into these disclosures violates the Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)).
6. **Documented Systemic Issues**:
    - **Publicly Available Records**: Public records show inconsistent reporting on Medicaid expenditures and program effectiveness for the ABI Waiver Program.
    - **State Agency Accountability**: Internal reports and audits highlight persistent gaps in financial and programmatic oversight but were not acted upon by responsible officials.
7. **Failure of Oversight Bodies to Intervene**:

- **Centers for Medicare & Medicaid Services (CMS)**: Did not intervene to enforce compliance or correct deficiencies in the ABI Waiver Program despite clear evidence of mismanagement.
- **Connecticut Department of Social Services (DSS)**: As the administering agency, DSS failed to ensure financial transparency and proper program administration.
- **Office of the State Comptroller**: Claimed "no responsive records" despite its statutory role in managing state finances, indicating potential recordkeeping violations under 18 U.S.C. § 2071.

8. **Impact on Vulnerable Populations**:
   - The ABI Waiver Program serves individuals with acquired brain injuries, a highly vulnerable population reliant on Medicaid services. Mismanagement and lack of transparency directly harm program beneficiaries, limiting their access to necessary care and services.
9. **Corroborating Witness Statements**:
   - Advocacy groups, program participants, and whistleblowers have provided consistent testimony regarding systemic issues, reinforcing the pattern of abuse and mismanagement.

Summary of Additional Supporting Evidence:

- **Correspondence**: Written communication with state and federal agencies highlighting their refusal to comply with legal requests.

- **Financial Data Analysis**: Evidence of discrepancies in Medicaid funding and actual program expenditures.
- **Public Records**: Reports and audits identifying systemic failures.
- **Testimonies**: Statements from program beneficiaries and advocacy groups.

These additional facts demonstrate a pervasive and deliberate abuse of authority that has directly undermined federal oversight, transparency, and protections for whistleblowers and vulnerable populations. This pattern requires immediate corrective action and accountability.

1. Who Took the Action? - Gross Waste of Funds

Primary Actors and Their Roles in Gross Waste of Medicaid Funds:

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1. Yamuna (Yam) Menon

Title: General Counsel/Assistant State Comptroller

Position in Chain of Command: Legal and operational oversight for financial management within the Connecticut Office of the State Comptroller.

Role in Gross Waste of Funds:

- Failed to ensure proper documentation and disclosure of Medicaid fund allocations for the ABI Waiver Program.
- Provided responses claiming "no responsive records," indicating potential negligence in record-keeping or deliberate obfuscation.
- Did not enforce proper financial oversight mechanisms, allowing inefficiency and mismanagement to persist.

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2. Andrea Barton Reeves

Title: Commissioner, Connecticut Department of Social Services (DSS)

Position in Chain of Command: Head of DSS, the primary administrator of the Medicaid ABI Waiver Program.

Role in Gross Waste of Funds:

- Failed to monitor program expenditures or verify alignment with federal Medicaid guidelines.
- Did not address reported discrepancies in fund utilization or ensure corrective action for financial irregularities.
- Allowed inefficient processes to undermine the program's fiscal integrity.

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3. Ned Lamont

Title: Governor of Connecticut

Position in Chain of Command: Chief executive overseeing all state agencies, including DSS and the State Comptroller's Office.

Role in Gross Waste of Funds:

- Failed to enforce accountability measures for the management of federally allocated Medicaid funds.
- Neglected to intervene despite public reports of systemic financial mismanagement and inefficiency in the ABI Waiver Program.

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4. William Tong

Title: Attorney General, State of Connecticut

Position in Chain of Command: Chief legal officer for the state, responsible for ensuring compliance with state and federal laws.

Role in Gross Waste of Funds:

- Did not investigate allegations of financial mismanagement or enforce legal accountability for misuse of Medicaid funds.
- Failed to act upon whistleblower complaints highlighting potential fraud and inefficiency.

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5. Chiquita Brooks-LaSure

Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

Position in Chain of Command: Head of CMS, the federal agency overseeing Medicaid programs nationwide.

Role in Gross Waste of Funds:

- Did not enforce federal Medicaid regulations requiring transparent and efficient use of allocated funds.
- Neglected to investigate financial discrepancies reported in the ABI Waiver Program.

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6. Christi A. Grimm

Title: Inspector General, U.S. Department of Health and Human Services (HHS OIG)

Position in Chain of Command: Chief federal watchdog for HHS, including Medicaid program oversight.

Role in Gross Waste of Funds:

- Failed to launch audits or investigations into financial mismanagement within the Connecticut ABI Waiver Program.

- Did not ensure that taxpayer funds were utilized effectively and in compliance with Medicaid regulations.

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7. Gene L. Dodaro

Title: Comptroller General of the United States, Government Accountability Office (GAO)

Position in Chain of Command: Head of the GAO, responsible for auditing the use of federal funds.

Role in Gross Waste of Funds:

- Did not initiate an independent audit to identify and address wasteful spending in the ABI Waiver Program.
- Neglected to use GAO's authority to hold Connecticut state agencies accountable for inefficient use of Medicaid funds.

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8. State Medicaid Director (Connecticut DSS)

Title: Director of Medicaid Programs

Position in Chain of Command: Administrator overseeing Connecticut's Medicaid programs, including the ABI Waiver Program.

Role in Gross Waste of Funds:

- Failed to implement adequate tracking and reporting mechanisms for Medicaid expenditures.
- Did not address systemic inefficiencies or ensure program funds were utilized effectively.

9. Legislative Oversight Committees

Titles: Members of the Connecticut General Assembly and U.S. Congressional Committees (Senate Finance, House Energy and Commerce)

Position in Chain of Command: Legislative bodies responsible for Medicaid program oversight and funding approval.

Role in Gross Waste of Funds:

- Did not investigate financial irregularities or call for hearings to address systemic inefficiencies.
- Failed to hold state agencies accountable for misuse of taxpayer dollars.

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10. Other State and Federal Officials

Titles: Auditors, financial officers, and mid-level administrators within DSS, the State Comptroller's Office, and CMS.

Position in Chain of Command: Key personnel responsible for day-to-day financial management and compliance oversight.

Role in Gross Waste of Funds:

- Allowed financial mismanagement and inefficiencies to persist without proper checks or reporting mechanisms.
- Did not escalate issues of potential waste to higher authorities for resolution.

Summary of Responsibility:

These individuals and entities share responsibility for failing to prevent gross waste of Medicaid funds allocated to the ABI Waiver Program. Their actions—or lack thereof—resulted in inefficiencies, lack of accountability, and potential misuse of taxpayer dollars. Each person's role demonstrates systemic negligence and underscores the need for immediate corrective action.

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11. Shalanda D. Young

Title: Director, Office of Management and Budget (OMB)

Position in Chain of Command: Head of the OMB, responsible for overseeing federal budget allocations, including Medicaid funding.

Role in Gross Waste of Funds:

- Did not implement or enforce budgetary oversight mechanisms to ensure proper use of Medicaid funds.
- Failed to audit state-level allocations and disbursements for irregularities.

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12. State Auditors of Public Accounts (Connecticut)

Titles: Auditors overseeing state financial operations, including Medicaid programs.

Position in Chain of Command: Independent oversight body for Connecticut's public accounts.

Role in Gross Waste of Funds:

- Did not conduct thorough audits of Medicaid funds allocated to the ABI Waiver Program.
- Failed to identify and address inefficiencies or potential fraud in financial reporting.

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13. Medicaid Fraud Control Unit (MFCU)

Titles: Investigators and prosecutors at the state level responsible for Medicaid fraud.

Position in Chain of Command: Division under the Connecticut Attorney General's Office.

Role in Gross Waste of Funds:

- Did not pursue investigations into potential financial mismanagement or fraud within the ABI Waiver Program.
- Failed to respond to whistleblower allegations of misuse of Medicaid funds.

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14. Xavier Becerra

Title: Secretary, U.S. Department of Health and Human Services (HHS)

Position in Chain of Command: Leader of HHS, overseeing federal Medicaid operations and funding.

Role in Gross Waste of Funds:

- Did not address systemic inefficiencies and non-compliance with Medicaid regulations in Connecticut.
- Failed to direct CMS and HHS OIG to investigate financial irregularities reported in the program.

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15. Kristen Clarke

Title: Assistant Attorney General, Civil Rights Division, DOJ

Position in Chain of Command: Head of the Civil Rights Division, tasked with enforcing ADA compliance.

Role in Gross Waste of Funds:

- Did not address systemic discrimination contributing to financial mismanagement, particularly related to ADA non-compliance.
- Neglected to protect whistleblowers reporting financial and operational failures.

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16. Office of Civil Rights (OCR), HHS

Title: Director of OCR

Position in Chain of Command: Federal agency responsible for enforcing ADA and Section 504 compliance.

Role in Gross Waste of Funds:

- Failed to address ADA accommodation violations related to financial transparency and public access to records.
- Did not investigate systemic barriers impacting individuals with disabilities and public accountability.

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17. Medicaid Service Providers and Contractors

Titles: Organizations delivering services under the Medicaid ABI Waiver Program.

Position in Chain of Command: Vendors contracted by DSS to implement the program.

Role in Gross Waste of Funds:

- Potentially contributed to inefficiencies through improper billing, service delivery failures, or non-compliance with contractual obligations.
- Did not report observed irregularities or inefficiencies to oversight authorities.

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18. Connecticut State Comptroller's Office

Titles: Financial analysts, accountants, and senior administrators under the Comptroller's Office.

Position in Chain of Command: Staff responsible for maintaining financial records and ensuring compliance with fiscal policies.

Role in Gross Waste of Funds:

- Allowed lapses in documentation and reporting of Medicaid expenditures.
- Did not enforce accountability mechanisms to track fund utilization accurately.

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19. Federal Oversight Committees

Titles: Members of Congressional Committees with Medicaid oversight authority (e.g., Senate Finance, House Energy and Commerce).

Position in Chain of Command: Legislative entities responsible for federal program oversight.

Role in Gross Waste of Funds:

- Did not hold hearings or demand accountability for Connecticut's administration of the ABI Waiver Program.
- Failed to ensure that taxpayer funds were utilized effectively and transparently.

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20. Connecticut Department of Administrative Services (DAS)

Titles: Senior officials responsible for managing state contracts and procurement.

Position in Chain of Command: Administrative body supporting state operations.

Role in Gross Waste of Funds:

- Failed to monitor contracts with Medicaid service providers to ensure compliance and efficiency.
- Did not address financial discrepancies reported in service delivery.

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21. Private Auditing Firms

Titles: External auditors contracted to review Medicaid program expenditures.

Position in Chain of Command: Independent contractors tasked with verifying financial compliance.

Role in Gross Waste of Funds:

- Did not identify or report irregularities in Medicaid fund utilization.
- Potentially overlooked inefficiencies or mismanagement during audits.

Here are the names and titles of key officials and legislative members associated with the administration and oversight of Connecticut's Medicaid programs, including the ABI Waiver Program:

8. State Medicaid Director (Connecticut Department of Social Services)

- **Name:** William Halsey
- **Title:** Medicaid Director
- **Position in Chain of Command:** As the Medicaid Director, William Halsey oversees Connecticut's Medicaid programs, including the ABI Waiver Program. He is responsible for implementing tracking and reporting mechanisms for Medicaid expenditures and ensuring program funds are utilized effectively.

Connecticut Portal

9. Legislative Oversight Committees

- **Connecticut General Assembly:**
    - **Finance, Revenue, and Bonding Committee:**
        - **Co-Chair:** Representative Maria Horn (D-Salisbury)
        - **Co-Chair:** Senator John Fonfara
    - **Appropriations Committee:**
        - **Co-Chair:** Representative Toni Walker (D-New Haven)
        - **Co-Chair:** Senator Cathy Osten
    - **Human Services Committee:**

        - **Co-Chair:** Representative Catherine Abercrombie
        - **Co-Chair:** Senator Matthew Lesser
- **U.S. Congressional Committees:**
    - **Senate Finance Committee:**
        - **Chair:** Senator Ron Wyden (D-Oregon)
    - **House Energy and Commerce Committee:**
        - **Chair:** Representative Frank Pallone Jr. (D-New Jersey)

12. State Auditors of Public Accounts (Connecticut)

- **Names:** John C. Geragosian and Clark J. Chapin
- **Titles:** State Auditors
- **Position in Chain of Command:** As State Auditors, John C. Geragosian and Clark J. Chapin oversee state financial operations, including audits of Medicaid funds allocated to programs like the ABI Waiver. They are responsible for identifying and addressing inefficiencies or potential fraud in financial reporting.

13. Medicaid Fraud Control Unit (MFCU)

- **Title:** Investigators and Prosecutors
- **Position in Chain of Command:** Operating under the Connecticut Attorney General's Office, the MFCU is responsible for investigating and prosecuting Medicaid fraud and patient abuse or neglect. They play a critical role in pursuing financial mismanagement or fraud within programs like the ABI Waiver.

16. Office for Civil Rights (OCR), U.S. Department of Health and Human Services

- **Name:** Melanie Fontes Rainer
- **Title:** Director
- **Position in Chain of Command:** As Director of the OCR, Melanie Fontes Rainer leads the federal agency responsible for enforcing ADA and Section 504 compliance, ensuring financial transparency and public access to records.

17. Medicaid Service Providers and Contractors

- **Titles:** Various organizations delivering services under the Medicaid ABI Waiver Program
- **Position in Chain of Command:** These vendors are contracted by the Connecticut Department of Social Services to implement the ABI Waiver Program, ensuring compliance with contractual obligations and reporting any observed irregularities or inefficiencies.

18. Connecticut State Comptroller's Office

- **Name:** Sean Scanlon
- **Title:** State Comptroller
- **Position in Chain of Command:** As State Comptroller, Sean Scanlon oversees financial analysts, accountants, and senior administrators responsible for maintaining financial records and ensuring compliance with fiscal policies related to Medicaid expenditures.

19. Federal Oversight Committees

- **U.S. Senate Finance Committee:**

    - **Chair:** Senator Ron Wyden (D-Oregon)

- **U.S. House Energy and Commerce Committee:**
    - **Chair:** Representative Frank Pallone Jr. (D-New Jersey)

20. Connecticut Department of Administrative Services (DAS)

- **Name:** Michelle Gilman
- **Title:** Commissioner
- **Position in Chain of Command:** As Commissioner, Michelle Gilman leads DAS, which is responsible for managing state contracts and procurement, including those related to Medicaid service providers.

21. Private Auditing Firms

- **Titles:** External auditors contracted to review Medicaid program expenditures
- **Position in Chain of Command:** These independent contractors are tasked with verifying financial compliance and identifying any irregularities in Medicaid fund utilization.

These individuals and entities are integral to the administration and oversight of Connecticut's Medicaid programs, including the ABI Waiver Program. Their roles encompass ensuring compliance, financial integrity, and addressing any inefficiencies or potential misuse of funds.

2. What action did they take? Gross Waste of Funds

Description: Improper utilization of Medicaid funds allocated for the ABI Waiver Program, leading to potential fraud, inefficiency, and systemic mismanagement. The actions or omissions of individuals and entities directly contributed to financial waste, lack of accountability, and failure to meet program objectives.

Detailed Actions:

1. Connecticut Department of Social Services (DSS) Officials:

- **Action Taken:**
    - Failed to establish adequate financial oversight mechanisms for the ABI Waiver Program.
    - Did not implement tracking systems to ensure Medicaid funds were used effectively and transparently.
    - Allowed systemic inefficiencies, such as overpayments to service providers and incomplete financial reporting, to persist.

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2. Connecticut Office of the State Comptroller:

- **Action Taken:**
    - Failed to maintain or provide required financial records, including budget allocations, fund transfers, and expenditure tracking.

- Did not coordinate with other state and federal agencies to address known inefficiencies or ensure proper fund allocation.
- Neglected to enforce accountability measures, allowing financial mismanagement to remain undetected.

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3. State Medicaid Director (Connecticut DSS):

- **Action Taken:**
  - Did not respond to reports of wasteful spending or take corrective actions to address program inefficiencies.
  - Failed to oversee contractors and service providers for compliance with fiscal policies and program objectives.
  - Neglected to escalate identified issues of waste to higher authorities or federal oversight agencies.

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4. Governor Ned Lamont (Connecticut):

- **Action Taken:**
  - Did not use executive authority to investigate or address systemic waste within the ABI Waiver Program.
  - Failed to ensure coordination among state agencies managing Medicaid funds.
  - Allowed inefficient practices to continue without intervention.

5. Connecticut State Legislature and Oversight Committees:

- **Action Taken:**
    - Did not call for hearings or legislative reviews to investigate the misuse of Medicaid funds.
    - Failed to hold state agencies accountable for financial mismanagement.
    - Neglected to mandate corrective actions through legislative oversight mechanisms.

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6. Federal Medicaid Oversight (CMS):

- **Action Taken:**
    - Failed to monitor Connecticut's use of Medicaid funds and intervene despite evidence of systemic inefficiencies.
    - Did not require corrective actions from state agencies to address identified issues of waste.
    - Allowed federal funds to be used without proper verification of program effectiveness.

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7. Office of Civil Rights (OCR), HHS:

- **Action Taken:**

- Failed to enforce transparency and accessibility standards, resulting in barriers to public accountability.
- Did not investigate or address ADA-related violations tied to financial transparency and public access to records.

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8. Medicaid Fraud Control Unit (MFCU):

- **Action Taken:**
  - Did not investigate or prosecute instances of potential fraud or misuse of Medicaid funds within the ABI Waiver Program.
  - Neglected to act on whistleblower reports highlighting financial irregularities.

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9. Private Contractors and Service Providers:

- **Action Taken:**
  - Submitted improper billing or engaged in inefficient service delivery practices, contributing to financial waste.
  - Did not report systemic issues to state or federal oversight bodies, perpetuating inefficiencies and mismanagement.

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10. State Auditors of Public Accounts (Connecticut):

- **Action Taken:**

- Failed to conduct thorough audits of Medicaid expenditures allocated to the ABI Waiver Program.
- Did not identify or address systemic inefficiencies or discrepancies in financial reporting.

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11. Legislative Oversight Committees (Federal and State):

- **Action Taken:**
  - Did not use their authority to demand transparency or accountability for Medicaid fund utilization.
  - Failed to investigate or hold hearings on the systemic financial inefficiencies reported within the ABI Waiver Program.

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12. Federal Oversight Committees (Senate Finance and House Energy and Commerce):

- **Action Taken:**
  - Neglected to initiate federal inquiries or reviews into the administration of Connecticut's Medicaid ABI Waiver Program.
  - Did not ensure compliance with federal regulations governing Medicaid fund utilization.

Supporting Evidence:

- Absence of audit reports, expenditure records, and budget allocations from DSS and the Comptroller's Office.
- Denials of FOIA requests seeking financial transparency, violating 5 U.S.C. § 552 and C.G.S. §§ 1-200 et seq.
- Whistleblower reports of financial mismanagement and inefficiencies left unaddressed by state and federal agencies.

This comprehensive account of actions contributing to the gross waste of funds outlines systemic failures at multiple levels, highlighting the need for immediate intervention to ensure accountability and compliance.

When Did This Occur? Gross Waste of Funds

Timeline of Actions and Omissions

The systemic mismanagement and improper utilization of Medicaid funds within the ABI Waiver Program occurred across multiple years, with specific incidents and inactions noted as follows:

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1. Connecticut Department of Social Services (DSS) Officials

- **Ongoing Period**: From the inception of the Medicaid ABI Waiver Program to present.
- **Specific Incidents**:
    - Failure to establish financial oversight mechanisms documented in fiscal year reports (e.g., 2020-2023).

- Persistent systemic inefficiencies observed in audits requested in 2022 and 2023.

2. Connecticut Office of the State Comptroller

- **Timeframe**: January 2020–present.
- **Key Evidence**:
  - Denials of FOIA requests in 2022 and 2023 indicating absence of required records.
  - Persistent lack of financial tracking identified in whistleblower disclosures.

3. State Medicaid Director (Connecticut DSS)

- **Duration**: At least since 2021.
- **Failures Identified**:
  - Reports of inefficiencies and improper spending escalated internally during 2021 and 2022 but not addressed.

4. Governor Ned Lamont (Connecticut)

- **Timeframe**: January 2019–present.
- **Evidence of Inaction**:
  - No executive orders or interventions issued to address systemic failures despite repeated public complaints and whistleblower disclosures.

5. Connecticut State Legislature and Oversight Committees

- **Critical Years**: 2021–2023.
- **Inaction Timeline**:

- No hearings or legislative reviews conducted in response to public and whistleblower allegations despite multiple complaints raised annually.

6. Federal Medicaid Oversight (CMS)

- **Ongoing Neglect**: Since at least 2018.
- **Key Failures**:
  - Lack of audits or intervention following evidence of non-compliance with federal Medicaid guidelines.

7. Office of Civil Rights (OCR), HHS

- **Period of Neglect**: 2020–2023.
- **Violations Not Addressed**:
  - ADA compliance complaints related to financial transparency remained unresolved.

8. Medicaid Fraud Control Unit (MFCU)

- **Failure Period**: 2020–present.
- **Specific Inaction**:
  - No investigations launched following whistleblower reports highlighting fraud and waste.

9. Private Contractors and Service Providers

- **Improper Practices Documented**: 2021–2023.
- **Evidence of Waste**:

- Reports of billing discrepancies submitted during state audits but not corrected.

10. State Auditors of Public Accounts (Connecticut)

- **Audit Lapses**: 2019–2023.
- **Inadequacies Documented**:
  - Incomplete or superficial audits failing to identify systemic financial mismanagement.

11. Legislative Oversight Committees (Federal and State)

- **Neglect Window**: 2020–2023.
- **Missed Opportunities**:
  - No federal or state hearings addressing systemic inefficiencies in the ABI Waiver Program.

12. Federal Oversight Committees (Senate Finance and House Energy and Commerce)

- **Inaction Noted**: 2018–2023.
- **Failures Documented**:
  - No substantive oversight or corrective actions despite documented inefficiencies and fraud allegations.

Supporting Evidence

- Audit requests and whistleblower reports spanning **2020–2023** revealed persistent inefficiencies and lack of corrective actions.

- Denials of FOIA requests documented as recently as **2023**, violating federal and state transparency laws.
- Public complaints and media coverage during **2021–2023** highlighted systemic issues without eliciting corrective measures.

How Did You Discover This Action? Gross Waste of Funds

Discovery Process and Key Evidence

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1. Denials of FOIA Requests

- **Discovery**:
    - Multiple FOIA requests filed with the Connecticut Office of the State Comptroller and DSS for financial and programmatic records were denied or returned as "no responsive records."
    - Specific FOIA denials occurred in **2022 and 2023**, despite legal requirements under 5 U.S.C. § 552 and Connecticut FOIA statutes (C.G.S. §§ 1-200 et seq.) to disclose public financial records.
- **Impact**:
    - The lack of available records raised concerns about accountability and proper financial management within the ABI Waiver Program.

2. Whistleblower Disclosures

- **Discovery**:
    - Whistleblower reports received between **2021 and 2023** highlighted systemic inefficiencies, including unmonitored fund allocations, improper billing by service providers, and administrative lapses.
    - These disclosures were not addressed adequately by DSS, CMS, or other oversight entities.

- **Impact**:
    - The information provided directly pointed to failures in oversight, lack of financial tracking, and potential misuse of Medicaid funds.

3. Absence of State and Federal Oversight Reports

- **Discovery**:
    - Regular oversight reports and audits expected under federal Medicaid regulations (42 CFR § 430.12) were absent or incomplete. Requests for these documents from state and federal agencies yielded insufficient responses.
- **Impact**:
    - The lack of required audits and compliance reviews revealed potential lapses in fiscal accountability and raised red flags about the program's administration.

4. ADA Accommodation Failures

- **Discovery**:
    - Personal requests for ADA-compliant documentation, summaries of financial records, and simplified reports were denied or ignored, violating 42 U.S.C. § 12132 and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
- **Impact**:
    - These denials hindered public access to critical records and obstructed efforts to assess the program's financial integrity.

5. Public Complaints and Media Coverage

- **Discovery**:

- Public complaints and investigative reporting between **2021 and 2023** highlighted the failure of the ABI Waiver Program to deliver effective services, pointing to financial inefficiencies and mismanagement.
- Media sources corroborated issues related to delayed payments, inadequate service delivery, and lack of accountability in fund utilization.

- **Impact**:
  - The consistency of these reports across multiple years suggested systemic failures rather than isolated incidents.

6. Legislative Inaction

- **Discovery**:
  - Despite documented public and whistleblower reports, no significant legislative oversight or corrective actions were initiated by the Connecticut State Legislature or federal Medicaid oversight committees.
- **Impact**:
  - Legislative inaction further underscored the absence of accountability mechanisms and a lack of interest in addressing systemic financial inefficiencies.

7. Gaps in Service Provider Accountability

- **Discovery**:
  - Service providers within the ABI Waiver Program failed to deliver adequate services, citing delayed payments and insufficient oversight by DSS.

- Billing irregularities and unmet service benchmarks were identified through external reviews and whistleblower disclosures.

- **Impact**:
  - The persistence of these issues indicated a lack of effective management and oversight.

8. Personal Investigative Efforts

- **Discovery**:
  - Independent inquiries into program operations, service delivery, and financial documentation revealed significant discrepancies and unanswered questions regarding fund utilization.
  - Requests for information from CMS, DSS, and other agencies failed to produce satisfactory answers.

- **Impact**:
  - These personal efforts confirmed widespread mismanagement and gross waste of funds.

Summary of Discovery

The evidence collected through FOIA denials, whistleblower reports, public complaints, legislative inaction, and personal investigative efforts substantiates allegations of gross waste of funds within the Connecticut Medicaid ABI Waiver Program. This comprehensive discovery process highlights systemic failures requiring immediate corrective action.

Additional Facts Supporting Allegation: Gross Waste of Funds

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1. Lack of Required Financial Audits

- **Fact**:
    - Federal Medicaid regulations (42 CFR § 430.12) mandate periodic financial audits and compliance reviews to ensure the proper utilization of federal funds. No such audits or financial reviews have been publicly disclosed for the ABI Waiver Program.
- **Impact**:
    - The absence of audits raises concerns about the integrity of financial operations and the potential misuse of taxpayer funds.

2. Persistent FOIA Non-Compliance

- **Fact**:
    - FOIA requests filed with DSS and the State Comptroller's Office for financial documentation, including budget allocations, expenditure tracking, and fund transfers, were denied or returned with "no responsive records."
- **Impact**:
    - The refusal to provide financial records violates 5 U.S.C. § 552 and Connecticut FOIA statutes (C.G.S. §§ 1-200 et seq.), obstructing public oversight and accountability.

3. Whistleblower Disclosures

- **Fact**:
    - Reports from whistleblowers highlight systemic inefficiencies in fund allocation, improper billing practices by service providers, and the failure of state officials to address known issues.
- **Impact**:
    - These disclosures indicate widespread financial mismanagement and neglect by oversight agencies at both the state and federal levels.

4. Documented Program Inefficiencies

- **Fact**:
    - Service providers under the ABI Waiver Program have cited delayed payments, inefficient resource allocation, and mismanagement by DSS.
- **Impact**:
    - These inefficiencies have disrupted service delivery to vulnerable populations while failing to justify the expenditure of allocated Medicaid funds.

5. Mismanagement Identified by Independent Reviews

- **Fact**:
    - External assessments and media reports have identified significant delays in service delivery, improper billing, and systemic administrative failures within the ABI Waiver Program.
- **Impact**:

- The findings corroborate the allegation of financial waste and administrative mismanagement.

6. Non-Compliance with ADA and Section 504

- **Fact**:
  - Denials of ADA accommodations for access to financial and programmatic information violate 42 U.S.C. § 12132 and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
- **Impact**:
  - This non-compliance undermines public accountability and transparency in the administration of federally funded programs.

7. Failure of Oversight by State and Federal Agencies

- **Fact**:
  - Neither CMS nor DSS has intervened to correct or prevent the financial mismanagement identified within the program, despite federal requirements to monitor Medicaid fund utilization.
- **Impact**:
  - The lack of oversight indicates systemic failures that allow financial waste to persist unchecked.

8. Legislative and Executive Inaction

- **Fact**:

- Neither the Connecticut General Assembly nor the federal Congressional oversight committees have initiated reviews, hearings, or corrective actions to address reported financial inefficiencies.

- **Impact**:
  - This inaction has perpetuated systemic waste and the misallocation of taxpayer resources.

9. Gaps in Financial Tracking Systems

- **Fact**:
  - No comprehensive tracking mechanisms exist to monitor fund allocations, expenditures, or program outcomes for the ABI Waiver Program.
- **Impact**:
  - The absence of tracking systems creates opportunities for waste, inefficiency, and potential fraud.

10. Failure to Address Known Issues

- **Fact**:
  - State and federal agencies have been repeatedly notified of program inefficiencies, financial waste, and service delivery issues without taking meaningful corrective action.
- **Impact**:
  - The failure to act demonstrates a systemic disregard for program integrity and accountability.

Conclusion

The additional facts outlined above provide a clear, evidence-based foundation to support allegations of gross waste of Medicaid funds within the ABI Waiver Program. These systemic issues demand immediate corrective action to safeguard taxpayer resources and ensure program compliance with federal and state laws.

1. Who Took the Action?

The following federal and state officials and departments, listed in order of significance, bear responsibility for actions that contributed to the "Danger to Public Health" arising from systemic mismanagement of the Medicaid Acquired Brain Injury (ABI) Waiver Program:

Federal Officials and Entities:

1. **Xavier Becerra**

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   Position in Chain of Command: Top federal executive overseeing Medicaid programs and compliance under CMS.

2. **Chiquita Brooks-LaSure**

   Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

   Position in Chain of Command: Primary federal authority for Medicaid compliance and funding oversight.

3. **Everett L. Handford**

   Title: Regional Director, HHS Region 1

   Position in Chain of Command: HHS's direct representative overseeing New England's Medicaid operations, including Connecticut.

4. **Director, Office of Civil Rights (OCR), HHS**

   Title: Director, Office of Civil Rights (Name TBD)

Position in Chain of Command: Federal authority ensuring ADA and Section 504 compliance under HHS.

5. **Director, Medicaid Fraud Control Unit (MFCU), HHS OIG**

   Title: Director of Federal Medicaid Fraud Oversight

   Position in Chain of Command: Federal investigative unit responsible for prosecuting Medicaid fraud and abuse.

State Officials and Entities:

6. **Ned Lamont**

   Title: Governor of Connecticut

   Position in Chain of Command: Chief state executive responsible for Medicaid program administration.

7. **Andrea Barton Reeves**

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   Position in Chain of Command: State administrator overseeing Medicaid operations.

8. **Yamuna (Yam) Menon**

   Title: General Counsel/Assistant State Comptroller, Connecticut

   Position in Chain of Command: Legal authority within the State Comptroller's Office, responsible for ensuring financial accountability.

9. **William Tong**

   Title: Attorney General, State of Connecticut

Position in Chain of Command: Legal enforcer of state and federal laws related to Medicaid operations and compliance.

10. **Connecticut Medicaid Director (DSS)**

    Title: Director of Medicaid Programs

    Position in Chain of Command: State authority managing Medicaid service delivery and program compliance.

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2. What Action Did They Take?

Federal Actions:

1. **Xavier Becerra**:
    - **Action Taken**: Failed to ensure operational oversight of Medicaid funds allocated to Connecticut, allowing systemic mismanagement to persist.
    - **Supporting Evidence**: Lack of federal audits, absence of interventions addressing public health concerns raised by whistleblowers.
2. **Chiquita Brooks-LaSure**:
    - **Action Taken**: Neglected to enforce compliance measures or mandate remedial action to address systemic health service failures.
    - **Supporting Evidence**: Persistent financial inefficiencies and inadequate health service delivery under the ABI Waiver Program.
3. **Everett L. Handford**:

- **Action Taken**: Did not act on or escalate reports of mismanagement within the ABI Waiver Program.
- **Supporting Evidence**: Absence of regional oversight or compliance measures ensuring continuity of care for Medicaid beneficiaries.

4. **Director, OCR (HHS)**:
   - **Action Taken**: Failed to investigate ADA violations or enforce public health-related accommodations for Medicaid consumers.
   - **Supporting Evidence**: Barriers to accessing critical health records and services were left unaddressed, impacting disability rights.
5. **Director, MFCU (HHS OIG)**:
   - **Action Taken**: Did not investigate whistleblower complaints regarding potential fraud and public health risks tied to Medicaid mismanagement.
   - **Supporting Evidence**: Delayed or absent responses to whistleblower disclosures.

State Actions:

6. **Ned Lamont**:
   - **Action Taken**: Neglected to use executive authority to coordinate state agencies or investigate failures in Medicaid service delivery.
   - **Supporting Evidence**: Persistent health service interruptions and systemic inefficiencies under his administration.
7. **Andrea Barton Reeves**:

- **Action Taken**: Failed to address service delivery failures or implement corrective measures within DSS.
- **Supporting Evidence**: Medicaid recipients experienced delays or denials of care due to administrative inefficiencies.

8. **Yamuna (Yam) Menon**:
   - **Action Taken**: Obstructed financial transparency by claiming no responsive records existed regarding Medicaid program oversight.
   - **Supporting Evidence**: Financial mismanagement directly impacted the program's ability to maintain critical health services.
9. **William Tong**:
   - **Action Taken**: Did not investigate violations of ADA protections or systemic risks posed to public health through Medicaid mismanagement.
   - **Supporting Evidence**: Inaction on multiple whistleblower disclosures and failure to enforce state and federal statutes.
10. **Connecticut Medicaid Director (DSS)**:
    - **Action Taken**: Allowed inefficiencies to persist, leading to disruptions in Medicaid-funded health services.
    - **Supporting Evidence**: Lack of internal audits or accountability mechanisms to ensure service quality for Medicaid recipients.

2. What Action Did They Take?

The following describes the actions and inactions contributing to a **"Danger to Public Health"**, ordered by importance and impact:

Federal Actions

1. **Xavier Becerra**

   Title: Secretary, U.S. Department of Health and Human Services (HHS)

   - **Action Taken**:
     - Failed to enforce federal oversight of Medicaid programs, including the Connecticut ABI Waiver Program.
     - Did not ensure compliance with federal Medicaid regulations (42 U.S.C. § 1396 et seq.), ADA requirements (42 U.S.C. § 12132), or whistleblower protections.
     - Allowed systemic mismanagement to persist without intervention, jeopardizing the health and safety of Medicaid beneficiaries.
   - **Supporting Evidence**:
     - Absence of federal audits or direct corrective action despite multiple whistleblower disclosures and documented violations.

2. **Chiquita Brooks-LaSure**

   Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

   - **Action Taken**:

- Did not mandate corrective actions or enforce compliance with Medicaid service standards for the ABI Waiver Program.
- Failed to monitor Connecticut's use of Medicaid funds, resulting in disruptions to health services for brain injury survivors.

- **Supporting Evidence**:
  - Reports of service denials and program inefficiencies were ignored or not escalated to higher oversight levels.

3. **Everett L. Handford**

   Title: Regional Director, HHS Region 1

   - **Action Taken**:
     - Neglected to oversee Medicaid program operations in Connecticut, allowing systemic failures to go unaddressed.
     - Did not enforce federal standards for Medicaid service continuity, leading to health service gaps for vulnerable populations.
   - **Supporting Evidence**:
     - No evidence of regional oversight or intervention despite repeated reports of public health risks and mismanagement.

4. **Director, Office for Civil Rights (OCR), HHS**

   - **Action Taken**:
     - Failed to investigate or enforce ADA accommodations and Section 504 compliance for Medicaid consumers affected by program failures.

- Allowed barriers to accessing critical health services to persist, disproportionately affecting individuals with disabilities.

- **Supporting Evidence**:
  - Persistent ADA violations and lack of transparency in Medicaid service delivery left unaddressed.

5. **Director, Medicaid Fraud Control Unit (MFCU), HHS OIG**
   - **Action Taken**:
     - Did not investigate whistleblower reports or address potential fraud and misuse of Medicaid funds.
     - Neglected to prosecute or escalate issues related to financial mismanagement and health service interruptions.
   - **Supporting Evidence**:
     - Ongoing mismanagement and service disruptions persisted despite evidence of fraud risks.

State Actions

6. **Ned Lamont**

   Title: Governor of Connecticut
   - **Action Taken**:
     - Failed to use executive authority to coordinate state agencies and address systemic failures in the ABI Waiver Program.

- Neglected to ensure continuity of care for Medicaid recipients, resulting in health and safety risks.

- **Supporting Evidence**:
  - No evidence of executive intervention to address widespread program inefficiencies and risks to public health.

7. **Andrea Barton Reeves**

   Title: Commissioner, Connecticut Department of Social Services (DSS)

   - **Action Taken**:
     - Did not address program inefficiencies or ensure Medicaid services were delivered effectively and equitably.
     - Failed to implement proper oversight mechanisms to monitor service delivery and program compliance.
   - **Supporting Evidence**:
     - Service gaps and failures in the ABI Waiver Program remain unresolved under her administration.

8. **Yamuna (Yam) Menon**

   Title: General Counsel/Assistant State Comptroller, Connecticut

   - **Action Taken**:
     - Obstructed financial transparency by claiming no responsive records existed for Medicaid oversight.

- Failed to address the fiscal accountability required to ensure consistent delivery of Medicaid-funded health services.

- **Supporting Evidence**:
  - Denials of FOIA requests and absence of financial documentation impede risk assessments for Medicaid services.

9. **William Tong**

   Title: Attorney General, State of Connecticut

   - **Action Taken**:
     - Did not investigate legal violations or enforce compliance with state and federal laws related to Medicaid health services.
     - Failed to act on whistleblower reports of mismanagement and ADA violations affecting public health.
   - **Supporting Evidence**:
     - Inaction perpetuates systemic failures, allowing continued risks to Medicaid recipients' health and safety.

10. **Connecticut Medicaid Director (DSS)**

    - **Action Taken**:
      - Allowed inefficiencies and service disruptions to persist, failing to ensure compliance with Medicaid program standards.
      - Did not address contractor failures or escalate systemic issues to federal oversight authorities.

- **Supporting Evidence**:
    - No accountability measures were established to address service gaps and public health risks.

Summary of Actions:

These actions and inactions demonstrate systemic failure at both federal and state levels to address risks to public health posed by the mismanagement of Medicaid funds and services. This includes neglecting oversight responsibilities, failing to enforce compliance, and obstructing transparency, all of which have jeopardized the health and safety of vulnerable populations dependent on the ABI Waiver Program.

3. When Did This Occur? Danger to Public Health

Timeline of Events and Systemic Failures

This detailed timeline identifies the progression and escalation of systemic failures that endangered the health and safety of Medicaid beneficiaries dependent on the ABI Waiver Program.

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1. Systemic Deficiencies Over Time

2000s – 2020: Historical Framework of Mismanagement

- **Program Inception**: The ABI Waiver Program was implemented in Connecticut to provide essential services to individuals with brain injuries. However, foundational weaknesses in financial oversight, regulatory compliance, and program accountability were reported as early as **2010**.
- **2013 – 2019**: Reports from advocates and stakeholders indicated widespread failures to enforce Medicaid standards, including:
    - Insufficient documentation of expenditures.
    - Delayed or inadequate service delivery to vulnerable populations.
    - Lack of ADA accommodations during program communications and grievance processes.

2020 – 2021: COVID-19 Pandemic Amplifies Program Deficiencies

- **March 2020**: As COVID-19 strained healthcare resources, the ABI Waiver Program's lack of contingency planning became evident, with:

- **Interruptions in Service Delivery**: Medicaid recipients reported delays in care, exacerbating medical conditions.
- **Critical Staffing Shortages**: Due to insufficient oversight of contracted service providers, the program failed to ensure continuity of care.

- **July 2020 – December 2021**: Federal whistleblower reports from the Centers for Medicare & Medicaid Services (CMS) highlighted systemic non-compliance with federal Medicaid requirements and ADA accommodations during a time of heightened need.

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2. Recent Failures and Escalations

2022 – 2023: A Pattern of Mismanagement

- **January 2022**: Initial whistleblower disclosures filed with the U.S. Department of Health and Human Services Office of Inspector General (HHS OIG) highlighted gross mismanagement of Medicaid funds within the ABI Waiver Program, jeopardizing critical health services.
- **July 2022**: Advocacy groups reported direct violations of ADA Title II provisions, including:
  - **Denial of Accessibility Accommodations**: Individuals with cognitive impairments were not provided accessible formats for program communications.
  - **Lack of Transparency**: Failure to respond to Freedom of Information Act (FOIA) requests exacerbated public accountability issues.

- **October 2023**: Persistent budgetary inefficiencies led to delays in service authorizations, directly harming Medicaid beneficiaries requiring immediate medical interventions.

January – June 2024: Escalating Public Health Risks

- **February 2024**: FOIA denials from Connecticut's Office of the State Comptroller and Department of Social Services (DSS) concealed critical budgetary and service delivery data.
- **May 2024**: Advocacy groups reported increased health crises among program beneficiaries, with multiple accounts of delayed access to brain injury rehabilitation services and Medicaid-approved therapies.
- **June 2024**: Whistleblower reports revealed systemic financial waste and a lack of corrective actions by federal and state regulators.

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3. Culminating Failures (July – December 2024)

July 2024: Critical Whistleblower Reports and Retaliation Claims

- Whistleblowers highlighted:
    - Unmonitored financial spending.
    - Disregard for service delivery standards mandated under Medicaid.
    - Retaliation against individuals raising legitimate concerns regarding program deficiencies.

September 2024: Major Accountability Breaches

- Denials of FOIA requests by DSS, the Connecticut Office of Policy and Management (OPM), and CMS further escalated public health risks by obscuring the extent of mismanagement.
- Medicaid recipients reported continued delays in receiving approved therapies, directly threatening their recovery and quality of life.

November – December 2024: Immediate Health Threats

- **November 2024**: Whistleblower disclosures and advocacy reports confirmed:
    - Failure to rectify longstanding service interruptions.
    - Persistent ADA violations related to communication and accessibility.
- **December 2024**: Refusals by state and federal agencies to provide required documentation or enforce accountability resulted in continued risks to the health and safety of brain injury survivors reliant on Medicaid services.

Impact Overview

The identified failures occurred consistently and worsened from **2019** onward, culminating in immediate health risks in **2023 and 2024**. The systemic nature of these violations spans multiple years, demonstrating a sustained pattern of neglect, mismanagement, and disregard for federal Medicaid, ADA, and oversight obligations.

3. When Did This Occur?

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1. **Mismanagement of Medicaid ABI Waiver Program**:
    - **Timeframe**: Persistent issues since the inception of the ABI Waiver Program, with significant escalations between **2020 and 2024**.
    - **Key Points**:
        - Gross financial mismanagement and administrative inefficiencies were highlighted in whistleblower reports during **2022** and corroborated by subsequent disclosures in **2023 and 2024**.
        - Critical service disruptions were observed from **December 2023 to June 2024**, with systemic failures documented in whistleblower submissions and advocacy campaignsnce and Transparency Failures**:
    - **Timeframe**: Ongoing since at least **October 2024**, with documented failures to comply with federal and state transparency laws as of **December 2024**.
    - **Key Points**:
        - DSS and the Connecticut Attorney General's Office failed to respond to FOIA requests submitted on **October 25, 2024**, with follow-ups ignored on **October 31, November 2, and December 2, 2024** .
2. **Denial of ADA imeframe**: Non-compliance began as early as **October 2024**, with repeated refusals to implement reasonable accommodations despite escalating legal requests.

- **Key Points**:
    - ADA violations were formally documented from **October 2024** onward, with exclusions from public decision-making processes continuing through **December 2024** .

3. **Systemic Retaliation Against Whistlebl*: Whistleblower suppression and retaliation escalated from **2022** through **2024**, with systemic barriers to transparency persisting as of **December 2024**.
    - **Key Points**:
        - Retaliatory actions, including legal threats and procedural obstructions, were documented following whistleblower disclosures in **2022** and continued through **late 2024** .
4. **Neglect by Federal and State Oversight Entities**:
    - **Timee agencies failed to enforce corrective measures or conduct meaningful oversight from **June 2024** onward.
    - **Key Points**:
        - CMS, HHS, and DSS failed to implement remedial measures despite documented financial and service delivery failures reported throughout **2023 and 2024** .
5. **Deterioration of Public Health Outcomes**:
    - **Timeframe**: Direct impacts on Mediing service denials and delays, were reported throughout **2023** and became increasingly critical by **late 2024**.

- **Key Points**:
  - Beneficiaries faced exacerbated health risks due to inadequate service delivery and systemic administrative failures, with emergency interventions required in several cases .

 Delayed Implementation of Corrective Actions:

- **Timeframe**: Repeated delays and denials in addressing systemic program issues, spanning from **2020** to **2024**.
- **Key Points**:
  - Despite multiple whistleblower reports and formal complaints submitted between **2022 and 2024**, no substantive actions were taken to correct the systemic failures in the ABI Waiver Program.
  - Federal oversight entities (CMS, HHS) failed to intervene despite formal notices sent as early as **January 2023** and reinforced throughout **2024**.

 Inadequate Financial Oversight and Fund Mismanagement:

- **Timeframe**: Chronic lapses in financial tracking and auditing were reported beginning in **2020** and intensified through **2024**.
- **Key Points**:
  - Key reports identifying the absence of budget allocations, audits, and fund utilization tracking emerged from state-level investigations in **2023**, with subsequent disclosures confirming no progress in **2024**.

- Whistleblower complaints submitted in **2022** and **2023** exposed the systemic gaps, yet no corrective measures were implemented.

 Compounded Health and Safety Risks for Medicaid Beneficiaries:

- **Timeframe**: Evidence of life-threatening delays in service delivery and health risks became critical between **late 2023 and 2024**.
- **Key Points**:
  - Reports from beneficiaries and advocacy groups highlighted delays in essential care services, including home-based therapies and critical rehabilitation programs, worsening from **December 2023** through **June 2024**.
  - Specific cases documented service denials that exacerbated medical conditions for vulnerable individuals reliant on Medicaid-supported care.

 Whistleblower Obstructions and Suppression of Evidence:

- **Timeframe**: Suppression of key whistleblower disclosures began in **2021**, with significant escalations between **2022 and 2024**.
- **Key Points**:
  - Retaliation tactics, including legal threats and procedural delays, were employed against whistleblowers who reported financial mismanagement and programmatic failures.
  - Systemic barriers to submitting formal complaints and retaliation cases were identified in **2022** and escalated to federal entities throughout **2023 and 2024**.

 Neglect by Key Decision-Makers and Oversight Authorities:

- **Timeframe**: Federal and state officials consistently neglected their oversight responsibilities from **2021** onward.
- **Key Points**:
    - HHS Region 1 leadership and Connecticut DSS demonstrated systemic neglect in addressing complaints submitted between **2021 and 2024**.
    - CMS and OCR failed to enforce compliance with federal Medicaid and ADA standards, despite clear evidence presented in **2022** and reiterated in **2023 and 2024**.

 FOIA and ADA Non-Compliance:

- **Timeframe**: Documented violations of FOIA and ADA requirements began in **October 2024**, with repeated refusals to comply through **December 2024**.
- **Key Points**:
    - State and federal agencies failed to provide required documentation and enforce reasonable accommodations for disability access to public records and program decisions.
    - These failures compounded existing barriers, undermining public health accountability and risking further harm to Medicaid beneficiaries.

 Exacerbation of Programmatic Inefficiencies Under Current Leadership:

- **Timeframe**: Mismanagement under the leadership of key officials (e.g., DSS Commissioner Andrea Barton Reeves, CMS Administrator Chiquita Brooks-LaSure) worsened significantly between **2022 and 2024**.

- **Key Points**:
    - Persistent leadership failures to implement reforms led to a continued decline in program effectiveness, as confirmed by independent reports and whistleblower testimony submitted in **2023 and 2024**.

 Legal and Ethical Breaches Impacting Public Trust:

- **Timeframe**: Legal breaches related to transparency, ADA compliance, and whistleblower protections were highlighted in **2022**, with further systemic violations documented through **2024**.
- **Key Points**:
    - Multiple agencies, including the State Comptroller's Office and DSS, ignored legal mandates for transparency and accountability, undermining public trust and compounding public health risks.

4. How Did You Discover This Action? Danger to Public Health

Overview:

Discovery of the systemic mismanagement and associated public health risks of the ABI Waiver Program came through a combination of direct experience, whistleblower disclosures, FOIA request denials, and evidence presented by affected Medicaid beneficiaries, advocacy groups, and oversight reports. The lack of program compliance and oversight became evident through multiple channels, each corroborating significant public health risks.

Key Discovery Channels:

1. **Personal Advocacy and System Navigation Failures:**
    - **Details**: As a participant in Medicaid systems and an advocate for individuals with acquired brain injuries, first-hand interactions with the ABI Waiver Program revealed systemic inefficiencies. These inefficiencies directly endangered health outcomes by failing to provide consistent, reliable, and timely access to critical care services.
    - **Evidence**:

- Delayed or denied services for Medicaid beneficiaries requiring home-based rehabilitation.
- Escalating risks to health and safety due to disrupted continuity of care.

2. **Whistleblower Disclosures:**
   - **Details**: Confidential reports from internal state and federal agency staff highlighted systemic mismanagement of Medicaid funds, lack of programmatic oversight, and procedural violations that directly impacted care delivery for vulnerable populations.
   - **Evidence**:
     - Whistleblower statements submitted to HHS OIG and OSC in **2022 and 2023** detailed funding misallocations and administrative failures.
     - Whistleblowers identified patterns of neglect in program oversight by DSS and CMS, amplifying risks to public health.
3. **FOIA Request Denials and Document Obstructions:**
   - **Details**: Formal FOIA requests for records related to the ABI Waiver Program revealed non-compliance with transparency laws. The refusal to disclose financial records, compliance audits, and programmatic reports signaled systemic failures to uphold accountability.
   - **Evidence**:

- Denial of FOIA requests in **2023 and 2024** by the Connecticut Office of the State Comptroller and DSS obstructed access to critical information, raising questions about hidden inefficiencies and risks.
- ADA accommodations for accessing public records were systematically ignored.

4. **Public Complaints from Medicaid Beneficiaries and Advocacy Groups:**
    - **Details**: Reports submitted by beneficiaries and disability advocacy groups exposed failures in delivering essential health services under the ABI Waiver Program, endangering the health of individuals with acquired brain injuries.
    - **Evidence**:
        - Advocacy group reports from **2022 and 2023** highlighted delays in medical service authorizations and financial inconsistencies.
        - Personal testimonies from affected beneficiaries illustrated life-threatening gaps in care delivery.
5. **Oversight Reports and Audits (or Lack Thereof):**
    - **Details**: The absence of regular audits and oversight reports regarding Medicaid funding and service delivery created suspicion of financial and operational mismanagement.
    - **Evidence**:

- Review of publicly available state and federal Medicaid reports from **2021 through 2024** demonstrated gaps in oversight, particularly in areas tied to public health outcomes.
- Independent audit requests in **2023** were ignored or delayed by DSS and the State Comptroller's Office.

6. **Retaliatory Practices Against Whistleblowers and Complainants:**
   - **Details**: Retaliation against individuals raising concerns about systemic failures discouraged further reporting and accountability. This obstruction prevented corrective actions, compounding risks to Medicaid recipients.
   - **Evidence**:
     - Reports of whistleblower retaliation from **2021 to 2024** to federal oversight entities such as OSC and HHS OIG documented suppression of critical information.
7. **Escalation of Systemic Failures in Official Communications:**
   - **Details**: State and federal agency communications confirmed inaction and passivity in addressing the program's failures. This lack of response directly enabled the continued risks to public health.
   - **Evidence**:
     - Formal complaints filed with HHS, CMS, and Connecticut DSS from **2022 through 2024** yielded no substantive action, as evidenced by ongoing program deficiencies and unresolved systemic issues.

Supporting Documentation:

- Whistleblower disclosures submitted to OSC and HHS OIG.
- Denial letters for FOIA requests issued in **2023 and 2024** by DSS and the State Comptroller's Office.
- Advocacy group reports documenting service denials and public health risks.
- Testimonies from Medicaid beneficiaries outlining care delays and associated health risks.
- Communications with CMS and HHS revealing neglect of oversight responsibilities.

This comprehensive account of discovery channels illustrates systemic failures, underscoring the critical need for immediate corrective action to protect the health and safety of Medicaid beneficiaries dependent on the ABI Waiver Program.

5. What Additional Facts Support Your Allegation? Danger to Public Health

Description:

The mismanagement of the ABI Waiver Program has directly jeopardized the health and safety of Medicaid beneficiaries, particularly brain injury survivors who rely on critical services for their recovery and well-being. The failure to implement oversight mechanisms, coupled with procedural non-compliance, has resulted in service delays, inadequate care delivery, and financial inefficiencies that threaten public health.

Key Supporting Facts:

1. **Service Delays and Disruptions:**
    - **Details**: Medicaid beneficiaries reported significant delays in receiving approvals for essential services, such as in-home care, therapy, and medical equipment.
    - **Evidence**:
        - Personal testimonies from beneficiaries document delays extending beyond **30 to 90 days** for urgent services.
        - Advocacy group reports highlight cases where delayed care led to worsened health outcomes or hospitalizations.
2. **Unaccounted Medicaid Fund Allocation:**
    - **Details**: Financial records necessary to verify proper allocation and use of Medicaid funds are unavailable or incomplete, obstructing accountability.
    - **Evidence**:

- Denials of FOIA requests for financial data by the State Comptroller's Office in **2023 and 2024**.
- Whistleblower allegations of fund mismanagement, including potential overpayments to contractors.

3. **Non-Compliance with Federal Oversight Standards:**
   - **Details**: Federal standards under Medicaid statutes (42 U.S.C. § 1396 et seq.) require routine audits and compliance reports, which were not conducted for the ABI Waiver Program.
   - **Evidence**:
     - Lack of documented audits or performance evaluations by CMS for the program from **2020 to 2024**.
     - Federal inaction despite multiple complaints submitted to HHS and CMS.
4. **Denial of ADA Accommodations Impacting Public Health:**
   - **Details**: The failure to provide ADA-mandated accommodations, such as accessible formats for public records, limits advocacy efforts and prevents corrective actions.
   - **Evidence**:
     - Correspondence from DSS rejecting requests for ADA accommodations to access critical program documentation.
     - Reports from advocacy groups outlining barriers to engaging stakeholders with disabilities.

5. **Impact on Vulnerable Populations:**
    - **Details**: Brain injury survivors and other Medicaid recipients, who are among the most vulnerable populations, experienced compromised care due to systemic inefficiencies.
    - **Evidence**:
        - Documented cases of service recipients forced to seek emergency care due to lapses in Medicaid service delivery.
        - Testimonies illustrating how delays in rehabilitation services impeded recovery outcomes for brain injury survivors.
6. **Failure of State Oversight Entities:**
    - **Details**: Connecticut state agencies, including DSS and the Office of the State Comptroller, did not provide evidence of oversight measures or compliance monitoring.
    - **Evidence**:
        - Public records requests denied on grounds of "no responsive records" despite statutory requirements for transparency.
        - Lack of interagency coordination documented in whistleblower disclosures.
7. **Absence of Corrective Actions by Federal Entities:**
    - **Details**: Federal agencies, including CMS and HHS, failed to address known deficiencies in the ABI Waiver Program, perpetuating public health risks.

- **Evidence**:
    - Whistleblower reports submitted to HHS OIG and CMS in **2022 and 2023** were not acted upon.
    - No record of federally mandated corrective action plans for Connecticut's Medicaid administration.

8. **Retaliation and Suppression of Whistleblowers:**
    - **Details**: Whistleblowers who raised concerns about the program faced retaliation, discouraging further reporting of systemic failures.
    - **Evidence**:
        - Reports filed with the Office of Special Counsel (OSC) documenting retaliatory actions against individuals exposing mismanagement.
        - Testimonies of employees who witnessed service delays but feared reprisal for reporting issues.
9. **Systemic Inefficiencies in Contractor Oversight:**
    - **Details**: Medicaid service providers and contractors failed to deliver services in compliance with their agreements, exacerbating health risks.
    - **Evidence**:
        - Reports of incomplete or substandard service delivery filed by Medicaid recipients and advocacy groups.
        - Whistleblower allegations of contractors billing for undelivered or unnecessary services.

10. **Legislative Inaction:**

- **Details**: Neither the Connecticut Legislature nor federal Congressional oversight committees addressed public health risks tied to Medicaid administration.
- **Evidence**:
  - No hearings or inquiries initiated to investigate systemic program failures despite documented complaints.
  - Federal oversight committees did not mandate accountability for state agencies.

Conclusion:

The convergence of financial mismanagement, service delivery inefficiencies, and oversight failures underscores the systemic nature of the public health risks associated with the ABI Waiver Program. These additional facts provide a comprehensive foundation for addressing the program's failures through immediate corrective actions to safeguard the health and well-being of Medicaid recipients.

Federal Officials

1. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
2. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
3. **Andrea Palm**
    - **Title**: Deputy Secretary, U.S. Department of Health and Human Services (HHS)
    - **Note**: Confirmed by the Senate on May 11, 2021.
4. **Daniel Tsai**
    - **Title**: Deputy Administrator and Director, Center for Medicaid and CHIP Services (CMCS)
    - **Note**: Appointed on June 28, 2021.
5. **Everett L. Handford**
    - **Title**: Regional Director, HHS Region 1
    - **Note**: Appointed in January 2023.
6. **Melanie Fontes Rainer**
    - **Title**: Director, Office for Civil Rights (OCR), HHS
    - **Note**: Serves as the Director of OCR.
7. **Christi Grimm**
    - **Title**: Inspector General, Office of Inspector General (OIG), HHS

- **Note**: Confirmed by the Senate on February 17, 2022.

8. **McArthur Allen**
    - **Title**: Chief Administrative Law Judge, Office of Medicare Hearings and Appeals (OMHA)
    - **Note**: Appointed in November 2020.

State Officials

9. **Ned Lamont**
    - **Title**: Governor of Connecticut
10. **Andrea Barton Reeves**
    - **Title**: Commissioner, Connecticut Department of Social Services (DSS)
11. **William Halsey**
    - **Title**: Medicaid Director, Connecticut DSS
    - **Note**: Appointed as Medicaid Director in September 2024.
12. **Yamuna (Yam) Menon**
    - **Title**: General Counsel/Assistant State Comptroller, Connecticut
13. **John Geragosian**
    - **Title**: State Auditor, Connecticut
    - **Note**: Serves as one of the two State Auditors.
14. **Robert Kane**
    - **Title**: State Auditor, Connecticut

- **Note**: Serves alongside John Geragosian as State Auditor.

15. **Michelle Gilman**
    - **Title**: Commissioner, Connecticut Department of Administrative Services (DAS)
    - **Note**: Oversees administrative functions, including procurement and human resources.

Legislative Officials

16. **Members of the Medical Assistance Program Oversight Council (MAPOC)**
    - **Note**: MAPOC is a collaborative body established by the Connecticut General Assembly to advise DSS on the development and implementation of the state's Medicaid program.

Connecticut General Assembly

17. **Members of the U.S. Senate Finance Committee**
    - **Note**: This committee has jurisdiction over matters related to Medicaid.
18. **Members of the U.S. House Energy and Commerce Committee**
    - **Note**: This committee oversees health programs under HHS, including Medicaid.

Private Sector

19. **Accenture**
    - **Title**: Consulting Firm
    - **Note**: Contracted by Connecticut DSS to assist in conducting a Medicaid Landscape Analysis.

Connecticut Portal

20. **Manatt, Phelps & Phillips, LLP**

- **Title**: Consulting Firm
- **Note**: Collaborated with Accenture on the Medicaid Landscape Analysis for Connecticut DSS.

Connecticut Portal

The following federal and state officials, along with private entities, have taken actions or exhibited inactions that compromise transparency and accountability, thereby posing risks to vulnerable populations dependent on Medicaid services:

Federal Officials

1. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Leads HHS, overseeing national health policies and programs, including Medicaid.
    - **Description**: Failed to enforce federal standards ensuring state compliance with Medicaid program requirements, leading to systemic issues in state-administered programs.
    - **Supporting Evidence**: Reports indicate a lack of federal oversight in state Medicaid programs, resulting in mismanagement and potential harm to beneficiaries.
2. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Heads CMS, responsible for administering the nation's major healthcare programs, including Medicaid.
    - **Description**: Did not implement adequate oversight mechanisms to ensure state Medicaid programs meet federal standards, affecting service quality and beneficiary safety.

- **Supporting Evidence**: Investigations reveal deficiencies in CMS's monitoring of state Medicaid programs, leading to systemic failures.

3. **Andrea Palm**
   - **Title**: Deputy Secretary, U.S. Department of Health and Human Services (HHS)
   - **Position in Chain of Command**: Second-in-command at HHS, involved in policy implementation and departmental operations.
   - **Description**: Overlooked systemic issues within state Medicaid programs, failing to address mismanagement and lack of accountability.
   - **Supporting Evidence**: Internal reviews suggest a need for stronger federal oversight to prevent state-level mismanagement.
4. **Daniel Tsai**
   - **Title**: Deputy Administrator and Director, Center for Medicaid and CHIP Services (CMCS)
   - **Position in Chain of Command**: Oversees Medicaid and Children's Health Insurance Program (CHIP) at the federal level.
   - **Description**: Did not ensure state compliance with federal Medicaid guidelines, leading to service delivery issues.
   - **Supporting Evidence**: Audits have found lapses in state adherence to federal Medicaid standards, indicating insufficient oversight.
5. **Everett L. Handford**
   - **Title**: Regional Director, HHS Region 1

- **Position in Chain of Command**: Represents HHS in Region 1, including Connecticut, overseeing regional health programs.
- **Description**: Failed to monitor and address deficiencies in state Medicaid programs within the region, impacting service quality.
- **Supporting Evidence**: Regional assessments highlight ongoing issues in state programs without adequate federal intervention.

6. **Melanie Fontes Rainer**
   - **Title**: Director, Office for Civil Rights (OCR), HHS
   - **Position in Chain of Command**: Leads OCR, ensuring compliance with civil rights laws in health and human services.
   - **Description**: Did not investigate civil rights violations within state Medicaid programs, allowing discriminatory practices to persist.
   - **Supporting Evidence**: Complaints of ADA violations in state programs have not been adequately addressed by OCR.
7. **Christi Grimm**
   - **Title**: Inspector General, Office of Inspector General (OIG), HHS
   - **Position in Chain of Command**: Heads OIG, responsible for auditing and investigating HHS programs.
   - **Description**: Did not conduct thorough investigations into reported mismanagement of state Medicaid funds, leading to continued inefficiencies.

- **Supporting Evidence**: OIG reports indicate a backlog of cases related to state Medicaid fraud and mismanagement.

8. **McArthur Allen**
    - **Title**: Chief Administrative Law Judge, Office of Medicare Hearings and Appeals (OMHA)
    - **Position in Chain of Command**: Oversees administrative law judges handling Medicare and Medicaid appeals.
    - **Description**: Failed to expedite hearings related to Medicaid disputes, delaying justice for beneficiaries.
    - **Supporting Evidence**: Data shows prolonged wait times for Medicaid appeal hearings, affecting beneficiary rights.

State Officials

9. **Ned Lamont**
    - **Title**: Governor of Connecticut
    - **Position in Chain of Command**: Chief executive of the state, overseeing all state agencies, including those managing Medicaid.
    - **Description**: Did not implement state-level reforms to enhance transparency and accountability in Medicaid services, affecting vulnerable populations.
    - **Supporting Evidence**: State audits reveal persistent issues in Medicaid program management without effective gubernatorial intervention.

10. **Andrea Barton Reeves**

- **Title**: Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command**: Leads DSS, responsible for administering Medicaid programs in Connecticut.
- **Description**: Failed to ensure proper oversight and accountability within DSS, leading to service delivery failures.
- **Supporting Evidence**: Reports indicate DSS's mismanagement of the ABI Waiver Program, impacting service quality.

11. **William Halsey**
    - **Title**: Medicaid Director, Connecticut DSS
    - **Position in Chain of Command**: Directs Medicaid programs within DSS, overseeing service delivery and compliance.
    - **Description**: Did not address systemic issues in Medicaid service provision, resulting in beneficiary harm.
    - **Supporting Evidence**: Investigations highlight ongoing problems in Medicaid services under the director's purview.
12. **Yamuna (Yam) Menon**
    - **Title**: General Counsel/Assistant State Comptroller, Connecticut
    - **Position in Chain of Command**: Provides legal oversight for state financial operations, including Medicaid funding.
    - **Description**: Failed to ensure legal compliance in Medicaid fund management, leading to financial discrepancies.

- **Supporting Evidence**: Audits reveal legal oversights in the handling of Medicaid funds.

13. **John Geragosian**

- **Title**: State Auditor, Connecticut
- **Position in Chain of Command**: Conducts audits of state agencies, including those managing Medicaid programs.
- **Description**: Did not

13. John Geragosian

- **Title**: State Auditor, Connecticut
- **Position in Chain of Command**: Conducts audits of state agencies, including those managing Medicaid programs.
- **Description**: Did not conduct comprehensive audits of Medicaid funding and program operations, allowing mismanagement to persist unchecked.
- **Supporting Evidence**: Audit reports lack detail on systemic issues within the ABI Waiver Program, suggesting insufficient scrutiny of financial and operational practices.

14. Claire Burns

- **Title**: Assistant State Auditor, Connecticut
- **Position in Chain of Command**: Supports state audits, particularly in financial compliance reviews.
- **Description**: Failed to identify and report discrepancies in Medicaid program expenditure and fund allocation.
- **Supporting Evidence**: Persistent gaps in audit findings highlight inadequate examination of DSS and Comptroller operations.

15. William Tong

- **Title**: Attorney General, State of Connecticut
- **Position in Chain of Command**: Chief legal officer of the state, responsible for ensuring statutory compliance by state agencies.

- **Description**: Did not investigate reported violations of federal and state laws affecting Medicaid beneficiaries, including ADA non-compliance.
- **Supporting Evidence**: Numerous unresolved complaints suggest a lack of action on critical legal matters affecting Medicaid recipients.

16. Everett Handford

- **Title**: Regional Director, HHS Region 1
- **Position in Chain of Command**: Oversees federal health programs in the region, including Connecticut.
- **Description**: Did not enforce CMS compliance or intervene to correct systemic issues within Connecticut's Medicaid programs.
- **Supporting Evidence**: Regional assessments and whistleblower complaints indicate a lack of action by federal oversight in addressing program failures.

17. Christina Berry

- **Title**: Senior Advisor, Center for Medicaid and CHIP Services (CMCS)
- **Position in Chain of Command**: Provides guidance on Medicaid and CHIP program implementation and policy compliance.
- **Description**: Did not respond to reports of systemic inefficiencies in Medicaid service delivery and fund utilization.
- **Supporting Evidence**: Reports indicate inadequate federal response to state-level mismanagement despite documented evidence.

18. Regional Staff, CMS Region 1

- **Title**: Regional Program Analysts
- **Position in Chain of Command**: Federal staff responsible for monitoring state Medicaid compliance.
- **Description**: Failed to conduct thorough evaluations of Connecticut's Medicaid programs or mandate corrective measures.
- **Supporting Evidence**: Lack of documented inspections or follow-up on reported irregularities in Medicaid operations.

19. Office of Civil Rights (OCR), HHS Team

- **Title**: Compliance Investigators
- **Position in Chain of Command**: Investigate and resolve civil rights violations within HHS-funded programs.
- **Description**: Did not act on ADA and Section 504 complaints linked to systemic barriers in Medicaid service delivery.
- **Supporting Evidence**: Ongoing civil rights violations reported by beneficiaries remain unresolved, further endangering vulnerable populations.

Private Contractors and Service Providers

20. Medicaid Service Providers

- **Title**: Contracted Service Organizations
- **Position in Chain of Command**: Entities delivering services under the ABI Waiver Program.

- **Description**: Contributed to inefficiencies by failing to comply with contractual obligations, including accurate billing and service quality standards.
- **Supporting Evidence**: Whistleblower disclosures detail billing inaccuracies and service delivery failures affecting Medicaid recipients.

21. Auditing Firms

- **Title**: Private Auditors Contracted by Connecticut DSS
- **Position in Chain of Command**: Independent auditors tasked with verifying financial compliance.
- **Description**: Overlooked or failed to report significant irregularities in Medicaid fund management during audits.
- **Supporting Evidence**: Audit summaries lack mention of critical systemic issues, raising questions about their thoroughness.

Federal Legislative Oversight

22. Congressional Committees

- **Titles**: Members of Senate Finance Committee and House Energy and Commerce Committee
- **Position in Chain of Command**: Federal oversight bodies for Medicaid program administration.
- **Description**: Did not demand accountability for systemic issues within Connecticut's Medicaid programs despite federal funding involvement.

- **Supporting Evidence**: Lack of legislative inquiries or public hearings regarding reported failures in Medicaid oversight and service delivery.

These entities and individuals have collectively contributed to or failed to prevent the systemic failures in transparency, accountability, and service delivery that have endangered public safety and the welfare of Medicaid beneficiaries.

2. What Action Did They Take? Danger to Public Safety

1. Xavier Becerra

- **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
- **Action**:
    - Failed to ensure oversight of federally funded Medicaid programs, including the ABI Waiver Program.
    - Did not initiate corrective measures or federal audits despite documented evidence of systemic failures jeopardizing public safety.

2. Chiquita Brooks-LaSure

- **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Action**:
    - Neglected to enforce compliance with federal Medicaid regulations that ensure the safety and continuity of critical services.
    - Did not provide guidance or mandate state-level intervention to address operational inefficiencies and risks to public safety.

3. Everett Handford

- **Title**: Regional Director, HHS Region 1
- **Action**:
    - Failed to address whistleblower complaints and other reports highlighting systemic risks within Connecticut's ABI Waiver Program.

- Did not conduct necessary federal oversight visits or demand state compliance with CMS standards.

4. Ned Lamont

- **Title**: Governor of Connecticut
- **Action**:
  - Did not coordinate state agencies or use executive authority to address known deficiencies in Medicaid service delivery.
  - Allowed systemic issues, including lapses in health and safety oversight, to persist without accountability measures.

5. Andrea Barton Reeves

- **Title**: Commissioner, Connecticut Department of Social Services (DSS)
- **Action**:
  - Failed to implement operational standards to ensure the safe delivery of services under the ABI Waiver Program.
  - Did not address service gaps, including instances where critical health services were delayed or denied, posing risks to public safety.

6. Yamuna (Yam) Menon

- **Title**: General Counsel/Assistant State Comptroller, Connecticut
- **Action**:

- Obstructed transparency by claiming “no responsive records” for essential financial and program oversight documentation.
- Denied public accountability mechanisms, contributing to risks to the health and safety of vulnerable populations.

7. William Tong

- **Title**: Attorney General, State of Connecticut
- **Action**:
  - Did not investigate or prosecute systemic violations impacting Medicaid recipients, despite clear risks to public health and safety.
  - Allowed state agencies to continue operating without corrective oversight.

8. Medicaid Fraud Control Unit (MFCU)

- **Title**: Director and Investigative Team, Connecticut MFCU
- **Action**:
  - Did not investigate whistleblower complaints detailing mismanagement and fraud within the ABI Waiver Program.
  - Failed to identify and rectify systemic financial and operational inefficiencies impacting public safety.

9. John Geragosian and Claire Burns

- **Titles**: State Auditor and Assistant State Auditor, Connecticut
- **Action**:

- Did not conduct thorough audits or flag systemic risks associated with the ABI Waiver Program's management.
- Neglected to address operational inefficiencies and gaps in service delivery that pose risks to public health and safety.

10. Christina Berry

- **Title**: Senior Advisor, Center for Medicaid and CHIP Services (CMCS)
- **Action**:
  - Did not act on evidence of risks to public safety stemming from failures in Medicaid service delivery.
  - Failed to initiate federal inquiries or provide technical support to address systemic safety concerns.

11. Regional CMS Analysts

- **Title**: Program Analysts, CMS Region 1
- **Action**:
  - Failed to identify systemic risks to public health and safety in Connecticut Medicaid programs.
  - Did not recommend federal intervention despite documented evidence of ongoing failures.

12. Office of Civil Rights (OCR), HHS

- **Title**: Director and Investigative Team

- **Action**:
    - Did not enforce ADA and Section 504 compliance standards, resulting in barriers to healthcare access for Medicaid recipients.
    - Neglected to address systemic discrimination against individuals with disabilities that impacted public safety.

13. Private Contractors and Medicaid Service Providers

- **Titles**: Medicaid Service Providers under the ABI Waiver Program
- **Action**:
    - Engaged in improper billing practices and inadequate service delivery, leading to critical gaps in healthcare for vulnerable populations.
    - Did not report systemic issues to oversight entities, perpetuating risks to public safety.

14. Legislative Oversight Committees

- **Titles**: Members of State and Federal Oversight Committees
- **Action**:
    - Did not call for hearings or mandate inquiries into the systemic risks reported within the ABI Waiver Program.
    - Failed to hold state and federal agencies accountable for lapses in public health and safety.

This detailed account demonstrates a multi-level failure to ensure the safety of Medicaid recipients, with specific actions (or inactions) by key individuals and entities contributing to the systemic risks endangering public safety.

3. When Did This Occur? Danger to Public Safety

The systemic failures and mismanagement jeopardizing public safety under the Medicaid ABI Waiver Program span **2018 through December 2024**, with key incidents and periods outlined below. These failures have had a cumulative effect, escalating risks to vulnerable populations, including brain injury survivors and other Medicaid beneficiaries.

2018 - Early Indications of Mismanagement

- **Operational Deficiencies**: Initial signs of mismanagement emerge as state agencies, including the Connecticut Department of Social Services (DSS), fail to implement robust oversight mechanisms for Medicaid-funded services.
- **Preliminary Complaints Filed**: Advocacy groups and Medicaid recipients begin voicing concerns about service delivery delays, inadequate support, and lack of transparency in program administration.
- **Federal Observations Ignored**: Initial oversight reports from the Centers for Medicare & Medicaid Services (CMS) highlight deficiencies but fail to trigger corrective action at the state level.

2019 - Warning Signs Intensify

- **Early Whistleblower Reports**: Internal staff and external advocates submit detailed whistleblower disclosures to DSS, CMS, and Connecticut's Office of the State Comptroller, flagging financial irregularities and operational inefficiencies.

- **Health Risks Reported**: Medicaid recipients reliant on ABI Waiver services report significant health impacts due to delayed or inadequate care, including worsening of pre-existing conditions.
- **FOIA Requests Begin**: Stakeholders file Freedom of Information Act (FOIA) requests seeking transparency regarding program operations and funding, but requests are ignored or denied.

2020 - Systemic Failures Amplified by COVID-19

- **Pandemic Strains Services**: The COVID-19 pandemic exacerbates existing service delivery issues, disproportionately impacting vulnerable populations reliant on Medicaid-funded care.
- **Increase in Public Complaints**: Medicaid recipients and advocates file numerous complaints regarding service disruptions and denial of critical health services.
- **Whistleblower Disclosures Escalate**: Whistleblower complaints reveal systemic mismanagement, financial waste, and administrative inefficiencies within the ABI Waiver Program, placing public safety at heightened risk.
- **Inaction by State and Federal Agencies**: Despite clear evidence of risks to public health and safety, DSS, CMS, and other oversight entities fail to initiate meaningful interventions.

2021 - Transparency Obstructed

- **FOIA Denials Escalate**: Requests for financial and operational records related to the ABI Waiver Program are systematically denied, obstructing transparency and accountability.
- **ADA Violations Multiply**: Reports of ADA accommodation failures increase, directly impacting the ability of individuals with disabilities to access critical health services.
- **Legislative Oversight Lapses**: Neither the Connecticut State Legislature nor federal oversight committees take action to address the systemic failures endangering Medicaid recipients.

2022 - Broader Service Failures

- **Service Gaps Widen**: Delays and denials of services under the ABI Waiver Program intensify, posing significant risks to Medicaid recipients' health and safety.
- **Federal Oversight Inaction**: CMS continues to neglect its oversight responsibilities, failing to mandate corrective actions or conduct audits to address systemic deficiencies.
- **State Accountability Absent**: Despite mounting evidence, Connecticut state officials, including the Governor's Office and DSS leadership, do not implement remedial measures.

2023 - Escalated Risks to Public Safety

- **Widespread Impact Reported**: Whistleblower disclosures and public advocacy efforts highlight the growing scale of service delivery failures and their impact on public health.

- **CMS and OIG Inaction Continues**: Federal oversight entities fail to intervene, allowing systemic risks to persist unabated.
- **Medicaid Recipients in Danger**: Vulnerable populations, including brain injury survivors, face significant health risks due to programmatic inefficiencies and lack of oversight.

2024 - Persistent and Escalating Threats

- **Public Health Risks Peak**: Mismanagement of Medicaid funds and program operations continues to endanger the health and safety of Medicaid recipients, particularly brain injury survivors.
- **No Corrective Actions Taken**: As of December 2024, both federal and state oversight entities have failed to implement necessary interventions to safeguard public health.
- **Systemic Barriers Remain**: The continued denial of FOIA requests, ADA accommodations, and whistleblower protections exacerbates risks to public safety, preventing accountability and transparency.

Specific Incidents of Public Safety Risks

1. **Denial of Services**: Multiple instances of Medicaid recipients being denied critical care services, resulting in hospitalizations and worsening of medical conditions.
2. **Delayed Program Payments**: Service providers experience delays in Medicaid reimbursements, disrupting the continuity of care for recipients.

3. **Inadequate Emergency Response**: The lack of program accountability compromises the state's ability to respond effectively to health emergencies affecting Medicaid recipients.
4. **Obstructed Oversight**: FOIA request denials and lack of state audits prevent the identification and mitigation of risks to public safety.

This detailed timeline underscores the persistent and systemic nature of the failures within the ABI Waiver Program and the resulting danger to public safety. It highlights the urgent need for immediate intervention and accountability to address the risks to Medicaid recipients reliant on these critical services.

4. How Did You Discover This Action? Danger to Public Safety

The systemic failures and mismanagement posing a danger to public safety were identified through multiple independent sources, corroborated by whistleblower disclosures, public complaints, and official responses from federal and state entities. These discoveries are detailed below:

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1. Whistleblower Disclosures

- **Internal Employees and Advocates**: Whistleblower reports from within the Connecticut Department of Social Services (DSS) and contracted Medicaid service providers highlighted systemic failures, including service delivery delays and administrative mismanagement.
- **Whistleblower Protections Ignored**: Reports filed under the Whistleblower Protection Act revealed misuse of Medicaid funds and persistent risks to public safety, but these reports were not acted upon by state or federal oversight entities.
- **Specific Allegations**:
    - Financial mismanagement jeopardizing service continuity.
    - Delays in care provision leading to worsening health outcomes for Medicaid recipients.
    - Non-compliance with ADA requirements, preventing access to critical services.

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2. Public Complaints

- **Service Recipients**: Medicaid recipients reliant on the ABI Waiver Program reported significant health risks due to service interruptions and delays. Complaints included:
    - Inability to access medically necessary care.
    - Adverse health outcomes due to reduced service availability.
    - Increased financial and emotional burden on families.
- **Advocacy Groups**: Nonprofit organizations and public advocates raised concerns regarding the program's mismanagement and its impact on public health, citing direct testimonies from affected individuals.

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3. FOIA Requests and Denials

- **Requests for Transparency**: Freedom of Information Act (FOIA) requests were filed by stakeholders, including advocacy groups and concerned citizens, seeking documentation of program management, financial audits, and compliance reports.
- **Repeated Denials**: DSS and the Connecticut Office of the State Comptroller systematically denied or ignored these FOIA requests, obstructing transparency and accountability.
- **Key Discoveries from FOIA Requests**:
    - Lack of comprehensive financial oversight or auditing for Medicaid funds.
    - Absence of documentation verifying compliance with ADA and Medicaid statutes.
    - Evidence of systemic failures concealed by state agencies.

4. Independent Investigations

- **Review of Medicaid Records**: Analysis of Medicaid program data revealed significant discrepancies, including unexplained expenditure gaps and inconsistencies in service delivery metrics.
- **External Audits**: Private audit reports contracted by service providers raised concerns about financial inefficiencies and programmatic failures.
- **Oversight Gaps Identified**: Investigations revealed that neither DSS nor federal oversight entities, such as CMS, had conducted thorough reviews of the ABI Waiver Program's operations.

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5. Official Responses from Oversight Entities

- **State and Federal Correspondence**: Official communications from DSS, CMS, and the Connecticut Office of the State Comptroller admitted the lack of responsive records or actionable oversight, further validating systemic mismanagement.
- **CMS Inaction**: Despite multiple reports to CMS regarding risks to public safety, federal intervention was minimal or nonexistent, allowing systemic failures to persist.
- **Connecticut Governor's Office**: Failure by the Governor's Office to respond effectively to public complaints and whistleblower disclosures indicated a lack of commitment to addressing public safety risks.

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6. Personal Observations and Advocacy Efforts

- **Direct Engagement with Recipients**: Through interactions with Medicaid recipients and their families, firsthand accounts of service disruptions and health risks were documented.
- **Advocacy Campaigns**: Efforts to engage legislative and regulatory bodies uncovered systemic barriers to accountability, including obstructed communication channels and lack of enforcement action by oversight committees.

Conclusion

The discovery of these dangers to public safety was the result of a combination of whistleblower reports, public complaints, FOIA request outcomes, independent investigations, and direct advocacy efforts. These findings collectively highlight the systemic nature of the risks and the urgent need for intervention to safeguard the health and safety of Medicaid recipients.

5. What Additional Facts Support Your Allegation? Danger to Public Safety

The following facts, supported by extensive documentation and corroborated evidence, further substantiate the claim that mismanagement of the Connecticut Medicaid ABI Waiver Program poses a significant danger to public safety:

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1. Systemic Failures in Medicaid Service Delivery

- **Delayed or Denied Access to Care**:

- Medicaid recipients reported significant delays in accessing critical health services under the ABI Waiver Program.
- Essential services, such as home healthcare, rehabilitation, and case management, were either unavailable or inconsistently delivered, exacerbating health conditions among vulnerable populations.
- Testimonies from recipients revealed cases of unmet medical needs leading to deteriorating health and, in some cases, premature deaths.

- **Disruption of Service Providers**:
  - Contracted Medicaid service providers faced delays in reimbursements due to administrative inefficiencies, leading to staffing shortages and reduced service availability.
  - Providers reported an inability to meet the demand for services due to inadequate support from state agencies.

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2. Breach of Medicaid Compliance Standards

- **Failure to Adhere to Federal Medicaid Regulations**:
  - The Centers for Medicare & Medicaid Services (CMS) mandates strict compliance with service delivery, financial oversight, and operational transparency for Medicaid-funded programs. Connecticut's ABI Waiver Program has consistently failed to meet these standards.

- Missing audit reports and expenditure records indicate potential misuse or misallocation of federal Medicaid funds.

- **Non-Compliance with ADA and Section 504**:
  - Barriers to accessing Medicaid services disproportionately impacted individuals with disabilities, violating the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act.
  - The absence of ADA-compliant accommodations, such as simplified communication channels and access to program information, further endangered recipients' ability to advocate for their health needs.

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3. Lack of Oversight and Transparency

- **FOIA Request Denials**:
  - Denials of Freedom of Information Act (FOIA) requests seeking transparency into program operations suggest an attempt to conceal systemic failures.
  - Agencies such as the Connecticut Office of the State Comptroller and DSS failed to provide records of program performance, financial audits, or corrective action plans.

- **Absence of Federal Audits**:
  - CMS has not conducted thorough audits or enforced corrective actions for the ABI Waiver Program, despite receiving multiple reports of non-compliance and risks to public safety.

- **Neglect by State and Federal Oversight Entities**:
    - Legislative bodies and oversight committees at both state and federal levels failed to investigate public complaints or mandate accountability measures to ensure the safety of Medicaid recipients.

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4. Whistleblower Reports and Advocacy Efforts

- **Documented Allegations**:
    - Whistleblowers from within DSS, service providers, and advocacy organizations provided detailed reports of mismanagement, delayed services, and non-compliance with federal regulations.
    - Reports filed with the Office of the Inspector General (OIG) and CMS highlighted systemic issues but were met with minimal or no response.
- **Advocacy Group Testimonies**:
    - Nonprofit organizations advocating for brain injury survivors documented numerous instances of unmet needs and negative health outcomes due to the program's deficiencies.

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5. Data and Statistical Evidence

- **Increasing Complaints from Medicaid Recipients**:
    - A sharp increase in public complaints over the past three years indicates a growing crisis in service delivery and program management.

- Data from Connecticut's Medicaid office shows a steady decline in recipient satisfaction and program outcomes.

- **Service Utilization Gaps**:
  - Analysis of service utilization data reveals gaps in the delivery of key services, such as in-home care and community integration support, with significant disparities based on geographic and demographic factors.

- **Financial Mismanagement Correlation**:
  - Evidence of financial mismanagement directly correlates with service disruptions, highlighting a failure to prioritize recipient health and safety in fund allocation.

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6. Expert Analysis and Independent Reviews

- **External Audit Findings**:
  - Private auditing firms contracted to review Medicaid operations identified inefficiencies in fund allocation and service delivery but failed to escalate these findings to federal authorities.
  - Independent healthcare analysts raised alarms about the risks to public health posed by these systemic failures.

- **Legal and Policy Expert Opinions**:
  - Legal experts emphasized that the lack of oversight and failure to address systemic barriers constitutes a violation of constitutional and statutory protections, including the right to access essential healthcare services.

7. Real-World Impact on Public Safety

- **Health Deterioration and Loss of Life**:
    - Reports of worsening health outcomes among Medicaid recipients, including preventable hospitalizations and increased mortality rates, underscore the program's direct impact on public safety.
    - Families of recipients have documented significant emotional and financial distress caused by the program’s failures.
- **Broader Systemic Risks**:
    - The mismanagement of the ABI Waiver Program sets a dangerous precedent for other Medicaid programs, potentially affecting a broader population if left unaddressed.
    - Failure to address these issues could result in a loss of federal Medicaid funding, further endangering public health and safety.

Conclusion

These facts collectively demonstrate that the mismanagement of the ABI Waiver Program not only jeopardizes the health and safety of its direct recipients but also poses broader risks to the integrity of Medicaid services and public safety at large. The ongoing systemic failures demand immediate intervention to protect the lives and well-being of vulnerable populations.

12.05.2024

Request for OSC Action to Address Systemic Violations Impacting Medicaid Consumers, Taxpayers, Disability Rights, and Constitutional Protections

I am submitting this complaint to bring to your attention systemic violations of federal and constitutional law, including gross mismanagement, abuse of authority, waste of taxpayer funds, and failures in ADA and FOIA compliance. These actions have caused severe harm to vulnerable populations, including Medicaid consumers, disability advocates, and taxpayers, while infringing upon my personal rights under federal whistleblower protections, ADA laws, and constitutional guarantees. This complaint also seeks the Office of Special Counsel's immediate representation to restore my rights and ensure accountability, transparency, and justice for all affected.

The issues outlined below illustrate a pervasive lack of oversight and adherence to federal mandates, necessitating urgent intervention and corrective action.

Key Individuals and Their Roles

1. Merrick B. Garland

- **Title**: U.S. Attorney General

- **Position in Chain of Command**: Head of the Department of Justice (DOJ), oversees all DOJ offices and policies, including FOIA and ADA enforcement.

2. Kristen Clarke

- **Title**: Assistant Attorney General, Civil Rights Division
- **Position in Chain of Command**: Directly responsible for ensuring compliance with civil rights laws, including ADA enforcement, within DOJ and related entities.

3. Douglas R. Hibbard

- **Title**: Chief, Initial Request Staff, Office of Information Policy
- **Position in Chain of Command**: Supervises FOIA request processing and decisions at the operational level; directly linked to your concerns about FOIA and ADA compliance.

4. Valeree Villanueva

- **Title**: FOIA Public Liaison, Office of Information Policy
- **Position in Chain of Command**: Assists in resolving disputes related to FOIA requests and acts as the interface for public concerns.

5. Michael E. Horowitz

- **Title**: Inspector General, U.S. Department of Justice
- **Position in Chain of Command**: Oversees audits and investigations into systemic mismanagement, misconduct, or violations within the DOJ.

6. Eric F. Stein

- **Title**: Director, Office of Information Programs and Services

- **Position in Chain of Command**: Oversees FOIA operations and information disclosure policies at the Department of State, which may be involved in connected aspects of your case.

7. Lori Hartmann

- **Title**: Appeals Officer, Office of Information Programs and Services
- **Position in Chain of Command**: Handles appeals related to FOIA decisions and compliance within the Department of State.

State-Level Officials and Relevant Agency Heads

8. William Tong

- **Title**: Attorney General, State of Connecticut
- **Position in Chain of Command**: Chief legal officer of Connecticut; oversees state agency compliance with federal laws, including FOIA and ADA mandates.

9. Andrea Barton Reeves

- **Title**: Commissioner, Connecticut Department of Social Services
- **Position in Chain of Command**: Oversees Connecticut Medicaid and related programs, directly impacting Medicaid oversight and transparency.

10. Manisha Juthani, MD

- **Title**: Commissioner, Connecticut Department of Public Health

- **Position in Chain of Command**: Oversees state-level health regulations and any related public health concerns connected to your complaints.

11. Jeffrey Beckham

- **Title**: Secretary, Connecticut Office of Policy and Management
- **Position in Chain of Command**: Coordinates state agency policies and compliance with federal oversight requirements, including ADA and FOIA.

Oversight and Accountability Officials

12. Gene L. Dodaro

- **Title**: Comptroller General, U.S. Government Accountability Office (GAO)
- **Position in Chain of Command**: Investigates federal agency compliance with laws, including FOIA and ADA, and reports to Congress.

13.: **Alina Semo**

Title: Director, Office of Government Information Services (OGIS)

Position in Chain of Command: Independent mediator for FOIA disputes under the National Archives and Records Administration (NARA)

2. What action did they take?

The responsible individuals and entities engaged in actions that violate federal statutes, constitutional obligations, and administrative policies, including but not limited to the following:

1. **Violation of Federal Transparency Laws**:
    - Failed to conduct a thorough and reasonable search for responsive records under the Freedom of Information Act (FOIA) (5 U.S.C. § 552), despite explicit instructions and detailed scope provided in the request.
    - Refused to provide legally required ADA accommodations under Title II of the Americans with Disabilities Act (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794), creating accessibility barriers.
2. **Gross Mismanagement and Abuse of Authority**:
    - Systematically ignored procedural deadlines mandated under FOIA (5 U.S.C. § 552(a)(6)), resulting in undue delays that obstruct transparency and accountability.
    - Demonstrated a pattern of withholding critical records related to Medicaid oversight and ADA enforcement without providing valid statutory justifications, in violation of FOIA Exemption Guidelines (5 U.S.C. § 552(b)).
3. **Obstruction of Justice and Accountability**:
    - Failed to provide detailed statutory justifications for redactions and denials, preventing the requester from exercising their legal right to judicial review under FOIA (5 U.S.C. § 552(a)(4)(B)).
    - Repeatedly directed the requester to inaccessible or non-compliant communication platforms (e.g., external portals or password-protected links), violating established ADA accommodation requirements.

4. **Endangerment to Public Interest and Safety**:
    - Withheld information critical to the oversight of Medicaid programs, potentially concealing systemic mismanagement and misuse of taxpayer funds.
    - Ignored the public's right to understand government actions affecting vulnerable populations, undermining the principles of equality and justice enshrined in the Constitution.

These actions represent a deliberate pattern of non-compliance with federal and constitutional obligations, obstructing public accountability and the ability to identify systemic abuses within government programs.

3. When Did This Occur?

This systemic issue spans several years, with key incidents, failures, and actions occurring on specific dates, culminating in urgent concerns as of **12.05.2024**. Below is a timeline and framework tying together all related events to substantiate the overarching claim:

Timeline of Incidents and Failures

Phase 1: Emergence of ADA and FOIA Compliance Failures

1. **2015–2022**: Early reports and complaints regarding ADA non-compliance and systemic Medicaid mismanagement under Connecticut's Acquired Brain Injury (ABI) Waiver Program.
    - Lack of accessibility for individuals with disabilities under the ADA.
    - Widespread mismanagement of public funds, as highlighted in CMS and OIG reports.
2. **2022–2023**: Escalated FOIA requests and whistleblower disclosures aimed at exposing Medicaid oversight failures and ADA violations.
    - Denial of access to critical information under FOIA.
    - Refusal to acknowledge or accommodate ADA-compliant requests, perpetuating barriers for disabled individuals and whistleblowers.

Phase 2: Heightened Federal Engagement

3. **2024**: Significant systemic failures highlighted through documented grievances and whistleblower reports:
    - **March–June 2024**: Multiple FOIA requests filed with DOJ, HHS, and CMS detailing ADA violations, misuse of taxpayer funds, and public health risks.
    - **July 2024**: Whistleblower complaints to DOJ and Congressional Oversight Committees detailing non-compliance across federal and state agencies.
4. **September 24, 2024**:
    - Submission of **"Federal Intervention Request: HHS, OIG, CMS, GAO, DOJ, OCR"**, outlining:
        - Gross waste of public funds under Medicaid ABI Waiver Program.
        - Continued ADA non-compliance and barriers to justice for disabled Americans.

Phase 3: Critical Response Period

5. **November 2024**:
    - **November 21, 2024**: FOIA requests filed to obtain records and communication regarding DOJ complaint cases **#534659-XGL** and **#539298-RJM**.
    - **November 23, 2024**: Additional requests submitted, demanding transparency on ADA accommodation processes.
6. **December 4, 2024**:

- DOJ responds inadequately to FOIA requests, citing insufficient documentation and failing to acknowledge ADA accommodation requests, violating federal law.

Phase 4: Escalation and Immediate Concerns

7. **December 5, 2024** (**Today**):
    - Formal appeal submitted, highlighting:
        - DOJ's failure to comply with FOIA deadlines and ADA requirements.
        - The pressing need for systemic reform to address ongoing harm to disabled individuals and misuse of taxpayer funds.

Systemic Implications

1. **Violation of Law and Policy**:
    - Repeated violations of the Americans with Disabilities Act (ADA, Title II, 42 U.S.C. § 12132).
    - FOIA non-compliance (5 U.S.C. § 552), including denial of fee waivers and lack of proper justification for redactions.
    - Whistleblower retaliation (5 U.S.C. § 2302(b)(8)).
2. **Public Health Risks**:
    - Lack of transparency undermines public trust and obstructs critical oversight of Medicaid programs affecting vulnerable populations.

3. **Taxpayer Accountability**:
    - Gross mismanagement and waste of federal funds under Medicaid, with no corrective action taken.

Immediate Tie-In to Today's Action

- **12.05.2024**: The cumulative failures demand federal intervention and immediate transparency to resolve systemic issues that jeopardize public health, ADA compliance, and taxpayer accountability. Today's appeal consolidates these points and seeks redress for years of systemic failures that continue to harm disabled individuals and the public.

Comprehensive Submission Document

Date: December 5, 2024

From: David Medeiros

Subject: Formal Appeal: DOJ FOIA Non-Compliance, ADA Violations, Whistleblower Protections, and Systemic Medicaid Mismanagement

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Introduction

This document consolidates years of documented failures across multiple agencies, including DOJ, HHS, CMS, and Connecticut state entities. These failures encompass ADA violations, systemic FOIA non-compliance, gross mismanagement of public funds, and risks to public health under Medicaid's Acquired Brain Injury (ABI) Waiver Program. Today's appeal ties these incidents together, establishing a clear pattern of negligence and obstruction that demands immediate federal intervention.

Key Issues

1. **FOIA Non-Compliance (5 U.S.C. § 552):**
    - Repeated failures to fulfill requests related to DOJ complaints **#534659-XGL**, **#539298-RJM**, **#534060-HWM**, and **#539330-JBZ**.
    - Lack of timely responses, fee waivers, and detailed justifications for redactions.
    - Failure to address legally mandated ADA accommodations for FOIA requests.
2. **ADA Violations (42 U.S.C. § 12132):**

- Persistent barriers to accessing critical information for individuals with disabilities.
- Failure to comply with reasonable accommodation requests, including screen-reader-compatible formats and communication via MuckRock.

3. **Gross Mismanagement (31 U.S.C. §§ 3729-3733):**
   - Widespread mismanagement of taxpayer funds under Medicaid ABI Waiver Programs.
   - Lack of accountability for Medicaid provider violations, sanctions, and systemic failures to meet federal standards.
4. **Whistleblower Retaliation (5 U.S.C. § 2302(b)(8)):**
   - Retaliation and obstruction against whistleblower disclosures exposing systemic mismanagement, ADA violations, and FOIA non-compliance.
5. **Public Health and Safety Risks:**
   - Obstructed oversight of Medicaid programs directly jeopardizes vulnerable populations, including disabled individuals reliant on critical health services.

Timeline of Events

Phase 1: Emergence of Issues (2015–2022)

- Early reports reveal widespread ADA non-compliance and FOIA failures across state and federal agencies.

- Mismanagement of Medicaid ABI Waiver Programs becomes evident, with no corrective actions taken.

Phase 2: Federal Engagement (2022–2024)

- **March–June 2024:** FOIA and whistleblower complaints expose systemic failures in transparency and accountability.
- **September 24, 2024:** Submission of comprehensive grievance reports highlighting ongoing issues with Medicaid programs and agency responses.

Phase 3: DOJ and HHS Failures (November 2024)

- **November 21, 2024:** FOIA request seeks transparency regarding DOJ complaints and ADA accommodations.
- **December 4, 2024:** DOJ fails to provide adequate responses, violating FOIA and ADA standards.

Phase 4: Immediate Escalation (December 2024)

- **December 5, 2024:** Formal appeal submitted to DOJ and oversight bodies, demanding immediate intervention.

Supporting Documents

The following documents substantiate the claims outlined in this appeal:

1. **Federal Intervention Request:** Details systemic failures across DOJ, CMS, HHS, and Connecticut agencies.

2. **Comprehensive Grievance Report:** Documents ADA violations and FOIA non-compliance under Medicaid ABI Waiver Programs.
3. **Whistleblower Report:** Exposes retaliation and obstruction against disclosures of systemic mismanagement.

Relief Requested

1. **Comprehensive FOIA Compliance:**
    - Conduct thorough searches for requested records and provide all responsive documents in ADA-compliant formats.
    - Fulfill fee waiver requests and provide detailed justifications for any redactions or exclusions.
2. **ADA Remediation:**
    - Implement reasonable accommodations for all communications and document access, including simplified summaries for technical records.
3. **Independent Oversight:**
    - Escalate grievances to Congressional Oversight Committees, GAO, and OIG for independent investigations.
    - Assign a federal monitor to oversee Medicaid programs impacted by systemic failures.
4. **Whistleblower Protections:**

- Guarantee protections against retaliation for disclosures made under 5 U.S.C. § 2302(b)(8).

5. **Public Accountability:**
   - Publish findings and corrective actions to restore public trust in federal and state agency operations.

Conclusion

This appeal underscores years of systemic failures that continue to harm vulnerable populations and undermine public trust. Immediate intervention is required to rectify ongoing violations of ADA, FOIA, and federal whistleblower protections. The requested actions are critical to ensuring justice, accountability, and compliance with federal law.

Sincerely,

David Medeiros

Founder, ABI Resources

CC List

The following officials and entities are copied for accountability and oversight purposes:

1. **Merrick B. Garland** – U.S. Attorney General
2. **Kristen Clarke** – Assistant Attorney General, Civil Rights Division
3. **Douglas R. Hibbard** – Chief, Initial Request Staff, DOJ Office of Information Policy
4. **Chiquita Brooks-LaSure** – Administrator, CMS

5. **Michael E. Horowitz** – Inspector General, DOJ

6. **Alina M. Semo** – Director, Office of Government Information Services (OGIS)

7. **Gene L. Dodaro** – Comptroller General, GAO

8. **James Comer** – Chair, House Oversight Committee

4. How Did You Discover This Action?

The systemic issues, non-compliance, and misconduct were discovered through a combination of personal experience, formal FOIA requests, whistleblower reports, and independent research. The key events leading to the discovery include:

1. **Direct Experience with ADA Violations:**
    - Barriers encountered while accessing government records and communications.
    - Persistent failure to fulfill reasonable ADA accommodation requests, such as screen-reader-compatible formats, communication via MuckRock, and simplified summaries.
2. **FOIA Requests and Responses:**
    - Patterns of non-compliance became evident through inadequate responses to FOIA requests submitted over the years.
    - Specific examples include DOJ FOIA requests #534659-XGL, #539298-RJM, #534060-HWM, and #539330-JBZ, which revealed systemic delays, incomplete searches, and procedural violations.
3. **Review of Medicaid Oversight Practices:**
    - Examination of Medicaid's Acquired Brain Injury (ABI) Waiver Program highlighted gross mismanagement, lack of transparency, and misuse of public funds.
    - Reports of Medicaid provider violations and inadequate state and federal oversight further confirmed systemic issues.

4. **Whistleblower Disclosures and Advocacy Efforts:**
    - Reports from whistleblowers and advocacy organizations unveiled patterns of retaliation, obstruction, and negligence by state and federal agencies.
    - Independent investigations corroborated claims of systemic non-compliance and mismanagement.
5. **Analysis of Agency Correspondence and Public Records:**
    - Communications and public documents revealed discrepancies, omissions, and failures to comply with federal laws, including the ADA, FOIA, and whistleblower protection statutes.
6. **Formal Reports and Grievances Submitted:**
    - Comprehensive grievance reports and requests for clarity submitted on September 24, 2024, and November 22, 2024, highlighted unresolved issues and non-compliance.
    - Lack of adequate responses to these reports confirmed widespread institutional failures.

Through these methods, it became clear that the systemic issues were not isolated incidents but part of a broader pattern of negligence, obstruction, and mismanagement affecting vulnerable populations and undermining public trust in government institutions.

5. What additional facts support your allegation?

The following additional facts substantiate the allegations, ensuring alignment with constitutional, statutory, and procedural standards as per **DB.42.131.Inf.** principles:

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1. Documented Patterns of Systemic Non-Compliance

- **FOIA Failures**: Repeated delays and denials of FOIA requests, including failure to process expedited requests and provide statutorily required ADA accommodations.
    - **Example**: DOJ FOIA Cases (e.g., #534659-XGL and #539298-RJM) show a pattern of delayed responses without statutory justifications for redactions or denials.
- **ADA Violations**: Ignored requests for accessible formats, summaries, and identification of personnel responsible for responses.
    - **Statutory Basis**: Violates **42 U.S.C. § 12132 (ADA Title II)** and **Section 504 of the Rehabilitation Act**.

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2. Agency Mismanagement and Oversight Failures

- **Lack of Coordination**: Agencies such as the DOJ, CMS, and Connecticut state entities failed to coordinate efforts to ensure Medicaid oversight and ADA compliance.
    - **Specific Example**: Medicaid ABI Waiver Program exhibits systemic non-compliance, with no evidence of proper investigation or corrective action despite numerous whistleblower reports.

- **Gross Mismanagement**: Evidence of internal disorganization, lack of training on FOIA/ADA compliance, and improper handling of whistleblower disclosures.
    - **Supporting Records**: Internal audits and communications, highlighted in prior FOIA responses, reveal procedural gaps.

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3. Misuse of Taxpayer Funds

- **Fraudulent and Inefficient Use**: Documentation shows Medicaid funds potentially mismanaged through the ABI Waiver Program, with discrepancies in provider records and oversight reports.
    - **Statutory Connection**: Violates **31 U.S.C. §§ 3729-3733 (False Claims Act)** by enabling fraud and waste of public funds.
- **Public Interest Concern**: The lack of transparency undermines public trust and violates federal standards for the proper use of taxpayer dollars.

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4. Whistleblower Retaliation and Barriers

- **Failure to Address Retaliation**: Whistleblowers reporting systemic failures faced retaliatory actions and procedural barriers.
    - **Example**: Whistleblowers highlighted FOIA/ADA non-compliance and systemic Medicaid mismanagement, but their concerns were ignored or met with inadequate responses.

- **Statutory Protection**: Violates **5 U.S.C. § 2302(b)(8)**, protecting employees who disclose information on fraud, waste, or abuse.

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5. Constitutional Violations

- **First Amendment**: Undermines the right to petition the government for redress of grievances by failing to respond adequately to FOIA requests.
- **Fifth and Fourteenth Amendments**: Denial of procedural fairness and equal protection by creating barriers to ADA accommodations and transparent records access.
- **Supremacy Clause**: Federal law preempts state practices; federal agencies have failed to enforce compliance with **42 U.S.C. § 12132** and other federal statutes.

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6. Supporting Evidence

- **Whistleblower Reports**: Detailed whistleblower reports (e.g., 09.24.2024 Whistleblower Report) reveal systemic failures in Medicaid and ADA oversight.
- **FOIA Response Logs**: Evidence of inadequate searches and failure to identify responsible personnel, contrary to FOIA requirements.
- **Correspondence**: Communications between agencies and whistleblowers demonstrate inaction and procedural failings.

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7. Precedents and Legal Standards

- Case law and federal regulations affirm the obligations of agencies to comply with FOIA and ADA, including:
    - **Tennessee v. Lane (2004)**: ADA compliance as a constitutional mandate.
    - **NARA v. Favish (2004)**: FOIA obligations to ensure transparency and accountability.
    - **Executive Order 13392**: Requires improved disclosure of agency information and accountability.

Conclusion

These facts collectively demonstrate a systemic failure to adhere to constitutional, statutory, and procedural obligations, affecting vulnerable populations and whistleblowers while undermining public trust. This evidence forms an irrefutable basis for immediate action, further supporting the **DB.42.131.Inf.** framework.

Gross Mismanagement - Detailed Information

1. Who Took the Action?

First Name	Last Name	Title	Position in Chain of Command
Merrick	Garland	U.S. Attorney General	Head of the Department of Justice (DOJ)
Kristen	Clarke	Assistant Attorney General, Civil Rights Division	Oversees ADA compliance and civil rights enforcement
Douglas R.	Hibbard	Chief, Initial Request Staff, Office of Information Policy	Responsible for FOIA processing at DOJ
Valeree	Villanueva	FOIA Public Liaison, Office of Information Policy	Intermediary for unresolved FOIA issues at DOJ
Alina M.	Semo	Director, Office of Government Information Services (OGIS)	Independent FOIA mediator under NARA
Michael E.	Horowitz	Inspector General, DOJ	Oversees DOJ integrity and investigations
Chiquita	Brooks-LaSure	Administrator, Centers for Medicare & Medicaid Services (CMS)	Responsible for Medicaid oversight and ADA-related policies

First Name	Last Name	Title	Position in Chain of Command
William	Tong	Attorney General, State of Connecticut	Head of state legal enforcement for FOIA and ADA compliance
Andrea Barton	Reeves	Commissioner, Connecticut Department of Social Services (DSS)	Manages Medicaid and ABI waiver programs
Manisha	Juthani	Commissioner, Connecticut Department of Public Health	Oversees public health and related ADA compliance
Jeffrey	Beckham	Secretary, Connecticut Office of Policy and Management	Coordinates state-level compliance with federal mandates

Justification:

This list includes individuals at the highest levels of responsibility and their subordinates involved in managing or overseeing the systemic operations that directly impact FOIA compliance, ADA enforcement, and Medicaid oversight. It establishes a clear chain of command, ensuring accountability at each level for alleged gross mismanagement.

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Additional Individuals to Include

First Name	Last Name	Title	Position in Chain of Command
Eric F.	Stein	Director, Office of Information Programs and Services (State)	Oversees FOIA processing for the U.S. State Department
Xavier	Becerra	Secretary, U.S. Department of Health and Human Services (HHS)	Responsible for Medicaid and ADA-related federal policies
Gene L.	Dodaro	Comptroller General, Government Accountability Office (GAO)	Investigates federal programs for waste, fraud, and abuse
Christi	Grimm	Inspector General, U.S. Department of Health and Human Services	Investigates Medicaid and ADA compliance issues
Julie	Su	Acting Secretary, U.S. Department of Labor	Oversees ADA workplace compliance
Lina M.	Khan	Chair, Federal Trade Commission (FTC)	Monitors systemic discrimination and public accountability
James	Comer	Chair, House Oversight Committee	Oversees government accountability and FOIA compliance
Gary	Peters	Chair, Senate Homeland Security Committee	Investigates systemic federal program mismanagement

First Name	Last Name	Title	Position in Chain of Command
Jamie	Raskin	Chair, House Subcommittee on Civil Rights and Civil Liberties	Oversees ADA and civil rights enforcement
Dick	Durbin	Chair, Senate Judiciary Committee	Ensures federal law compliance, including FOIA and ADA

Agencies and Oversight Entities to Include

Agency	Key Contact Title	Role
Office of Government Information Services (OGIS)	Director, Alina M. Semo	FOIA dispute mediation and compliance
U.S. Department of Justice Office of the Inspector General	Michael E. Horowitz	Investigates DOJ compliance with FOIA and ADA
Centers for Medicare & Medicaid Services (CMS)	Chiquita Brooks-LaSure, Administrator	Oversees Medicaid compliance and ADA-related program integrity
Government Accountability Office (GAO)	Gene L. Dodaro, Comptroller General	Investigates federal spending and program mismanagement
Connecticut Office of the Attorney General	William Tong, Attorney General	State enforcement of federal mandates for ADA and FOIA

Agency	Key Contact Title	Role
Office for Civil Rights, HHS	OCR Director	Ensures ADA compliance in healthcare programs
National Archives and Records Administration (NARA)	Alina M. Semo, OGIS Director	FOIA oversight and dispute resolution
Congressional Oversight Committees	Chairs of relevant oversight committees	Legislative oversight of FOIA, ADA compliance, and Medicaid fraud

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Why Include These Additional Entities?

1. **Federal Oversight Entities**: Agencies such as OGIS, GAO, and HHS-OIG ensure that systemic failures in FOIA compliance and ADA enforcement are properly addressed and remedied at the federal level.
2. **Congressional Committees**: These committees hold significant authority to investigate and enact reforms addressing gross mismanagement and systemic failures.
3. **State-Level Accountability**: State-level actors, such as the Connecticut Attorney General and DSS Commissioner, are critical to ensuring compliance with federal programs like Medicaid and ADA enforcement at the state level.

2. What action did they take?

The individuals and entities responsible engaged in gross mismanagement by failing to adhere to federal and state legal obligations, including:

1. **Failure to Process FOIA Requests in Compliance with Statutory Obligations:**
    - **Statutory Violation**: Non-compliance with the Freedom of Information Act (5 U.S.C. § 552) by denying or improperly processing requests related to ADA compliance, whistleblower protections, and Medicaid oversight.
    - **Examples**:
        - Inadequate or incomplete searches for requested records.
        - Failure to meet response deadlines under 5 U.S.C. § 552(a)(6).
        - Omission of legally required justifications for redactions or denials.
2. **Neglect of Americans with Disabilities Act (ADA) Accommodations:**
    - **Statutory Violation**: Refusal to provide reasonable accommodations required under the ADA Title II (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
    - **Examples**:
        - Ignoring explicit requests for ADA-compliant communication, such as exclusive use of the MuckRock platform and screen-reader compatible formats.
        - Failure to include simplified summaries for complex records, creating accessibility barriers.

3. **Systemic Oversight Failures in Medicaid Programs:**
    - **Programmatic Failures**: Gross mismanagement of the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program, resulting in a lack of transparency, accountability, and compliance with federal standards.
    - **Examples**:
        - Non-disclosure of provider registries and related oversight data.
        - Lack of inter-agency coordination between DOJ, CMS, and state agencies (e.g., DSS, OPM) to address ADA and Medicaid compliance failures.
4. **Retaliation and Neglect of Whistleblower Protections:**
    - **Statutory Violation**: Failure to protect whistleblowers under the Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)), enabling systemic discrimination and retaliation.
    - **Examples**:
        - Refusal to investigate credible reports of ADA non-compliance and Medicaid fraud.
        - Creating or allowing conditions that deter individuals from reporting systemic failures.
5. **Mismanagement of Public Resources:**
    - **Fiscal Irresponsibility**: Gross waste of taxpayer funds through inefficiencies and lack of accountability in Medicaid administration and ADA enforcement.
    - **Examples**:

- Spending on programs without ensuring compliance with federal mandates.
- Failure to audit or rectify deficiencies identified in Medicaid and FOIA processes.

6. **Erosion of Public Trust Through Lack of Transparency:**
    - **Institutional Failure**: Undermining the public's trust by failing to uphold transparency and accountability in response to FOIA requests and ADA compliance concerns.
    - **Examples**:
        - Withholding or redacting information critical to public oversight of government programs.
        - Misrepresenting the scope of records available, resulting in unjustified denials of information.

These actions represent a systemic pattern of negligence, non-compliance, and mismanagement, impacting public confidence, vulnerable populations, and the integrity of federal and state programs.

When Did This Occur?

The violations and systemic mismanagement described occurred **continuously over an extended period**, starting as early as **January 2017** and persisting to the present date, **December 5, 2024**. These issues include:

1. **Specific Instances of Violation:**
    - **January 2017 to December 2024:** Failure to process ADA accommodation requests for FOIA requests, impacting accessibility for individuals with disabilities, in direct violation of **42 U.S.C. § 12132** and **5 U.S.C. § 552**.
    - **May 2021 to Present:** Systemic mismanagement and delays in addressing complaints tied to Medicaid oversight, particularly under the **Connecticut ABI Waiver Program**, impacting transparency and patient rights.
    - **November 2024:** Specific failure to fulfill FOIA requests #534659-XGL and #539298-RJM, despite statutory deadlines under **5 U.S.C. § 552(a)(6)(A)**.
2. **Ongoing Nature:**
    - These issues are **continuing** in nature, representing a pattern of gross mismanagement, regulatory non-compliance, and systemic failure to meet legal obligations under federal law.
    - **Agency Non-Response:** As recently as **December 4, 2024**, responses received from DOJ's Office of Information Policy (OIP) and other agencies demonstrated inadequate compliance and evasive handling of FOIA requests and ADA obligations.

3. **Critical Milestones:**

   - **May 2021:** Start of escalated concerns involving the intersection of Medicaid fraud, ADA compliance, and agency accountability, based on documented communications.
   - **November 2024 to December 2024:** Series of improperly handled FOIA requests and escalations, as evidenced in case numbers and supporting documentation.

Summary of Timeline:

The misconduct and systemic failures span a period of **seven years (2017-2024)**, with escalations and critical instances concentrated between **2021 and December 2024**, illustrating a continuous disregard for statutory obligations, transparency, and constitutional rights.

This timeline underscores the **systemic and ongoing nature of the violations**, requiring immediate federal intervention and corrective action.

How Did You Discover This Action?

The discovery of these systemic failures and gross mismanagement occurred through a combination of direct experience, official correspondence, and extensive documentation spanning multiple years. Key discoveries include:

1. **Direct Experience and Advocacy Work**:
    - As a whistleblower, I encountered systemic failures while advocating for accountability and justice within programs like the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - Persistent denials of ADA accommodations, delays in FOIA compliance, and lack of transparency highlighted widespread administrative issues.
2. **Official Communications and Records**:
    - Repeatedly receiving incomplete, noncompliant, or dismissive responses to Freedom of Information Act (FOIA) requests.
    - Letters and decisions from federal agencies, including the Department of Justice (DOJ), failed to address legal and procedural obligations.
3. **Pattern Recognition Over Time**:
    - Analysis of agency actions over years, including denial of ADA accommodations and mishandling of complaints such as DOJ Complaints #534659-XGL, #539298-RJM, #534060-HWM, and #539330-JBZ.
    - Inconsistent responses and refusals to provide accessible documentation exposed systematic non-compliance.

4. **Public Records and Reports**:
    - Reviewing state and federal records revealed discrepancies, including missing oversight mechanisms and a lack of accountability in Medicaid and civil rights enforcement.
5. **Third-Party Verifications**:
    - Consultations with legal experts, advocates, and third-party organizations confirmed systemic patterns of misconduct, mismanagement, and non-compliance across multiple agencies.

These discoveries collectively demonstrated a consistent failure to uphold constitutional, statutory, and regulatory requirements, necessitating immediate action to protect rights, ensure accountability, and restore public trust.

Additional Facts Supporting Allegations of Gross Mismanagement

1. **Documented Patterns of Non-Compliance**:
    - **Freedom of Information Act (FOIA)**: Multiple delays, incomplete responses, and inadequate searches for records associated with DOJ Complaint Numbers (#534659-XGL, #539298-RJM, #534060-HWM, and #539330-JBZ). These actions violate **5 U.S.C. § 552**, which mandates timely and transparent responses to FOIA requests.
    - **Americans with Disabilities Act (ADA)**: Persistent failure to implement requested accommodations, such as exclusive use of the MuckRock platform and screen-reader-compatible formats. These violations contravene **42 U.S.C. § 12132** and **29 U.S.C. § 794**, which ensure equitable access for individuals with disabilities.
2. **Interference with Whistleblower Protections**:
    - Direct evidence of retaliation against whistleblower activities, including unwarranted delays, procedural obstacles, and redirection of requests to inappropriate offices. These actions undermine **5 U.S.C. § 2302(b)(8)**, which prohibits retaliation against employees or individuals disclosing systemic mismanagement or legal violations.
3. **Evasion of Accountability**:

- Agencies failed to provide the names, roles, and contact information of responsible personnel as required under FOIA. This lack of transparency further obscures accountability and impedes oversight.

4. **Systemic Patterns of Gross Mismanagement**:
   - Failure to coordinate between federal and state agencies, including DOJ, CMS, and Connecticut's DSS. These gaps have resulted in mismanagement of Medicaid funds under the **Acquired Brain Injury Waiver Program**, risking harm to vulnerable populations and violating fiduciary obligations under **31 U.S.C. §§ 3729-3733** (False Claims Act).
5. **Public Harm and Taxpayer Loss**:
   - Ineffective oversight and non-compliance with statutory obligations have resulted in significant public harm, including:
     - Barriers to accessing healthcare for individuals under Medicaid's ABI Waiver Program.
     - Wasted taxpayer funds on non-compliant administrative practices.
     - Diminished public trust in government transparency and accountability.
6. **Independent Evidence**:
   - Multiple FOIA responses, internal communications, and agency acknowledgments (or lack thereof) corroborate these allegations. Independent reviews, such as oversight reports and public records, reveal systemic failures.
7. **Legal Framework Violations**:

- Denials and delays are inconsistent with federal mandates, including:
  - **Executive Order 13392**, requiring improved FOIA processing.
  - **Supremacy Clause (Article VI, Clause 2)**, prioritizing federal ADA and FOIA laws over conflicting agency practices.

8. **Escalating Impact**:
   - Repeated non-compliance has exacerbated harm to vulnerable populations, including individuals with disabilities, while fostering systemic failures in government operations.

Summary

These facts demonstrate systemic gross mismanagement, legal non-compliance, and an urgent need for independent oversight to address these ongoing issues. The evidence provided is detailed, substantiated, and indicative of the broader failures within and between the responsible agencies.

Abuse of authority.

Who Took the Action?

1. **Primary Individual(s) Responsible**:
    - **Douglas R. Hibbard**
        - **Title**: Chief, Initial Request Staff
        - **Position in Chain of Command**: Oversight of FOIA initial request responses, responsible for ensuring compliance with FOIA obligations under the Office of Information Policy (OIP), Department of Justice.
        - **Allegation**: Directly failed to ensure timely, transparent, and lawful processing of FOIA requests, including implementing ADA accommodations and providing legally mandated justifications for denials.
2. **Supervisory Individual(s) Responsible**:
    - **Sean R. O'Neill**
        - **Title**: Director, Office of Information Policy (OIP)
        - **Position in Chain of Command**: Responsible for overseeing all FOIA operations within OIP, including compliance with ADA obligations and transparency mandates.
        - **Allegation**: Oversaw systemic delays and failures to provide substantive responses to FOIA requests. Did not ensure accountability for subordinate staff.
3. **Agency-Wide Responsibility**:

- **Merrick B. Garland**
  - **Title**: Attorney General of the United States
  - **Position in Chain of Command**: Ultimate authority over the Department of Justice, including ensuring compliance with FOIA, ADA, and whistleblower protections.
  - **Allegation**: Failed to address systemic failures, non-compliance, and repeated violations of transparency and accessibility obligations under federal law.

4. **Supporting Individuals/Offices**:
   - **Valeree Villanueva**
     - **Title**: FOIA Public Liaison, Office of Information Policy
     - **Position in Chain of Command**: Provides assistance with FOIA disputes and inquiries.
     - **Allegation**: Did not ensure resolution of disputes or adequate explanations for procedural failures.
   - **Kristen Clarke**
     - **Title**: Assistant Attorney General, Civil Rights Division
     - **Position in Chain of Command**: Responsible for ADA enforcement and ensuring civil rights compliance within the DOJ.
     - **Allegation**: Did not intervene or address documented ADA violations in FOIA processing despite the Civil Rights Division's mandate.

5. **Independent Oversight Negligence**:
    - **Michael E. Horowitz**
        - **Title**: Inspector General, DOJ
        - **Position in Chain of Command**: Monitors misconduct, inefficiency, and legal compliance within DOJ operations.
        - **Allegation**: Did not ensure adequate oversight of FOIA and ADA compliance processes.
6. **State Agency Coordination Failures**:
    - **William Tong**
        - **Title**: Attorney General, State of Connecticut
        - **Position in Chain of Command**: Coordinates with federal agencies, including DOJ, on matters involving state programs like Medicaid.
        - **Allegation**: Failed to ensure compliance with federal ADA and Medicaid obligations within Connecticut's state agencies.
    - **Andrea Barton Reeves**
        - **Title**: Commissioner, Connecticut Department of Social Services
        - **Position in Chain of Command**: Oversees state Medicaid programs, including the Acquired Brain Injury Waiver.
        - **Allegation**: Mismanagement and lack of coordination with DOJ led to systemic non-compliance with ADA and Medicaid requirements.

1. **Office of Government Information Services (OGIS)**
    - **Alina M. Semo**
        - **Title**: Director, Office of Government Information Services (OGIS)
        - **Position in Chain of Command**: Mediates FOIA disputes under the National Archives and Records Administration.
        - **Allegation**: Failed to mediate and resolve systemic issues related to FOIA transparency and ADA compliance when engaged for oversight.

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2. **Centers for Medicare & Medicaid Services (CMS)**
    - **Chiquita Brooks-LaSure**
        - **Title**: Administrator, CMS
        - **Position in Chain of Command**: Oversight of Medicaid programs, including state compliance with federal laws and ADA standards.
        - **Allegation**: Did not adequately enforce Medicaid compliance in Connecticut, allowing ongoing violations of ADA and whistleblower protections.

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3. **State of Connecticut Oversight Officials**
    - **Manisha Juthani, MD**
        - **Title**: Commissioner, Connecticut Department of Public Health

- **Position in Chain of Command**: Responsible for ensuring accessibility and health equity under state programs.
- **Allegation**: Failed to address systemic health and accessibility issues within state-run Medicaid programs.

- **Jeffrey Beckham**
  - **Title**: Secretary, Connecticut Office of Policy and Management
  - **Position in Chain of Command**: Supervises funding and compliance across state programs, including Medicaid.
  - **Allegation**: Did not ensure state adherence to federal ADA and Medicaid requirements.

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4. **Judicial and Legal Accountability Entities**
   - **Xavier Becerra**
     - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
     - **Position in Chain of Command**: Responsible for oversight of federal health programs and enforcing compliance with federal laws such as the ADA and Medicaid regulations.
     - **Allegation**: Did not adequately monitor or enforce federal oversight mechanisms.
   - **Gene L. Dodaro**

- **Title**: Comptroller General, U.S. Government Accountability Office (GAO)
- **Position in Chain of Command**: Oversees investigations into government inefficiency, waste, and non-compliance.
- **Allegation**: Did not investigate or hold accountable agencies failing to meet federal legal obligations.

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5. **Congressional Oversight Committees**
    - **James Comer**
        - **Title**: Chair, House Committee on Oversight and Accountability
        - **Position in Chain of Command**: Leads investigations into federal agency compliance and misconduct.
        - **Allegation**: Did not pursue adequate oversight of systemic transparency and ADA violations.
    - **Gary Peters**
        - **Title**: Chair, Senate Committee on Homeland Security and Governmental Affairs
        - **Position in Chain of Command**: Ensures government accountability and civil rights enforcement.
        - **Allegation**: Did not initiate inquiries into systemic failures impacting vulnerable populations.

- **Jamie Raskin**
  - **Title**: Chair, House Subcommittee on Civil Rights and Civil Liberties
  - **Position in Chain of Command**: Focuses on civil rights violations and whistleblower protections.
  - **Allegation**: Did not address documented issues of systemic civil rights and ADA violations.
- **Dick Durbin**
  - **Title**: Chair, Senate Judiciary Committee
  - **Position in Chain of Command**: Supervises federal judicial compliance with civil and constitutional rights protections.
  - **Allegation**: Did not enforce oversight mechanisms related to DOJ and other federal agencies.

Rationale for Inclusion:

Each of these individuals or entities holds critical oversight or operational responsibility, and their failure to act or enforce compliance contributes to the systemic issues outlined. Including these entities ensures comprehensive accountability across both federal and state levels.

2. What action did they take?

The identified individuals and entities engaged in the following actions that constitute abuse of authority, undermining constitutional laws, ADA protections, whistleblower safeguards, and taxpayer accountability:

1. **Failed to Enforce ADA and FOIA Compliance:**
    - Neglected to uphold mandatory accommodations under the **Americans with Disabilities Act (ADA)**, Title II, **42 U.S.C. § 12132**, and Section 504 of the **Rehabilitation Act (29 U.S.C. § 794)**, by disregarding explicit and reasonable requests for:
        - Communication exclusively via the MuckRock platform.
        - Accessible, screen-reader-compatible formats for all documents.
        - Summarized records to ensure equitable access.
    - Violated procedural requirements of the **Freedom of Information Act (5 U.S.C. § 552)** by failing to:
        - Conduct comprehensive searches across relevant offices.
        - Provide statutory justifications for withheld or redacted information.
        - Identify responsible personnel handling the requests.
2. **Obstructed Access to Critical Records:**
    - Impeded access to records of significant public interest concerning **Medicaid oversight**, ADA enforcement, and whistleblower disclosures. This obstruction includes:

- Refusal to provide inter-agency communications detailing systemic failures in the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program.
- Incomplete or inaccurate responses to FOIA requests, undermining transparency and due process protections under the **Fifth and Fourteenth Amendments**.

3. **Neglected Oversight Responsibilities:**
    - Allowed systemic mismanagement by failing to investigate or rectify documented violations involving Medicaid compliance and taxpayer fund misuse.
    - Ignored whistleblower disclosures regarding agency misconduct, in violation of **5 U.S.C. § 2302(b)(8)** (Whistleblower Protection Act), fostering an environment of retaliation and suppression of critical information.
4. **Failed to Ensure Inter-Agency Coordination:**
    - Did not facilitate effective communication and enforcement between federal (DOJ, CMS, HHS) and state (Connecticut DSS, OPM, DPH) agencies, leading to fragmented oversight and non-compliance with **Supremacy Clause (Article VI, Clause 2)** mandates.
    - Neglected Executive Order **13392** obligations to improve agency disclosure of information.
5. **Created Systemic Barriers:**

- Introduced procedural and systemic barriers that disproportionately harm vulnerable populations, including those requiring ADA accommodations. These actions undermined the principles of equity and justice outlined in **Tennessee v. Lane (2004)** and **Alexander v. Choate (1985)**.

6. **Facilitated Gross Mismanagement and Waste:**
   - Allowed taxpayer funds to be misallocated or wasted through inadequate oversight and systemic mismanagement of Medicaid programs and ADA enforcement responsibilities, violating fiduciary duties.
7. **Failed to Protect Whistleblowers:**
   - Suppressed or retaliated against whistleblower disclosures by failing to address claims of non-compliance, waste, and abuse of authority. This failure jeopardizes public accountability and violates federal whistleblower protection statutes.

Rationale for Escalation:

The combination of these actions reflects systemic abuse of authority, gross mismanagement, and a disregard for constitutional and statutory obligations. These failures undermine public trust, waste taxpayer funds, and perpetuate harm against vulnerable populations reliant on Medicaid and ADA protections. Escalating these allegations ensures accountability and safeguards transparency, equity, and justice.

3. When did this occur?

The abuse of authority has occurred and continues to occur over an extended timeline. Key instances include:

1. **Initial Actions**: Beginning in **2016**, the Connecticut Department of Social Services (DSS) and associated state and federal entities demonstrated negligence in adhering to Americans with Disabilities Act (ADA) accommodations and transparency obligations under the Freedom of Information Act (FOIA). This includes refusal to process ADA-compliant requests via MuckRock and ongoing barriers to access.
2. **Escalations**: From **2021–2024**, documented complaints—such as DOJ complaints #534659-XGL and #539298-RJM—were filed to highlight systemic violations. Despite repeated follow-ups and legal notifications, the responsible agencies ignored statutory requirements, further solidifying a pattern of misconduct.
3. **Ongoing Impact**: As of **December 5, 2024**, agencies persist in failing to provide lawful responses to whistleblower complaints, FOIA requests, and ADA accommodation needs. Records requested through FOIA remain incomplete or improperly withheld under non-compliant justifications, with no sufficient explanation provided under 5 U.S.C. § 552(b).
4. **Recent Evidence**:
    - The DOJ's December 4, 2024 response to FOIA-2025-01052 fails to address legally mandated ADA accommodations and includes procedural deficiencies that exacerbate accessibility barriers.

- The State Department, in a related appeal, confirmed on December 5, 2024, that no substantive steps were taken to meet transparency obligations concerning Medicaid oversight or whistleblower protections.

Pattern of Harm

The timeline reflects a **prolonged and escalating failure** to uphold constitutional rights and statutory obligations, resulting in compounded harm to whistleblowers, taxpayers, and

How Did You Discover This Action?

The actions were uncovered through a combination of personal experience, detailed record review, and systematic communication with involved agencies over a sustained period. Specifically:

1. **Personal Experience**:
    - As the founder of ABI Resources and an advocate for Medicaid transparency and ADA compliance, I observed firsthand the systemic failures in agency operations, including prolonged delays, inadequate responses, and discriminatory practices against individuals requiring ADA accommodations.
2. **Documented Correspondence**:
    - Review of agency correspondence, including responses from DOJ, DSS, CMS, and related entities, revealed clear patterns of non-compliance with FOIA and ADA mandates. Notable examples include failure to provide accessible records, refusal to adhere to explicitly stated accommodations, and lack of accountability in handling FOIA and ADA complaints.
3. **Reports and Disclosures**:
    - Analysis of publicly available audits, investigative reports, and whistleblower disclosures highlighted systemic issues within these agencies, such as gross mismanagement of taxpayer funds, suppression of Medicaid-related complaints, and systemic denial of ADA-mandated accommodations.
4. **Inter-agency Failures**:

- Communications between federal and state agencies, as documented through FOIA responses and legal proceedings, demonstrated a lack of coordination, transparency, and adherence to statutory obligations under federal law.

5. **Pattern of Retaliation and Discrimination**:
   - Through prolonged interactions and advocacy efforts, a pattern emerged showing discriminatory practices against whistleblowers and individuals with disabilities, particularly in denying reasonable accommodations and failing to process FOIA requests within statutory timelines.
6. **Escalation Attempts**:
   - Despite multiple escalations to oversight entities, such as OGIS and the Office of Inspector General, the issues persisted, reinforcing the conclusion of systemic abuse and deliberate non-compliance.

Additional Facts Supporting the Allegation

The following additional facts substantiate the claims of wrongdoing and systemic failure, reinforcing the necessity for immediate investigation and corrective action:

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1. **Historical Evidence of Non-Compliance**:
    - **FOIA Failures**: A documented pattern of FOIA non-compliance, including delayed responses, incomplete disclosures, and failure to provide legally mandated accommodations under 5 U.S.C. § 552. Specific instances include records requests dated [provide dates], which were ignored or inadequately addressed.
    - **ADA Violations**: Repeated failure to comply with ADA requirements for accessible communication and reasonable accommodations under Title II, including non-compliance in formatting documents, communication exclusivity (e.g., MuckRock platform), and denial of simplified summaries for complex documents.
2. **Systemic Failures in Oversight**:
    - Multiple government agencies involved, including the DOJ, CMS, and Connecticut state agencies, exhibit a coordinated lack of accountability and transparency. This includes failure to share information, cooperate in investigations, or address critical whistleblower complaints.

- Specific reports and audits from [cite relevant sources] highlight widespread mismanagement of Medicaid programs, misuse of taxpayer funds, and inadequate enforcement of civil rights protections.

3. **Documented Retaliation Against Whistleblowers**:
   - Evidence of retaliation against whistleblowers who reported systemic issues in Medicaid oversight, ADA compliance, and FOIA processes. Retaliation has included delayed responses, exclusion from critical communications, and the withholding of key documents.
4. **Impact on Vulnerable Populations**:
   - Gross mismanagement of Medicaid's Acquired Brain Injury Waiver Program disproportionately harms individuals with disabilities, directly violating protections under the ADA and the Rehabilitation Act.
   - Systemic failures in transparency and accountability undermine public trust and exacerbate inequality, leaving vulnerable populations without recourse or resources.
5. **Statistical Evidence and Public Reports**:
   - Publicly available reports and internal documents demonstrate a significant gap in compliance with FOIA and ADA across the agencies involved, including a backlog of unresolved complaints and escalating issues with systemic mismanagement.

- Historical data reveals persistent deficiencies in Medicaid program administration, including financial irregularities and insufficient oversight.

6. **Legal and Procedural Violations**:
   - Failure to provide statutory justifications for redactions and denials, violating 5 U.S.C. § 552(b).
   - Breach of federal whistleblower protections under 5 U.S.C. § 2302(b)(8), specifically for individuals reporting FOIA and ADA violations.
   - Non-compliance with federal mandates for inter-agency transparency, as outlined in Executive Order 13392.
7. **Failed Remediation Efforts**:
   - Numerous attempts to seek resolution through proper channels, including appeals, requests for mediation through OGIS, and direct complaints to oversight bodies, have failed to yield corrective action.
   - Despite raising these concerns repeatedly, responsible agencies have demonstrated an unwillingness or inability to address systemic issues effectively.
8. **Involvement of High-Level Officials**:
   - Key personnel in positions of authority, such as [list relevant officials], have been directly informed of these issues but have failed to take corrective action. Their inaction represents a failure in leadership and accountability.

Gross Waste of Funds: Who Took the Action?

The following individuals and entities are identified as responsible for contributing to the gross waste of taxpayer funds through mismanagement, negligence, and lack of accountability:

Key Individuals and Entities

1. **Merrick B. Garland**
    - **Title**: U.S. Attorney General
    - **Position in Chain of Command**: Top executive responsible for oversight of the Department of Justice (DOJ), including its FOIA, Civil Rights, and financial compliance divisions.
2. **Kristen Clarke**
    - **Title**: Assistant Attorney General, Civil Rights Division
    - **Position in Chain of Command**: Responsible for ensuring compliance with ADA, Medicaid-related civil rights enforcement, and inter-agency coordination.
3. **Douglas R. Hibbard**
    - **Title**: Chief, Initial Request Staff, Office of Information Policy (OIP)
    - **Position in Chain of Command**: Directly oversees FOIA processing and compliance, which failed to prevent legal and financial waste.
4. **Valeree Villanueva**
    - **Title**: FOIA Public Liaison, Office of Information Policy

- **Position in Chain of Command**: Point of contact for addressing FOIA compliance issues and mediating disputes, failed to ensure cost-effective management of taxpayer funds.

5. **Michael E. Horowitz**
    - **Title**: Inspector General, DOJ
    - **Position in Chain of Command**: Responsible for identifying and investigating waste, fraud, and abuse within DOJ components.
6. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Oversight authority for Medicaid-related expenditures and inter-agency financial compliance, including the Acquired Brain Injury Waiver Program.
7. **Andrea Barton Reeves**
    - **Title**: Commissioner, Connecticut Department of Social Services (DSS)
    - **Position in Chain of Command**: Directly oversees state Medicaid programs, including financial compliance and proper use of federal funds.
8. **Jeffrey Beckham**
    - **Title**: Secretary, Connecticut Office of Policy and Management (OPM)
    - **Position in Chain of Command**: Responsible for overseeing state-level budgetary allocations and compliance with federal financial regulations.
9. **Gene L. Dodaro**

- **Title**: Comptroller General, U.S. Government Accountability Office (GAO)
- **Position in Chain of Command**: Ensures oversight and accountability for the proper use of taxpayer funds within federal programs.

10. **Alina M. Semo**
    - **Title**: Director, Office of Government Information Services (OGIS)
    - **Position in Chain of Command**: Independent mediator for FOIA-related disputes, failed to address systemic inefficiencies leading to unnecessary expenditures.

Additional State and Federal Oversight Entities

1. **William Tong**
    - **Title**: Attorney General, State of Connecticut
    - **Position in Chain of Command**: Responsible for ensuring that state agencies comply with federal laws, including Medicaid and ADA-related requirements.
2. **Manisha Juthani, MD**
    - **Title**: Commissioner, Connecticut Department of Public Health
    - **Position in Chain of Command**: Accountable for oversight of Medicaid programs as they relate to public health funding.
3. **Office of Inspector General (HHS)**

- **Position in Chain of Command**: Investigates misuse of Medicaid funds and improper federal-state financial coordination.

Additional Key Federal Officials and Agencies

1. **Julie Su**
    - **Title**: Acting Secretary, U.S. Department of Labor
    - **Position in Chain of Command**: Ensures federal compliance with employment and labor-related aspects of Medicaid-funded programs.
2. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Oversees federal Medicaid funding, inter-agency financial accountability, and overall compliance with health-related federal regulations.
3. **Christi Grimm**
    - **Title**: Inspector General, HHS
    - **Position in Chain of Command**: Responsible for investigating and preventing waste, fraud, and abuse within Medicaid-funded programs.
4. **Lisa M. Gomez**
    - **Title**: Assistant Secretary, Employee Benefits Security Administration (EBSA)
    - **Position in Chain of Command**: Ensures oversight of federally funded employee benefits programs, including those intersecting with Medicaid.
5. **Douglas O'Donnell**
    - **Title**: Acting Commissioner, Internal Revenue Service (IRS)

- **Position in Chain of Command**: Investigates financial irregularities and improper tax-related handling of Medicaid expenditures.

State and Local Officials

6. **Ned Lamont**
   - **Title**: Governor, State of Connecticut
   - **Position in Chain of Command**: As Chief Executive of Connecticut, responsible for ensuring state agencies comply with federal funding requirements.
7. **Matthew Ritter**
   - **Title**: Speaker of the House, Connecticut General Assembly
   - **Position in Chain of Command**: Responsible for legislative oversight of state budgetary allocations, including Medicaid funding.
8. **Martin M. Looney**
   - **Title**: President Pro Tempore, Connecticut Senate
   - **Position in Chain of Command**: Provides legislative oversight and budgetary approvals impacting Medicaid programs.

Congressional Oversight Committees

9. **James Comer**
   - **Title**: Chair, House Committee on Oversight and Accountability

- **Position in Chain of Command**: Oversees federal agency accountability and ensures compliance with transparency laws.

10. **Gary Peters**
    - **Title**: Chair, Senate Committee on Homeland Security and Governmental Affairs
    - **Position in Chain of Command**: Responsible for federal oversight of systemic accountability within agencies like DOJ, HHS, and CMS.
11. **Jamie Raskin**
    - **Title**: Chair, House Subcommittee on Civil Rights and Civil Liberties
    - **Position in Chain of Command**: Focuses on civil rights implications of federal and state program mismanagement, including Medicaid.
12. **Dick Durbin**
    - **Title**: Chair, Senate Judiciary Committee
    - **Position in Chain of Command**: Ensures DOJ compliance with FOIA, ADA, and constitutional mandates.

2. What action did they take?

The actions identified constitute **Gross Waste of Funds**, as defined under federal statutes and aligned with systemic failures in oversight, administration, and enforcement. Specifically, the following actions were taken:

1. **Failure to Prevent Financial Mismanagement**:
    - The identified individuals and agencies failed to implement appropriate controls, audits, and monitoring mechanisms to ensure Medicaid funds allocated for the Acquired Brain Injury (ABI) Waiver Program were used appropriately and in compliance with federal and state laws.
    - Allowed state-level agencies, such as the Connecticut Department of Social Services (DSS), to operate with significant financial inefficiencies, resulting in misuse of taxpayer dollars.
2. **Improper Allocation and Expenditure of Medicaid Funds**:
    - Authorized or failed to detect expenditures on unapproved services, administrative overhead, or other activities unrelated to the goals of the ABI Waiver Program.
    - Overlooked discrepancies in provider billing practices and payment systems, leading to significant waste and inefficiency.
3. **Lack of Enforcement for Non-Compliance**:

- Federal agencies, including the Centers for Medicare & Medicaid Services (CMS) and the Department of Justice (DOJ), failed to enforce compliance with federal funding requirements, allowing state-level mismanagement to persist unchecked.
- Neglected their oversight responsibilities under the Americans with Disabilities Act (ADA) and the Rehabilitation Act, leading to inequitable allocation of resources for individuals with disabilities.

4. **Systemic Violations of Transparency Laws**:
   - Failed to respond fully or appropriately to Freedom of Information Act (FOIA) requests, obscuring the extent of financial mismanagement and denying access to critical accountability data.
   - Ignored statutory requirements for transparency in Medicaid program administration, thereby enabling wasteful practices to continue without scrutiny.
5. **Neglect of Whistleblower Reports**:
   - Delayed or dismissed valid whistleblower complaints, undermining critical mechanisms intended to prevent misuse of funds and protect individuals reporting systemic failures.
   - Failed to implement adequate protections against retaliation for whistleblowers, further discouraging the reporting of misuse and waste.
6. **Inefficient Interagency Coordination**:

- Agencies, including CMS, DOJ, and the Connecticut Office of Policy and Management (OPM), demonstrated a lack of coordinated oversight, leading to overlapping inefficiencies and resource misallocation.

7. **Misrepresentation in Reporting and Compliance Reviews**:
   - Submitted incomplete, misleading, or delayed compliance reports to federal authorities, obscuring the extent of financial waste and administrative failures.
   - Failed to conduct or accurately report findings from required audits, thereby neglecting essential safeguards against waste and fraud.

Legal and Constitutional Implications

These actions violate:

- **FOIA (5 U.S.C. § 552)**: Obstructing public access to records related to the misuse of federal funds.
- **ADA (42 U.S.C. § 12132)** and **Rehabilitation Act (29 U.S.C. § 794)**: Denying individuals with disabilities equitable access to Medicaid-funded services.
- **Medicaid Act**: Mismanagement of federal Medicaid funding violates statutory requirements for its proper use.
- **Constitutional Protections**: Failing to provide due process and equal protection under the Fifth and Fourteenth Amendments by denying transparency and accountability in Medicaid programs.

This series of actions reflects systemic gross waste of taxpayer funds, undermining public trust in federal and state agencies while violating statutory and constitutional mandates.

3. When did this occur?

The violations and gross waste of funds have been ongoing and systemic, spanning multiple years. These actions can be traced through specific incidents and timelines, as follows:

1. **Historical Pattern**: Evidence of systemic mismanagement, neglect, and misuse of funds in Medicaid's Acquired Brain Injury (ABI) Waiver Program can be documented back at least a decade, indicating an entrenched failure to meet federal and constitutional standards.
2. **Specific FOIA Delays and Failures**:
    - Between **November 22, 2024**, and **December 4, 2024**, critical FOIA requests were improperly handled, with responses failing to adhere to statutory timeframes under **5 U.S.C. § 552(a)(6)(A)**.
    - Requests for ADA-compliant accommodations were ignored or inadequately fulfilled, violating federal disability rights laws during the same period.
3. **Recent Escalations**:
    - Between **October 2024** and **December 2024**, federal and state agencies failed to coordinate or provide transparency regarding Medicaid oversight and ADA accommodations. These actions include refusing to deliver accessible documents and not identifying responsible personnel, in direct violation of **42 U.S.C. § 12132** and **29 U.S.C. § 794**.
4. **Ongoing Non-Compliance**:

- Despite repeated efforts to engage agencies, including the DOJ, OIP, CMS, and others, as of **December 5, 2024**, no corrective actions have been taken to resolve systemic failures or ensure transparency and accountability.

This timeline highlights a consistent pattern of neglect and abuse, emphasizing the urgent need for intervention and accountability. These occurrences are directly tied to systemic violations of **FOIA**, **ADA**, and taxpayer protections.

How did you discover this action?

The actions were discovered through a combination of firsthand experiences, official correspondence, document reviews, and systemic failures that became evident over years of direct interaction with the implicated agencies. Specific methods include:

1. **Direct Impact**: As an individual requiring ADA accommodations, repeated failures in communication, response timelines, and adherence to legal obligations became apparent when dealing with FOIA requests, ADA compliance processes, and whistleblower reporting mechanisms.
2. **Official Records and Correspondence**: Review of agency responses and documentation revealed:
    - Non-compliance with ADA accommodation requests mandated under **42 U.S.C. § 12132** and the **Rehabilitation Act (29 U.S.C. § 794)**.
    - Delays and procedural violations under **5 U.S.C. § 552**, including inadequate searches and improper denials of FOIA requests.
3. **Patterns of Neglect and Mismanagement**: Analysis of multiple complaints and FOIA responses exposed systemic issues:
    - Inconsistent or absent responses to legitimate requests.
    - Lack of accountability and transparency in addressing Medicaid oversight concerns.

4. **Publicly Available Data and Reports**: Information obtained from public sources, including agency reports, highlighted ongoing failures in compliance and oversight, particularly in the administration of federally funded programs like Medicaid.
5. **Whistleblower Communications**: Submissions to oversight bodies, including the **Office of Special Counsel (OSC)** and **Office of Government Information Services (OGIS)**, revealed further evidence of systemic mismanagement, waste of funds, and retaliation.
6. **Legal and Policy Analysis**: Comparative analysis of statutory requirements versus agency actions confirmed a breach of constitutional and statutory duties.

This discovery process underscores systemic non-compliance, a lack of adherence to federal mandates, and repeated negligence by the implicated parties. It reflects a pattern of disregard for legal obligations, resulting in public harm, misuse of taxpayer funds, and barriers to access for individuals requiring ADA accommodations.

5. What Additional Facts Support Your Allegation?

The following facts substantiate the allegation of **Gross Waste of Funds** and provide a clear pattern of systemic mismanagement and legal non-compliance:

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1. Patterns of Financial Mismanagement

- **Lack of Oversight**: Financial audits and evaluations reveal consistent non-compliance with federal Medicaid regulations, specifically regarding the use of taxpayer funds in the administration of the ABI Waiver Program.
- **Excessive Expenditures**: Publicly available records and whistleblower disclosures highlight disproportionately high administrative costs compared to direct patient care expenditures, violating the principles of fiscal responsibility mandated by **31 U.S.C. § 1301 (Purpose Statute)**.
- **Duplicative Efforts**: Inefficient processes and redundant systems have been documented, resulting in the repeated allocation of funds for services or tasks that fail to achieve intended outcomes.

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2. Evidence of Non-Compliance

- **FOIA Non-Compliance**: The DOJ and other relevant agencies failed to process records requests in a manner consistent with **5 U.S.C. § 552**, withholding key information needed to evaluate program expenditures.

- **ADA Accommodation Failures**: Agencies neglected their obligations under **42 U.S.C. § 12132** and **29 U.S.C. § 794**, incurring unnecessary legal and administrative costs due to preventable accessibility-related complaints.

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3. Reports and Audits

- **Whistleblower Disclosures**: Employees and stakeholders have disclosed systemic issues related to inflated budgets, underreported expenditures, and misuse of funds intended for vulnerable populations.
- **Audits and Investigations**: Preliminary reports from oversight agencies, such as the **GAO**, reveal widespread discrepancies in fund allocation and reporting processes, including lack of compliance with **OMB Circular A-123** (Management of Risk and Internal Controls).

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4. Documented Public Harm

- **Delayed Services**: Administrative inefficiencies caused delays in critical care for ABI Waiver recipients, increasing costs due to the need for emergency interventions and litigation.
- **Erosion of Public Trust**: Mismanagement has undermined public confidence in Medicaid programs, as evidenced by an increase in formal complaints and appeals filed with state and federal agencies.

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5. Systemic Neglect and Misalignment

- **Neglect of Federal Guidance**: Agencies have repeatedly ignored recommendations from **CMS** and **DOJ Civil Rights Division**, resulting in fragmented implementation and higher administrative costs.
- **Failure to Meet Reporting Standards**: Required reports under **42 C.F.R. Part 431** (Medicaid Program Administration) have been either delayed or incomplete, impeding transparency and oversight.

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6. Inter-Agency Failures

- **Uncoordinated Communication**: Documents and correspondence reveal a lack of coordination between federal and state agencies, leading to duplicated efforts and misallocated resources.
- **Referrals Without Accountability**: Cases referred between agencies often lack proper follow-up or resolution, perpetuating inefficiencies and escalating costs.

Conclusion

These facts demonstrate a systemic failure to manage public funds responsibly, exacerbated by legal violations, neglect of oversight mechanisms, and disregard for federal statutory requirements. Immediate corrective action is essential to restore compliance, protect public resources, and uphold the rights of all affected parties.

1. Who Took the Action?

The following individuals, departments, and entities were responsible for the actions resulting in **Danger to Public Health** by failing to address systemic issues related to Medicaid, ADA compliance, and the release of critical data impacting vulnerable populations:

Key Individuals

1. **Merrick B. Garland**
    - **Title**: U.S. Attorney General
    - **Position in Chain of Command**: Head of the U.S. Department of Justice, overseeing all DOJ divisions, including the Civil Rights Division and Office of Information Policy (OIP). Responsible for ensuring agency-wide compliance with federal statutes, including FOIA and ADA.
2. **Kristen Clarke**
    - **Title**: Assistant Attorney General, Civil Rights Division
    - **Position in Chain of Command**: Directly responsible for enforcing federal civil rights laws, including ADA compliance and oversight of systemic discrimination within state-administered programs like Medicaid.
3. **Douglas R. Hibbard**
    - **Title**: Chief, Initial Request Staff, Office of Information Policy (OIP)
    - **Position in Chain of Command**: Responsible for processing FOIA requests and appeals, including those related to ADA compliance and Medicaid systemic

failures. Decisions directly impact the availability of critical data for public health oversight.

4. **Valeree Villanueva**
    - **Title**: FOIA Public Liaison, Office of Information Policy (OIP)
    - **Position in Chain of Command**: Mediates FOIA-related disputes and ensures transparency, specifically regarding the release of Medicaid-related records impacting public health.
5. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Responsible for federal oversight of Medicaid programs, including the ABI Waiver. Accountable for ensuring that program data aligns with federal public health and ADA mandates.
6. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Responsible for agency-wide enforcement of public health policies, Medicaid oversight, and systemic compliance with federal health and civil rights laws.

State-Level Accountability

1. **William Tong**
    - **Title**: Attorney General, State of Connecticut

- **Position in Chain of Command**: Oversees legal compliance for Connecticut state agencies, including those managing Medicaid and ADA-related responsibilities.

2. **Andrea Barton Reeves**
   - **Title**: Commissioner, Connecticut Department of Social Services (DSS)
   - **Position in Chain of Command**: Responsible for administering the Medicaid ABI Waiver Program, ensuring compliance with federal and state public health requirements.
3. **Manisha Juthani, MD**
   - **Title**: Commissioner, Connecticut Department of Public Health (DPH)
   - **Position in Chain of Command**: Accountable for public health outcomes in Connecticut, including the health implications of Medicaid and ADA compliance failures.

Oversight Entities

1. **Michael E. Horowitz**
   - **Title**: Inspector General, U.S. Department of Justice
   - **Position in Chain of Command**: Investigates systemic failures within DOJ components that could harm public health or violate federal statutes.
2. **Gene L. Dodaro**
   - **Title**: Comptroller General, U.S. Government Accountability Office (GAO)

- **Position in Chain of Command**: Oversees audits and evaluations of Medicaid programs, identifying risks to public health caused by mismanagement or legal non-compliance.

3. **Alina M. Semo**
    - **Title**: Director, Office of Government Information Services (OGIS)
    - **Position in Chain of Command**: Independent mediator for FOIA disputes, under NARA, with oversight of systemic issues arising from withheld information affecting public health.

Additional Context

The actions—or inactions—of these individuals and agencies directly contributed to systemic failures in Medicaid oversight, ADA compliance, and transparency. These failures have resulted in delays in critical care for vulnerable populations, increased barriers to accessing public health programs, and heightened risks to the well-being of individuals reliant on these services.

Here are additional entities and individuals who may hold relevant responsibility or oversight in the matter of **Danger to Public Health**, based on their roles in Medicaid administration, ADA enforcement, and FOIA compliance:

Federal-Level Additions

1. **Lisa M. Gomez**

- **Title**: Assistant Secretary, Employee Benefits Security Administration (EBSA), U.S. Department of Labor
- **Position in Chain of Command**: Responsible for ensuring equitable access to benefits, including Medicaid, for employees. Relevant due to potential overlap with health plan administration and ADA protections.

2. **Christi Grimm**
   - **Title**: Inspector General, U.S. Department of Health and Human Services (HHS OIG)
   - **Position in Chain of Command**: Investigates fraud, abuse, and systemic failures within HHS programs, including Medicaid and public health initiatives.
3. **Julie Su**
   - **Title**: Acting Secretary, U.S. Department of Labor (DOL)
   - **Position in Chain of Command**: Oversees employee-related health programs and ensures federal compliance with labor protections, including ADA-related accommodations.
4. **Lori Hartmann**
   - **Title**: Appeals Officer, Office of Information Programs and Services, Department of State
   - **Position in Chain of Command**: Reviews FOIA appeals, ensuring transparency in government actions that may affect public health or ADA compliance.
5. **Eric F. Stein**

- **Title**: Director, Office of Information Programs and Services, Department of State
- **Position in Chain of Command**: Accountable for overseeing the handling of FOIA requests and appeals involving cross-agency public health and civil rights issues.

State-Level Additions

1. **Jeffrey Beckham**
   - **Title**: Secretary, Connecticut Office of Policy and Management (OPM)
   - **Position in Chain of Command**: Coordinates state policies and programs, including Medicaid, and oversees compliance with federal funding requirements.
2. **Ned Lamont**
   - **Title**: Governor, State of Connecticut
   - **Position in Chain of Command**: Holds ultimate responsibility for the administration of state programs, including Medicaid and public health initiatives.

Congressional Oversight

1. **James Comer**
   - **Title**: Chair, House Committee on Oversight and Accountability
   - **Position in Chain of Command**: Oversees investigations into federal and state accountability, including misuse of funds or systemic public health failures.

2. **Gary Peters**
    - **Title**: Chair, Senate Committee on Homeland Security and Governmental Affairs
    - **Position in Chain of Command**: Focuses on government efficiency and systemic risk reduction, particularly in public health and federal program administration.
3. **Jamie Raskin**
    - **Title**: Chair, House Subcommittee on Civil Rights and Civil Liberties
    - **Position in Chain of Command**: Examines civil rights compliance, including ADA enforcement and access to public health programs.
4. **Dick Durbin**
    - **Title**: Chair, Senate Judiciary Committee
    - **Position in Chain of Command**: Oversees the legal and constitutional implications of systemic public health failures.

2. What Action Did They Take?

The responsible parties took actions, or failed to act, that created significant barriers to transparency, compliance, and public accountability. These actions collectively endangered public health by obstructing access to vital information and undermining the administration of federal and state programs. The actions included:

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1. Obstruction of FOIA Compliance

- **Failure to Conduct Adequate Searches**: Federal and state agencies did not perform thorough and timely searches for requested records, including those critical to assessing the performance and compliance of Medicaid and ADA-related programs.
- **Improper Denials or Delays**: Requests were denied or delayed without adequate statutory justification under 5 U.S.C. § 552(b), leading to unnecessary obstacles in accessing records vital to public health oversight.

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2. Systemic Violations of ADA and Rehabilitation Act

- **Failure to Provide Requested ADA Accommodations**: Agencies ignored non-negotiable accommodations, including the use of the MuckRock platform, accessible formats, and simplified summaries, violating 42 U.S.C. § 12132 and 29 U.S.C. § 794.
- **Non-Compliance with Accessibility Standards**: Communications and records provided were not screen-reader compatible, preventing individuals with disabilities from accessing essential information.

3. Neglect in Addressing Medicaid Oversight Failures

- **Withholding Records on Medicaid Compliance**: Agencies failed to disclose internal audits, provider registries, and inter-agency communications, impeding accountability in Medicaid's Acquired Brain Injury Waiver Program and other federally funded initiatives.
- **Failure to Investigate Complaints**: Despite evidence of systemic non-compliance and mismanagement, responsible entities neglected to investigate or act upon complaints, leaving systemic issues unaddressed.

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4. Gross Mismanagement of Public Health Resources

- **Improper Use of Federal Funds**: There is evidence of funds being allocated inefficiently or diverted from their intended purposes, exacerbating barriers to healthcare access and public safety.
- **Systemic Inadequacies in Provider Oversight**: Records and reports critical to evaluating Medicaid provider performance and accountability were withheld, contributing to unchecked risks to beneficiaries' health.

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5. Abuse of Authority and Retaliatory Practices

- **Suppression of Whistleblower Disclosures**: Agencies failed to protect whistleblowers and dismissed critical disclosures related to public health and systemic program failures.

- **Imposing Undue Burdens on Requesters**: Agencies consistently imposed procedural and accessibility burdens on FOIA requesters, discouraging participation and oversight.

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6. Undermining Public Health Transparency

- **Censorship of Key Information**: By withholding critical records related to Medicaid compliance, ADA enforcement, and healthcare access, agencies obstructed public understanding and accountability.
- **Failure to Coordinate Across Agencies**: Lack of inter-agency collaboration further delayed the resolution of systemic issues and denied timely access to vital records.

Why These Actions Matter

The cumulative effect of these actions reflects gross mismanagement, abuse of authority, and systemic non-compliance with constitutional and statutory mandates. These failures directly jeopardize the health and safety of vulnerable populations, including individuals reliant on Medicaid services and protections under the ADA.

When Did This Occur?

This systemic issue has been ongoing for several years, with specific incidents and failures occurring at various critical junctures, including but not limited to:

1. **Initial Violations**:
    - As early as **2019**, the failure to provide timely and accurate responses to Freedom of Information Act (FOIA) requests became evident, particularly in matters involving Medicaid oversight and ADA compliance.
    - Specific failures tied to DOJ complaint numbers #534659-XGL, #539298-RJM, #534060-HWM, and #539330-JBZ began emerging in **2022**, escalating concerns about systemic non-compliance.
2. **Escalation of Harm**:
    - Between **2020 and 2023**, repeated denials and delays of ADA accommodations for FOIA requests compounded barriers for individuals with disabilities seeking transparency and accountability.
    - Critical complaints and reports highlighting deficiencies in Medicaid programs and systemic mismanagement were either ignored or inadequately addressed during this period, exacerbating risks to public health and taxpayer accountability.
3. **Recent Failures**:
    - In **2024**, these issues reached a critical point with documented failures in communication, lack of accountability, and refusal to implement legally required accommodations. Specific examples include:

- **June 2024**: The Department of Justice failed to address specific FOIA requests related to the Connecticut Medicaid ABI Waiver Program, impacting vulnerable populations dependent on these services.
- **November 2024**: Deliberate obfuscation and unjustified denials of critical information tied to FOIA requests emerged, violating statutory deadlines and accessibility requirements.
- **December 2024**: The DOJ's response to FOIA appeals explicitly failed to rectify violations, further delaying justice and increasing risks to public health and systemic transparency.

4. **Systemic Timeline**:
    - The pattern of non-compliance indicates a deeply entrenched issue within the responsible agencies, dating back to **at least 2015**, when initial whistleblower reports and grievances highlighted similar deficiencies. These systemic failures have persisted and compounded over time, demonstrating a lack of corrective action despite documented warnings and appeals.

This timeline underscores the ongoing and escalating nature of these violations, emphasizing the urgent need for immediate corrective action to protect public health, uphold ADA and FOIA obligations, and restore public trust in government accountability systems.

How Did You Discover This Action?

The actions were discovered through a combination of personal involvement in the submission and follow-up of FOIA requests and ADA accommodation requests, detailed reviews of agency responses, and extensive documentation of non-compliance patterns. Specifically:

1. **Direct Correspondence**:
    - Received responses from the DOJ, CMS, OPM, DSS, and other related agencies that either failed to provide the requested information or did so in a manner inconsistent with FOIA (5 U.S.C. § 552) and ADA (42 U.S.C. § 12132) requirements.
    - Encountered systemic failures to comply with mandated ADA accommodations, such as the refusal to communicate exclusively via the MuckRock platform and the provision of inaccessible documents.
2. **Pattern of Non-Compliance**:
    - Identified repeated instances where statutory deadlines under FOIA were missed without proper justification, indicating gross mismanagement.
    - Observed systemic issues in ADA compliance across agencies, including the lack of screen-reader compatible documents, failure to provide simplified summaries for complex records, and omissions of required identification of personnel responsible for handling requests.
3. **Document Review and Analysis**:

- Conducted an in-depth review of all communications and records related to the complaints and requests, revealing inconsistencies, incomplete disclosures, and unjustified redactions contrary to 5 U.S.C. § 552(b).
- Cross-referenced agency responses with statutory requirements and guidance from the Office of Government Information Services (OGIS), uncovering violations of transparency and accessibility obligations.

4. **Engagement with Oversight Bodies**:
   - Corresponded with oversight entities, including the Office of the Inspector General (OIG) and OGIS, which confirmed ongoing deficiencies in agency compliance with federal law.
   - Utilized mediation channels provided by OGIS to validate findings and gather additional evidence of systemic issues.
5. **Impact on Stakeholders**:
   - Firsthand observations of how these failures disproportionately harm vulnerable populations dependent on Medicaid programs, specifically those under the Acquired Brain Injury Waiver Program.
   - Reports from other affected parties and whistleblowers corroborated the systemic nature of these issues, reinforcing the need for immediate action.

This discovery process underscores the deep-rooted issues within the agencies and highlights a significant threat to public trust, fiscal accountability, and the equitable treatment of individuals requiring ADA accommodations and Medicaid services.

What Additional Facts Support Your Allegation?

The following facts substantiate the allegations and demonstrate a pattern of systemic failures, legal non-compliance, and negligence, highlighting the significant public harm caused by these actions:

1. Non-Compliance with FOIA Requirements

- **Missed Deadlines**: FOIA requests, including DOJ Complaints #534659-XGL and #539298-RJM, exceeded statutory response deadlines outlined in 5 U.S.C. § 552(a)(6)(A), without valid justification.
- **Inadequate Searches**: Responses failed to include a thorough search of relevant agency divisions such as the DOJ Civil Rights Division, CMS, and DSS. Records explicitly relevant to ADA compliance and Medicaid oversight were not provided.
- **Improper Redactions**: Information was withheld or redacted without proper statutory justification under FOIA's exemptions (5 U.S.C. § 552(b)).
- **Lack of Transparency**: Agencies failed to provide detailed search methodologies, names of responsible personnel, and complete records.

2. Violations of ADA Requirements

- **Failure to Provide Accommodations**: ADA accommodations explicitly requested, such as screen-reader-compatible documents, MuckRock-exclusive communication, and simplified summaries, were ignored, in violation of Title II of the ADA (42 U.S.C. § 12132).

- **Barrier to Accessibility**: Records provided were inaccessible to individuals with disabilities, contravening Section 504 of the Rehabilitation Act (29 U.S.C. § 794).

3. Systemic Mismanagement of Medicaid Programs

- **Inadequate Oversight**: Failure to address systemic transparency failures in the Medicaid Acquired Brain Injury (ABI) Waiver Program, which disproportionately affects vulnerable populations.
- **Mismanagement of Taxpayer Funds**: Lack of detailed documentation regarding Medicaid provider complaints, sanctions, and oversight points to gross mismanagement and potential misuse of federal and state funding.

4. Harm to Vulnerable Populations

- **Denial of Critical Services**: Non-compliance with ADA and FOIA directly impedes access to services for individuals with acquired brain injuries, placing an undue burden on already vulnerable populations.
- **Public Health Risk**: Delays and denials of critical information related to Medicaid compliance pose significant risks to public health, exacerbating systemic inequities.

5. Broader Systemic Failures

- **Agency Coordination Gaps**: Records indicate a lack of effective inter-agency coordination between DOJ, CMS, OPM, and DSS, undermining the enforcement of federal laws and policies.

- **Insufficient Accountability**: Agencies have not identified responsible personnel, provided explanations for procedural lapses, or demonstrated efforts to rectify systemic issues.

6. Testimony and Evidence from Stakeholders

- **Whistleblower Reports**: Independent accounts from whistleblowers corroborate allegations of systemic non-compliance and negligence.
- **Oversight Body Findings**: Correspondence with OGIS, OIG, and other oversight bodies validates claims of systemic failures, highlighting the need for intervention.

7. Precedents and Legal Violations

- Violations contravene federal statutes, including:
    - FOIA (5 U.S.C. § 552)
    - ADA Title II (42 U.S.C. § 12132)
    - Rehabilitation Act Section 504 (29 U.S.C. § 794)
    - Executive Order 13392 (Improving Agency Disclosure)
- Legal precedents such as **Tennessee v. Lane (2004)** affirm the constitutional right to accessibility and procedural fairness.

8. Documented Patterns

- Multiple FOIA requests and complaints demonstrate a consistent pattern of delays, redactions, and inadequate responses across multiple agencies, indicating systemic failures rather than isolated incidents.

Conclusion

The facts presented highlight a pervasive culture of non-compliance, mismanagement, and disregard for statutory obligations, endangering public health, eroding public trust, and violating the rights of vulnerable populations. Immediate federal intervention is warranted to ensure accountability, transparency, and systemic reform.

What Action Would You Like OSC to Take?

Overview: To address the systemic violations and failures identified, I request that the Office of Special Counsel (OSC) take immediate, thorough, and decisive action by employing the nation's top experts in governmental laws, constitutional rights, ADA enforcement, FOIA compliance, and public accountability. These actions should ensure the protection of vulnerable populations, Medicaid consumers, taxpayers, and disability advocates, while restoring public trust in the governmental systems.

Actions Requested:

1. Investigate and Rectify Systemic Violations:

- **Conduct an Independent Investigation**:
    - Launch a comprehensive investigation into the systemic failures of DOJ, CMS, DSS, OPM, and other involved agencies to comply with:
        - **FOIA (5 U.S.C. § 552)**: Analyze all procedural, operational, and compliance failures in responding to requests.
        - **ADA (42 U.S.C. § 12132)**: Assess compliance with ADA Title II requirements, focusing on reasonable accommodations for communication and document accessibility.
        - **Constitutional Violations**: Examine whether agency actions violated the **First, Fifth, and Fourteenth Amendments**, particularly with respect to equal protection, due process, and the right to petition the government.

- Ensure this investigation evaluates the cumulative harm to Medicaid consumers and other vulnerable populations.

- **Hold Agency Officials Accountable**:
  - Require accountability for individuals within the chain of command, from decision-making officers to FOIA coordinators, who failed to uphold legal obligations.
  - Include disciplinary measures and, if warranted, referrals for legal or civil penalties for gross mismanagement, waste of funds, and abuse of authority.

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2. Mandate Corrective Actions for FOIA and ADA Compliance:

- **Implement Systemic Changes**:
  - Direct all relevant agencies to:
    - Develop and execute clear protocols for handling FOIA and ADA requests in compliance with statutory timelines and accessibility standards.
    - Mandate the use of **accessible formats (screen-reader compatible PDFs)**, **simplified summaries for complex records**, and **identification of responsible personnel** in all communications.
  - Require quarterly compliance audits to ensure adherence to corrective measures.
- **Reprocess Denied or Mishandled Requests**:

- Mandate the immediate reprocessing of improperly denied FOIA requests and ADA accommodation requests, including those submitted by David Medeiros and ABI Resources.
- Ensure expedited review and full disclosure of withheld records, with detailed statutory justifications for any redactions.

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3. Enforce Transparency and Public Accountability:

- **Ensure Oversight by Independent Authorities**:
  - Refer this case to the **Office of Government Information Services (OGIS)** and **relevant Congressional Oversight Committees** to provide independent review and recommendations for systemic reforms.
  - Include mediation by OGIS to facilitate transparency and accountability in future FOIA and ADA-related interactions.
- **Publish Findings and Recommendations**:
  - Require all involved agencies to publicly disclose the results of the investigation, including recommendations for systemic changes.
  - Ensure that findings are presented in accessible formats for public review, emphasizing the impact on Medicaid consumers, taxpayers, and disability advocates.

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4. Protect Whistleblowers and Advocates:

- **Enforce Whistleblower Protections**:
    - Investigate retaliation claims against David Medeiros and ABI Resources for exposing systemic failures, and take swift action to prevent further harassment or discrimination.
    - Implement safeguards ensuring that whistleblowers and disability advocates are fully protected under the **Whistleblower Protection Act (5 U.S.C. § 2302)** and related statutes.
- **Compensate for Harm**:
    - Require the responsible agencies to issue public apologies and provide compensatory remedies for individuals and organizations harmed by their non-compliance and retaliatory actions.

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5. Enhance Medicaid Oversight and ADA Enforcement:

- **Develop a Federal Oversight Framework**:
    - Establish a task force with representatives from OSC, DOJ, CMS, and HHS to monitor and ensure Medicaid compliance across state and federal agencies.
    - Focus on the **Acquired Brain Injury (ABI) Waiver Program** to ensure it meets all federal standards for transparency, accessibility, and equitable service delivery.
- **Provide Training for Agency Officials**:

- Mandate training programs for agency officials and staff on FOIA, ADA, and constitutional law obligations, emphasizing best practices for transparency, accessibility, and public accountability.

Expected Outcomes:

1. **Immediate Relief for David Medeiros and ABI Resources**:
   - Full compliance with FOIA and ADA requests submitted on behalf of ABI Resources, Medicaid consumers, and disability advocates.
   - Assurance of protection against retaliation for exposing systemic failures.
2. **Restoration of Public Trust**:
   - Demonstrable improvements in the transparency and accountability of DOJ, CMS, and state agencies.
   - Reinstatement of confidence in government systems that serve vulnerable populations and taxpayers.
3. **Systemic Reform**:
   - Establishment of a precedent for compliance and accountability across all federal and state agencies, ensuring no individual or group faces similar barriers in the future.

By taking these actions, OSC can lead a transformative effort to uphold the principles of justice, equity, and accountability for all Americans, particularly those most vulnerable to systemic failures.

What action would you like OSC to take?

The U.S. Office of Special Counsel (OSC) must take immediate and comprehensive actions to address and rectify the systemic violations and failures detailed in this disclosure. These actions include the following:

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1. Immediate Investigative Actions

- **Appoint a Team of Experts**: Assemble a specialized task force of legal experts in government accountability, constitutional law, ADA compliance, FOIA enforcement, Medicaid oversight, and whistleblower protections.
- **Initiate Comprehensive Investigations**:
    - Investigate all named individuals and agencies for gross mismanagement, abuse of authority, gross waste of funds, and violations of law, rule, or regulation.
    - Focus on systemic failures impacting vulnerable populations, Medicaid consumers, taxpayers, and disability advocates, ensuring no violations are overlooked.
    - Investigate the improper denial of access to critical ADA accommodations and FOIA requests that directly harm individuals with disabilities and obstruct transparency.

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2. Enforce Accountability

- **Hold Responsible Parties Accountable**: Ensure that all individuals and entities identified in this disclosure are held accountable for their roles in these violations, using all legal remedies available under federal law.
- **Public Reporting**: Require public disclosure of findings to restore trust in governmental agencies, particularly regarding Medicaid and ADA compliance.

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3. Represent and Restore Rights

- **Legal Representation for David Medeiros**:
    - Appoint OSC as the representative for David Medeiros and ABI Resources in addressing these systemic failures.
    - Ensure the enforcement of David Medeiros' full constitutional rights, particularly those under the ADA, FOIA, and the First, Fifth, and Fourteenth Amendments.
    - Provide whistleblower protections and safeguard against further retaliation or harm.
- **Restore Rights**: Reinstate all denied ADA accommodations and provide immediate access to withheld records critical to David Medeiros and ABI Resources.

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4. Systemic Reform Recommendations

- **Policy Overhaul**: Mandate reforms in the Department of Justice (DOJ), Centers for Medicare & Medicaid Services (CMS), and other implicated entities to prevent recurrence of these failures.

- **Independent Oversight**:
    - Recommend congressional oversight hearings to address systemic noncompliance and misuse of taxpayer funds in Medicaid programs.
    - Collaborate with the Office of Government Information Services (OGIS) to improve FOIA processes and ADA enforcement across agencies.

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5. Legal and Procedural Remedies

- **Judicial Intervention**:
    - Pursue legal action under the Whistleblower Protection Act, FOIA, and ADA to address violations, seek damages, and enforce compliance.
    - Request injunctive relief to halt ongoing violations and ensure immediate access to necessary accommodations and records.
- **Immediate Reinstatement of Rights**:
    - Restore David Medeiros' access to all requested records and ADA accommodations without delay.
    - Ensure transparency and accountability for all involved agencies.

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6. Advocate for Vulnerable Populations

- **Elevate the Voices of Vulnerable Communities**:

- Amplify the concerns of Medicaid consumers, disability advocates, and taxpayers harmed by these systemic failures.
- Enforce systemic reforms that prioritize equity, transparency, and justice for all affected populations.

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7. Engage External Oversight

- **Congressional Notification**:
  - Notify key congressional committees, including the House Committee on Oversight and Accountability, the Senate Judiciary Committee, and the House Subcommittee on Civil Rights and Civil Liberties, of these violations to prompt legislative action.
- **Coordinate with Oversight Entities**:
  - Work closely with the Government Accountability Office (GAO), the DOJ Office of the Inspector General (OIG), and the Centers for Medicare & Medicaid Services (CMS) to address deficiencies and implement reforms.

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8. Report and Resolve

- **Provide Progress Reports**: Deliver periodic updates to David Medeiros and involved stakeholders on the progress of investigations and reforms.
- **Final Comprehensive Report**: Issue a final report detailing findings, actions taken, and systemic reforms implemented.

9. Guarantee Protection Against Retaliation

- **Whistleblower Protections**:
    - Ensure robust protections against retaliation for David Medeiros and any other individuals who have exposed these systemic failures.
    - Investigate any instances of retaliation and take corrective action.

Conclusion

OSC must take swift, transparent, and decisive action to address these systemic failures, restore rights to those harmed, and ensure justice for vulnerable populations, Medicaid consumers, taxpayers, and disability advocates. By representing David Medeiros and ABI Resources, OSC can set a precedent for accountability, transparency, and the enforcement of constitutional rights. The requested remedies and reforms will safeguard against future violations, ensuring that all individuals receive the protections and accommodations guaranteed by law.

12.04.2024

"Protecting and Representing All Americans: A Call for the United States to Uphold Justice, Accountability, and Constitutional Rights Representation"

2. What Action Did They Take?

The Connecticut Department of Public Health (DPH), along with other relevant state and federal officials and entities, engaged in a series of actions and omissions that constitute violations of law, rule, and regulation. These actions include:

Failure to Comply with FOIA (5 U.S.C. § 552 and Conn. Gen. Stat. § 1-200 et seq.)

1. **Incomplete Records Production**:

   DPH failed to provide comprehensive responses to the FOIA request submitted on November 2, 2024, concerning Medicaid services associated with NPI 1962278119 and NPI 1023012345. Requested records, such as contracts, compliance reports, and interagency communications, were not provided in full, hindering transparency and accountability.

2. **Lack of Referral to Relevant Agencies**:

   Despite the scope of the requested records, DPH failed to refer the request to other

relevant agencies, including the Connecticut Department of Social Services (DSS) and the Centers for Medicare & Medicaid Services (CMS), as required under FOIA when records are not within the agency's possession.

3. **Inadequate Justifications for Denials**:

   Redacted or withheld records lacked legally sufficient explanations, including specific citations of FOIA exemptions under 5 U.S.C. § 552(b). This non-compliance undermines statutory transparency obligations.

ADA Violations (42 U.S.C. § 12132 and 29 U.S.C. § 794)

1. **Failure to Provide ADA Accommodations**:

   DPH repeatedly ignored or failed to meet explicit, non-negotiable ADA accommodations necessary for equitable participation, including:

   - Exclusive use of the MuckRock platform for all communications.
   - Delivery of documents as screen-reader-compatible PDFs.
   - Inclusion of simplified summaries for complex or technical records.
   - Identification of FOIA officers and responsible personnel in all correspondence.

2. **Accessibility Barriers**:

   Directing the requester to external portals and password-protected links violated ADA standards by creating barriers for individuals with cognitive disabilities, contrary to Title II of the ADA and Section 504 of the Rehabilitation Act.

Mismanagement of Medicaid Records and Oversight (42 U.S.C. § 1396a)

1. **Failure to Ensure Regulatory Compliance**:

   By not producing records related to provider compliance, Medicaid funding allocation, and consumer complaints, DPH obstructed transparency in Medicaid administration. This omission raises concerns about potential misuse of federal funds, monopolistic practices, and violations of consumer rights.

2. **Lack of Provider Accountability**:

   No evidence was provided of efforts to address complaints, conduct inspections, or enforce standards related to the specified NPIs, reflecting systemic mismanagement.

Potential Retaliation Against Whistleblower Advocacy

1. **Deliberate Obfuscation**:

   Actions such as partial responses, procedural delays, and failure to adhere to statutory requirements appear to target efforts to expose systemic issues, potentially retaliating against whistleblower advocacy aimed at improving Medicaid transparency and ADA enforcement.

Conclusion

These actions collectively demonstrate systemic failures in compliance, transparency, and accessibility. They violate federal and state laws designed to uphold public accountability, protect individuals with disabilities, and ensure the proper use of taxpayer funds in Medicaid

programs. Immediate corrective measures are necessary to address these violations and prevent further harm to public trust and vulnerable populations.

When Did This Occur?

The violations occurred over an extended period, reflecting a pattern of systemic non-compliance and neglect:

1. **Initial Incident Timeline**:
    - The request was submitted on **November 2, 2024**, under the Connecticut Freedom of Information Act (FOIA) and federal FOIA statutes. This marked the start of the Department of Public Health's (DPH) obligation to respond promptly and transparently.
2. **Acknowledgment of Receipt**:
    - The Department acknowledged receipt of the request on **November 4, 2024** (Reference #: R000770-110424), initiating statutory deadlines for compliance.
3. **Ongoing Non-Compliance**:
    - From **November 4, 2024**, to **December 4, 2024**, the Department has repeatedly failed to adhere to FOIA and ADA requirements, despite follow-ups and formal appeals:

- Ignored mandated **ADA accommodations**, such as exclusive communication through MuckRock, accessible document formatting, and simplified summaries.
- Failed to provide a **substantive response** to the FOIA request, leaving critical questions unanswered.
- Provided **incomplete or inaccessible communications**, requiring external portals and other methods that do not comply with accessibility standards.

4. **Appeal Submitted**:
    - On **November 20, 2024**, a formal appeal was submitted, highlighting ongoing failures and demanding compliance. No substantive resolution has been achieved to date.
5. **Escalation and Continued Violations**:
    - As of **December 4, 2024**, the Department remains non-compliant with federal and state laws, creating barriers to transparency, accessibility, and accountability.

Broader Timeline and Impact

These systemic failures are not isolated. The Department's ongoing neglect of its obligations under FOIA and ADA reflects deeper systemic issues that have likely affected other individuals and entities over an extended period. This raises significant concerns about long-term non-compliance and the broader implications for Medicaid oversight and taxpayer accountability.

Why This Matters

This prolonged timeline underscores a pattern of disregard for legal obligations and individual rights, necessitating immediate corrective action, systemic reform, and oversight to ensure such violations do not persist.

How did you discover this action?

I discovered the violations and non-compliance by the Connecticut Department of Public Health (DPH) during my direct engagement with the agency regarding multiple Freedom of Information Act (FOIA) requests, including but not limited to FOIA Request #R000770-110424. Despite my submission of a legally compliant request and repeated follow-ups, DPH's failure to provide the requested documents in a timely manner and refusal to comply with clearly articulated ADA accommodations became evident through their responses—or lack thereof.

Key indicators of non-compliance included:

1. **Inadequate Responses to FOIA Requests**: Communications from DPH failed to address the scope of my request, did not provide the required records, and omitted any detailed justifications for redactions or denials, as mandated by FOIA statutes.
2. **Non-Adherence to ADA Accommodations**: Despite explicit requests for reasonable ADA accommodations, including communication exclusively through the MuckRock platform, screen-reader-compatible PDFs, and simplified summaries for complex records,

DPH consistently failed to comply. Their reliance on external portals and password-protected links excluded me from full and equal participation.

3. **Pattern of Systemic Failures**: Through the examination of DPH's handling of other FOIA-related matters and the broader operational challenges within Connecticut's Medicaid system, I identified a pattern of disregard for statutory obligations, transparency mandates, and equitable service delivery.
4. **Firsthand Experiences**: My direct interactions with the agency and its representatives highlighted procedural deficiencies, including the absence of responsible personnel's identification in communications, which impeded accountability and transparency.

These discoveries are supported by documentation, email correspondence, and records demonstrating DPH's continued non-compliance with federal laws such as FOIA (5 U.S.C. § 552) and the Americans with Disabilities Act (42 U.S.C. § 12101). This evidence underscores systemic issues requiring urgent intervention to safeguard the constitutional and statutory rights of individuals and taxpayers.

Additional Facts Supporting the Allegation

1. **Pattern of Non-Compliance**: The Connecticut Department of Public Health (DPH) has demonstrated a consistent failure to comply with FOIA and ADA requirements. For instance:
    - Repeated instructions to access external portals violate specific ADA accommodations requesting communication exclusively through the MuckRock platform.
    - Failure to provide screen-reader compatible PDFs and simplified summaries for complex records, as explicitly outlined in prior requests, hinders accessibility.
2. **Lack of Transparency and Accountability**:
    - DPH has not identified the individuals responsible for handling the FOIA requests, breaching the requirement to include names, titles, and roles for accountability.
    - There has been no detailed explanation for denied or redacted records, nor proper statutory citations, violating FOIA's transparency mandate under 5 U.S.C. § 552(b).
3. **Untimely Responses**:
    - FOIA requires agencies to respond promptly (5 U.S.C. § 552(a)(6)(A)(i)), and Connecticut FOIA statutes mandate a response within four business days (Conn. Gen. Stat. § 1-210(a)). Despite these obligations, significant delays have occurred with no justification provided.
4. **Harm to Vulnerable Populations**:

- The requested information directly impacts Medicaid consumers and providers under the Acquired Brain Injury Waiver Program, many of whom are disabled and rely on Medicaid-funded services. DPH's refusal to comply obstructs the ability to address systemic issues affecting their care and well-being.

5. **Legal Violations of ADA Title II and Section 504**:
   - DPH has ignored legally mandated accommodations under ADA Title II (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794). By failing to adhere to the requested accommodations, DPH has excluded individuals with disabilities from meaningful participation in public processes.
6. **Federal and State Oversight Failures**:
   - Despite DPH's responsibilities under state and federal Medicaid oversight frameworks, there is no evidence of coordination with federal entities like CMS to address concerns tied to Medicaid fraud, transparency, and provider accountability.
7. **Broader Implications**:
   - DPH's systemic failures suggest that similar issues may exist across other Connecticut state agencies, pointing to a potential pattern of mismanagement that warrants further investigation by federal oversight bodies.

Enhancements for Maximum Impact:

- Emphasize the urgency of federal intervention to protect taxpayer funds and ensure transparency in Medicaid programs.

- Highlight the violation of constitutional principles, particularly the First and Fourteenth Amendments, in restricting access to public information and due process.
- Reinforce that the requested records are vital for safeguarding the rights of disabled individuals and addressing potential misuse of public funds.

1. Who Took the Action?

Key Individuals and Their Roles in Gross Mismanagement:

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of the Connecticut Department of Social Services (DSS), overseeing Medicaid programs and regulatory compliance.
    - **Action**: Failed to enforce accountability in Medicaid oversight, leading to systemic mismanagement and disregard for consumer rights under the ABI Waiver Program.
2. **Manisha Juthani, MD**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of the Connecticut Department of Public Health (DPH), responsible for ensuring provider licensing, regulatory compliance, and investigation of consumer complaints.
    - **Action**: Neglected to address complaints and ensure adherence to federal and state standards, further perpetuating systemic failures.
3. **William Tong**
    - **Title**: Attorney General
    - **Position in Chain of Command**: Chief Legal Officer of Connecticut, tasked with enforcing state laws and protecting public interest.
    - **Action**: Failed to investigate systemic Medicaid mismanagement and potential legal violations despite complaints and whistleblower reports.
4. **Xavier Becerra**

- **Title**: Secretary
- **Position in Chain of Command**: Head of the U.S. Department of Health and Human Services (HHS), overseeing federal Medicaid program compliance and enforcement.
- **Action**: Did not ensure proper oversight of Connecticut's Medicaid program, despite federal obligations under FOIA and ADA laws.

5. **Chiquita Brooks-LaSure**
   - **Title**: Administrator
   - **Position in Chain of Command**: Leader of the Centers for Medicare & Medicaid Services (CMS), responsible for enforcing Medicaid regulations and ensuring program integrity.
   - **Action**: Allowed systemic inefficiencies to persist by failing to investigate complaints and enforce accountability measures for Connecticut's Medicaid programs.
6. **Jeffrey Beckham**
   - **Title**: Secretary
   - **Position in Chain of Command**: Head of the Connecticut Office of Policy and Management, managing state financial allocations, including Medicaid funding.
   - **Action**: Oversaw financial mismanagement and failed to ensure that taxpayer funds were properly allocated and accounted for within Medicaid programs.
7. **Kristen Clarke**

- **Title**: Assistant Attorney General for Civil Rights Division, U.S. DOJ
- **Position in Chain of Command**: Senior federal official tasked with enforcing civil rights laws, including ADA compliance in Medicaid programs.
- **Action**: Did not act on whistleblower complaints or enforce ADA compliance in Connecticut's Medicaid oversight.

Broader Context:

These individuals, through their roles and actions, contributed to systemic failures in Medicaid management, including:

- **Neglecting accountability mechanisms** required under FOIA, ADA, and Medicaid regulations.
- **Failing to address systemic inefficiencies** that harm vulnerable populations, particularly individuals with disabilities.
- **Ignoring whistleblower reports** and public complaints highlighting gross mismanagement and potential misuse of taxpayer funds.

These systemic issues highlight a clear failure to protect the public interest and ensure equitable access to Medicaid services for those most in need.

2. What Action Did They Take?

The identified individuals engaged in or allowed actions that constitute **gross mismanagement** of Medicaid oversight and administration, violating federal and state laws and failing to uphold their duties to protect vulnerable populations. The specific actions include:

Connecticut Department of Social Services (DSS):

1. **Andrea Barton Reeves (Commissioner):**
    - **Action**: Failed to enforce oversight mechanisms, resulting in unchecked fraud, waste, and abuse in Medicaid programs, particularly under the ABI Waiver Program.
    - **Impact**: Denied Medicaid beneficiaries equitable access to services, violating constitutional rights and federal Medicaid regulations under **42 U.S.C. § 1396a**.
2. **Matthew S. Antonetti (Legal Director):**
    - **Action**: Refused to investigate or respond adequately to whistleblower complaints about Medicaid provider malfeasance.
    - **Impact**: Enabled the continuation of unlawful practices, including financial mismanagement and ADA non-compliance.

Connecticut Department of Public Health (DPH):

1. **Manisha Juthani, MD (Commissioner):**

- **Action**: Neglected to ensure regulatory compliance and failed to act on complaints regarding substandard care and provider misconduct associated with Medicaid-funded services.
- **Impact**: Compromised public health and safety, particularly for disabled individuals relying on Medicaid services.

Connecticut Office of the Attorney General:

1. **William Tong (Attorney General):**
   - **Action**: Declined to investigate allegations of Medicaid fraud, financial mismanagement, and constitutional violations despite credible evidence from whistleblowers and advocacy groups.
   - **Impact**: Allowed systemic abuses to persist unchecked, undermining public trust and accountability.

U.S. Department of Health and Human Services (HHS):

1. **Xavier Becerra (Secretary):**
   - **Action**: Failed to enforce federal oversight of Medicaid programs in Connecticut, despite receiving numerous complaints of systemic non-compliance with federal standards.
   - **Impact**: Perpetuated gross mismanagement and ADA violations, harming Medicaid beneficiaries and taxpayers.

2. **Chiquita Brooks-LaSure (CMS Administrator):**
    - **Action**: Allowed systemic inefficiencies in Medicaid program operations, ignoring whistleblower allegations and failing to conduct necessary audits and compliance reviews.
    - **Impact**: Contributed to the misuse of taxpayer funds and erosion of public trust in government programs.

Office of Policy and Management (OPM):

1. **Jeffrey Beckham (Secretary):**
    - **Action**: Misallocated Medicaid funds and failed to enforce financial accountability measures, despite evidence of fraud and abuse.
    - **Impact**: Increased the financial burden on taxpayers and exacerbated inequities in Medicaid service delivery.

U.S. Department of Justice (DOJ):

1. **Kristen Clarke (Assistant Attorney General, Civil Rights Division):**
    - **Action**: Failed to investigate systemic ADA non-compliance and whistleblower retaliation within Connecticut Medicaid programs.
    - **Impact**: Denied justice to individuals reporting government wrongdoing and perpetuated discrimination against disabled Medicaid beneficiaries.

Key Failures Across Agencies:

1. **FOIA Non-Compliance:**
    - Agencies failed to respond adequately to Freedom of Information Act (FOIA) requests, violating **5 U.S.C. § 552** and Connecticut FOIA laws.
2. **ADA Violations:**
    - Neglected to provide reasonable accommodations under **42 U.S.C. § 12132** and **29 U.S.C. § 794**, excluding disabled individuals from participating in government programs.
3. **Whistleblower Retaliation:**
    - Ignored whistleblower protections under **5 U.S.C. § 2302(b)(8)**, discouraging the reporting of systemic abuses.
4. **Misuse of Medicaid Funds:**
    - Failed to prevent fraud, waste, and abuse, leading to the mismanagement of taxpayer dollars meant for essential services.

Overall Impact:

The combined actions of these individuals and agencies have resulted in significant harm to Medicaid beneficiaries, disabled individuals, and taxpayers. These failures undermine constitutional protections, ADA rights, and public trust in government institutions.

3. When Did This Occur?

The gross mismanagement, ADA violations, and systemic failures occurred over an extended period, highlighting persistent non-compliance and negligence across multiple agencies:

Timeline of Events:

1. **January 1, 2013 – Present:**
    - **Ongoing Medicaid Mismanagement:**
        - Misallocation of funds, lack of oversight, and failure to provide equitable services under the Medicaid Acquired Brain Injury (ABI) Waiver Program.
        - Non-compliance with ADA and FOIA standards reported consistently throughout this period.
2. **December 18, 2023:**
    - **Whistleblower Report Filed:**
        - Initial formal disclosure of systemic Medicaid mismanagement, ADA violations, and whistleblower retaliation to state and federal agencies, including the Department of Justice (DOJ) and Centers for Medicare & Medicaid Services (CMS).
3. **November 2, 2024:**
    - **FOIA Request Submitted:**

- Specific records requested from the Connecticut Department of Public Health (DPH) and other agencies regarding Medicaid services tied to NPIs 1962278119 and 1023012345.

4. **November 4, 2024:**
    - **Acknowledgment Received:**
        - DPH confirmed receipt of FOIA request #R000770-110424 but failed to comply with statutory requirements and ADA accommodations.
5. **November 20, 2024:**
    - **Initial Appeal Submitted:**
        - Appeal filed for non-compliance with ADA accommodations, FOIA obligations, and transparency standards.
6. **December 4, 2024:**
    - **Current Non-Compliance:**
        - Agencies have yet to adhere to FOIA requirements, ADA accommodations, or whistleblower protections, despite repeated follow-ups and formal appeals.

Summary of Ongoing Harm:

The failures began as early as 2013, reflecting entrenched systemic issues, and continue to persist as of the present date. These ongoing violations necessitate immediate corrective action to prevent further harm to vulnerable populations and uphold constitutional and statutory rights.

4. How Did You Discover This Action?

I discovered the systemic failures through a combination of direct interactions with state agencies, public records obtained via Freedom of Information Act (FOIA) requests, and reports from impacted individuals and organizations. Specifically:

1. **FOIA Requests**:
    - I submitted FOIA requests to the Connecticut Department of Public Health (DPH), Department of Social Services (DSS), and federal agencies including the Centers for Medicare & Medicaid Services (CMS). The records I received highlighted glaring inconsistencies, incomplete responses, and a failure to comply with federal and state transparency laws.
2. **Whistleblower Reports**:
    - As a whistleblower, I reported these violations to the Department of Justice (DOJ) and the Office of the Inspector General (OIG). Despite my detailed submissions, these agencies either failed to act or deferred responsibility, further evidencing systemic non-compliance and federal oversight gaps.
3. **Testimonies and Complaints**:
    - Numerous individuals, including Medicaid beneficiaries, healthcare providers, and advocates, have shared personal testimonies and complaints regarding the lack of accountability, restrictive referral practices, and systemic exclusion of vulnerable populations from decision-making processes.
4. **Analysis of Regulatory Non-Compliance**:

- My analysis of responses—or lack thereof—confirmed violations of:
  - FOIA (5 U.S.C. § 552): Agencies failed to provide complete records, justify redactions, or adhere to statutory deadlines.
  - ADA Title II (42 U.S.C. § 12132): Agencies systematically denied reasonable accommodations, including screen-reader compatible formats and simplified summaries, violating their obligations to ensure accessible communication.
  - Constitutional Rights: The procedural delays, lack of transparency, and systemic exclusion of individuals with disabilities constitute violations of due process and equal protection under the Fifth and Fourteenth Amendments.

Statutory and Case Law Citations:

1. **FOIA**:
   - FOIA mandates transparency and accessibility in government records. The failure to provide complete responses or justify denials violates 5 U.S.C. § 552 and U.S. Supreme Court precedent in *U.S. DOJ v. Reporters Committee for Freedom of the Press (1989)*, which emphasized the public's right to know about government operations.
2. **ADA Title II**:
   - Title II of the ADA (42 U.S.C. § 12132) requires public entities to ensure effective communication and prohibit discrimination. In *Tennessee v. Lane*

(2004), the Supreme Court affirmed the constitutional validity of Title II as it relates to accessibility and due process for individuals with disabilities.

3. **Constitutional Protections**:
    - The procedural failures infringe upon:
        - **First Amendment**: The right to petition the government is undermined by non-compliance and inaccessibility.
        - **Fifth and Fourteenth Amendments**: Systemic exclusion and denial of accommodations constitute violations of due process and equal protection.
4. **Supremacy Clause**:
    - Under the Supremacy Clause (Article VI, Clause 2), federal laws, including FOIA and the ADA, supersede conflicting state practices. The federal government has an obligation to intervene when state agencies fail to uphold these statutes.

Federal Obligations and Call for Action:

The systemic failures and ongoing non-compliance underscore the urgent need for federal oversight. Specifically, I demand the following remedies:

1. **Independent Federal Oversight**:
    - Establish an independent oversight body to audit Medicaid programs, ensure ADA compliance, and enforce transparency requirements in Connecticut.
2. **Corrective Action**:
    - Mandate immediate reforms to address procedural delays, inadequate responses, and systemic barriers to participation for individuals with disabilities.

3. **Accountability for Violations**:
    - Investigate and hold accountable state officials and agencies for repeated violations of FOIA, ADA, and constitutional rights.
4. **Structural Reform**:
    - Develop federal guidelines to prevent recurrence of such failures across all state-administered programs, ensuring consistency and compliance nationwide.

5. What Additional Facts Support Your Allegation?

This allegation is supported by a comprehensive body of evidence, direct agency actions, statutory violations, and documented patterns of systemic failures that emphasize the urgent need for federal intervention.

Key Supporting Facts:

1. **Non-Compliance with FOIA**:
    - Multiple requests under the Freedom of Information Act (FOIA) and Connecticut's FOIA statutes (Conn. Gen. Stat. § 1-200 et seq.) were either ignored, delayed, or responded to inadequately. This includes:
        - **Lack of Transparency**: Agencies failed to provide complete records or justify redactions in compliance with FOIA (5 U.S.C. § 552).
        - **Absence of Proper Search**: No evidence of thorough or good-faith efforts to retrieve records from databases, archived files, or inter-agency communications.
        - **Statutory Violations**: Agencies consistently failed to meet the statutory deadlines outlined in FOIA and Connecticut law.
2. **ADA Violations**:
    - Agencies failed to adhere to ADA Title II (42 U.S.C. § 12132) by:
        - Denying reasonable accommodations explicitly requested to support accessibility for individuals with disabilities.

- Providing inaccessible communication formats, such as password-protected links and portal-based responses, contrary to the outlined accommodations.
- Refusing to provide simplified summaries for complex records, preventing full participation by individuals with cognitive challenges.

3. **Procedural Failures and Constitutional Concerns**:
   - **Due Process Violations**: Denial of access to requested records obstructs my right to petition the government and seek redress, protected under the First and Fifth Amendments.
   - **Equal Protection Violations**: Individuals with disabilities were systematically excluded from accessing critical Medicaid program data due to procedural hurdles.
4. **Documented Complaints and Testimonies**:
   - Complaints and testimonies from Medicaid beneficiaries, healthcare providers, and advocates highlight:
     - **Restrictive Referral Practices**: Limitations on consumer choice and autonomy in provider selection.
     - **Neglect of Accountability**: Agencies failed to address consumer complaints regarding program mismanagement and accessibility barriers.
5. **Mismanagement of Medicaid Funds**:

- Evidence suggests possible misuse or inefficiency in allocating federal and state Medicaid funds, including:
    - Lack of transparency in provider payments, contracts, and oversight processes.
    - Potential misapplication of taxpayer dollars, as indicated by incomplete audits and inadequate inter-agency oversight.

6. **Inconsistent Enforcement of Federal and State Laws**:
    - Communications and records reveal conflicting policies and inconsistent enforcement of Medicaid standards, suggesting a systemic disregard for legal and procedural obligations.
7. **Whistleblower Retaliation**:
    - Efforts to expose these systemic issues through whistleblower channels were met with delays, deflections, and denials, contrary to protections under the Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)).

Legal Citations and Precedent Supporting Allegations:

1. **FOIA**:
    - *U.S. DOJ v. Reporters Committee for Freedom of the Press (1989)* affirms the public's right to government-held information to ensure transparency and accountability.
2. **ADA Title II**:

- *Tennessee v. Lane (2004)* reinforces the constitutional validity of the ADA in protecting access and due process for individuals with disabilities.

3. **Whistleblower Protections**:
    - The Whistleblower Protection Act mandates protections for individuals exposing legal and procedural violations, particularly those affecting public interest.
4. **Constitutional Protections**:
    - Procedural failures infringe upon First Amendment rights (petitioning the government) and Fifth/Fourteenth Amendment protections (due process and equal protection).
5. **Supremacy Clause (Article VI, Clause 2)**:
    - Federal laws, including FOIA and ADA, preempt state practices that undermine statutory rights and procedural integrity.

Federal Oversight and Remedy Required:

The documented failures underscore the necessity for immediate corrective actions, including:

1. **Federal Investigation and Oversight**:
    - Conduct a full audit of Medicaid programs in Connecticut, with specific focus on ADA compliance, FOIA transparency, and fiscal accountability.
2. **Systemic Reform**:
    - Mandate federal oversight to ensure consistency in implementing FOIA and ADA accommodations nationwide, preventing recurrence of these systemic issues.

3. **Accountability for Violations**:
    - Enforce disciplinary actions against agencies and individuals responsible for procedural delays, non-compliance, and mismanagement of public funds.
4. **Restoration of Public Trust**:
    - Publish findings and remedial measures to reaffirm the government's commitment to transparency, accessibility, and accountability.

2. What Action Did They Take?

The identified individuals and entities engaged in systemic abuse of authority by taking the following actions that violated constitutional laws, ADA rights, whistleblower protections, and taxpayer interests:

1. Suppressing Transparency and Public Accountability

- **Failure to Provide FOIA-Compliant Responses**:
    - Denied or delayed access to requested Medicaid records under FOIA (5 U.S.C. § 552) and Connecticut FOIA statutes (Conn. Gen. Stat. § 1-200 et seq.).
    - Repeatedly withheld or redacted records without citing appropriate legal exemptions, violating federal transparency laws.
    - Directed responses to inaccessible external portals and password-protected links, ignoring ADA accommodations.

2. Violating ADA Rights and Accessibility

- **Failure to Comply with ADA Title II (42 U.S.C. § 12132)**:
    - Refused to provide reasonable accommodations, including simplified summaries, screen-reader-compatible PDFs, and exclusive use of the MuckRock platform, as explicitly requested.
    - Created barriers to participation by directing communications to inaccessible formats and failing to identify responsible personnel in responses.

3. Engaging in Retaliatory Actions Against Whistleblowers

- **Obstructing Whistleblower Reports**:

- Targeted whistleblowers, including David Medeiros, by dismissing or disregarding submitted complaints and retaliation claims under the Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)).
- Failed to protect whistleblower anonymity and actively delayed investigations into alleged abuses.

4. Mismanaging Medicaid Oversight

- **Gross Mismanagement of Medicaid Programs**:
  - Failed to audit or address financial irregularities in Medicaid services tied to NPIs 1962278119 and 1023012345.
  - Allowed systemic provider referral restrictions and monopolistic practices that reduced consumer choice and violated Medicaid's fair access requirements (42 U.S.C. § 1396a).
  - Neglected enforcement of provider compliance with federal and state regulations.

5. Abusing Regulatory Authority

- **Restricting Consumer Rights**:
  - Imposed policies limiting consumer autonomy and choice in Medicaid services, violating federal Medicaid standards.
  - Manipulated referral practices to favor certain providers, creating conflicts of interest and reducing service availability.

6. Misuse of Taxpayer Funds

- **Gross Waste and Fraudulent Allocation of Public Resources**:

- Redirected Medicaid funds intended for vulnerable populations toward operational inefficiencies and potential misuse, violating the False Claims Act (31 U.S.C. §§ 3729–3733).
- Failed to ensure that taxpayer dollars were used to enhance equitable access to healthcare services, as mandated by federal law.

These actions collectively demonstrate systemic failures that undermined the constitutional rights of individuals, breached ADA requirements, retaliated against whistleblowers, and eroded public trust through gross mismanagement of Medicaid services.

3. When Did This Occur?

The abuse of authority, violations of law, and systemic failures occurred over a prolonged period, beginning no later than **January 1, 2013**, and continuing to the present. Specific instances include:

1. **FOIA Non-Compliance**:
    - Initial failures to comply with federal and state FOIA laws occurred with requests submitted on **November 2, 2024**, as detailed in FOIA Request #R000770-110424.
    - Ongoing violations include delayed responses, incomplete disclosures, and the provision of inaccessible records as of **December 4, 2024**.
2. **ADA Violations**:
    - Refusal to honor explicitly requested ADA accommodations began with initial correspondence and has persisted in subsequent responses and communications.
3. **Whistleblower Retaliation**:
    - Retaliatory actions against whistleblowers were reported following the submission of complaints on **December 18, 2023**, and subsequent disclosures.
    - Patterns of retaliation include dismissive responses, failure to protect anonymity, and delays in addressing complaints.
4. **Medicaid Mismanagement**:
    - Gross mismanagement of Medicaid programs, including the improper oversight of NPIs 1962278119 and 1023012345, spans a period from **2013** to the present.

- Specific regulatory failures and financial mismanagement were identified in audits and records requested in **2024**.

5. **Consumer Rights Violations**:
    - Policies restricting consumer choice and autonomy were implemented through referral practices and provider restrictions starting in **2019**, with documentation of ongoing enforcement as recently as **2024**.

These violations represent a continuous and systemic pattern of abuse that has persisted across multiple agencies and administrations, underscoring the urgent need for federal intervention and corrective action.

How Did You Discover This Action?

I discovered these systemic violations and failures through a combination of personal advocacy, formal reporting, and diligent documentation of state and federal agency responses. Each interaction, request, and investigation provided concrete evidence of the actions described:

1. **FOIA Requests and Deficient Responses**:
    - Submitted multiple FOIA requests, including #R000770-110424, seeking transparency regarding Medicaid oversight and ADA compliance. The responses, when provided, were incomplete, delayed, or contained unjustified redactions, violating FOIA's mandates under 5 U.S.C. § 552.
    - Agencies failed to comply with legal obligations to provide requested records, leaving critical gaps in accountability.
2. **ADA Accommodation Requests Ignored**:
    - Submitted explicit ADA accommodation requests to ensure accessibility under ADA Title II (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794). These accommodations included exclusive use of MuckRock for communication, screen-reader-compatible PDFs, simplified summaries, and identification of responsible personnel.
    - Despite clear requests, responses repeatedly ignored these accommodations, creating systemic barriers for individuals with disabilities.
3. **Reports and Testimonies from Affected Communities**:

- Engaged directly with impacted individuals, families, and providers who corroborated widespread failures, including restricted access to Medicaid services and retaliatory actions against whistleblowers.
- These accounts highlighted patterns of systemic mismanagement that disproportionately harm vulnerable populations.

4. **Regulatory and Financial Discrepancies**:
   - Identified inconsistencies in Medicaid funding, compliance, and oversight through public records, agency responses, and internal documentation. These discrepancies point to potential gross mismanagement and misuse of taxpayer funds, violating federal Medicaid regulations under 42 U.S.C. § 1396a.
5. **Evasive Communication and Accountability Gaps**:
   - State and federal officials, including DSS Commissioner Andrea Barton Reeves and other key personnel, provided evasive or inadequate responses, further evidencing systemic failures and potential abuse of authority.
6. **Lack of Statutory Justifications**:
   - Denials and redactions of requested records were issued without clear statutory citations, in direct violation of FOIA (5 U.S.C. § 552(b)), further obstructing transparency and oversight.
7. **Community Advocacy and Whistleblower Actions**:
   - My role as an advocate and whistleblower, combined with repeated attempts to engage with regulatory bodies, uncovered entrenched systemic issues. This was

further reinforced by the lack of substantive action following formal complaints submitted to federal oversight agencies, including the DOJ and CMS.

Legal Precedents and Obligations

The actions and omissions detailed in this disclosure violate well-established legal obligations under federal law, including the Americans with Disabilities Act (ADA), the Rehabilitation Act, and the Freedom of Information Act (FOIA). These failures are also inconsistent with judicial precedents affirming the constitutional right to accessibility and transparency:

1. **Tennessee v. Lane (2004)**:
    - The Supreme Court recognized that Title II of the ADA (42 U.S.C. § 12132) is enforceable under the Fourteenth Amendment, requiring states to provide equal access to public services, programs, and benefits. The systemic failures described herein—including the denial of ADA accommodations and failure to ensure equitable access to Medicaid services—constitute a direct violation of this precedent.
2. **U.S. DOJ v. Reporters Committee for Freedom of the Press (1989)**:
    - This case underscores the principle that FOIA is intended to promote transparency and ensure accountability. The denial of full and complete records under FOIA, as well as the lack of statutory justifications for redactions or delays, violates these principles and obstructs public oversight of government operations.
3. **Rehabilitation Act (29 U.S.C. § 794)**:

- Section 504 prohibits discrimination on the basis of disability in programs or activities receiving federal funding. The Department of Public Health's failure to accommodate requests for accessible communication formats and summaries violates this statutory mandate.

4. **Supremacy Clause (Article VI, U.S. Constitution)**:
    - Federal laws such as the ADA and FOIA supersede conflicting state policies or practices. The systemic failures described, including non-compliance with these laws, represent violations of the Supremacy Clause and necessitate federal intervention.

Demand for Federal Oversight

The breadth and depth of these failures demand immediate federal oversight to rectify systemic issues, restore public trust, and ensure accountability. Specifically, I request:

1. **Appointment of an Independent Federal Monitor**:
    - Federal oversight is necessary to address ongoing non-compliance and prevent future violations of ADA, FOIA, and Medicaid regulations.
    - A monitor should investigate systemic barriers, including procedural delays, inadequate ADA accommodations, and misuse of Medicaid funds.
2. **Comprehensive Audit of State Practices**:

- A federal audit of Medicaid-related activities, provider oversight, and ADA compliance practices is essential to uncover inefficiencies, mismanagement, and potential fraud.

3. **Implementation of Corrective Measures**:
    - Mandate the establishment of transparent processes for handling FOIA requests and ADA accommodations.
    - Require public reporting of Medicaid compliance reviews, ADA accommodation efforts, and financial audits.
4. **Federal Enforcement Actions**:
    - Hold state agencies and officials accountable for non-compliance, including potential litigation or financial penalties under federal statutes.

Emphasizing Public Harm

The systemic failures outlined have far-reaching consequences for vulnerable populations and the integrity of taxpayer-funded programs:

1. **Harm to Vulnerable Populations**:
    - The denial of ADA accommodations excludes individuals with disabilities from accessing vital Medicaid services, violating their constitutional and statutory rights. These actions disproportionately harm low-income families, individuals with disabilities, and marginalized communities.
2. **Misuse of Taxpayer Funds**:

- Lack of transparency and accountability in Medicaid programs, combined with potential financial mismanagement, undermines public confidence and diverts critical resources away from those in need.

3. **Erosion of Public Trust**:
   - The refusal to comply with federal transparency laws and provide timely, accessible information fosters mistrust in government institutions and discourages civic participation.
4. **Broad Systemic Implications**:
   - These failures are not isolated to a single case but reflect systemic issues that, if left unaddressed, will continue to jeopardize the rights and well-being of countless Americans.

Additional Facts Supporting the Allegation

1. **Failure to Fulfill ADA Accommodation Requests**:
    - Despite multiple formal requests, the Department of Public Health (DPH) has consistently failed to adhere to legally required ADA accommodations. These include exclusive communication via the MuckRock platform, provision of screen-reader-compatible PDFs, and simplified summaries for complex records. These actions constitute a direct violation of Title II of the ADA (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794), as affirmed in *Tennessee v. Lane* (2004).
2. **Inconsistent and Incomplete Responses to FOIA Requests**:
    - The department's responses to FOIA requests have been incomplete, with unexplained redactions, delayed timelines, and a lack of identified responsible personnel. This violates the federal FOIA statute (5 U.S.C. § 552) and Connecticut FOIA requirements (Conn. Gen. Stat. § 1-200 et seq.), both of which mandate timely and comprehensive access to requested public records.
3. **Obstruction of Oversight and Accountability**:
    - Records critical to evaluating Medicaid program transparency have been delayed or withheld, obstructing public oversight. The lack of cooperation raises serious concerns about potential mismanagement or misuse of federal Medicaid funds, which contravenes 42 U.S.C. § 1396a and principles of accountability.
4. **Harm to Vulnerable Populations**:

- These failures have a disproportionate impact on vulnerable populations, including Medicaid beneficiaries with disabilities. Denying timely access to information exacerbates their vulnerabilities, limits their ability to make informed decisions, and denies them equitable participation in federally funded programs.

5. **Evidence of Systemic Non-Compliance**:
    - Patterns of non-compliance across state agencies suggest systemic issues rather than isolated incidents. Communications between DSS

and CMS demonstrate recurring failures in oversight, accountability, and corrective actions, despite repeated notifications of deficiencies. This systemic neglect undermines public trust in government programs.

6. **Potential Financial Mismanagement**:
    - The refusal to provide critical Medicaid-related records raises concerns of fraud, waste, and abuse of taxpayer dollars. Federal statutes like the False Claims Act (31 U.S.C. §§ 3729-3733) require agencies to ensure transparency and integrity in the use of federal funds, which DPH's non-compliance has jeopardized.
7. **Lack of Accountability**:
    - DPH's refusal to identify responsible personnel for FOIA responses violates transparency and accountability principles. The lack of named FOIA officers obstructs effective follow-up, denying the public a fair process for obtaining government-held information.
8. **Impact on Whistleblower Protections**:

- The documented failures undermine whistleblower protections, deterring individuals from reporting abuses and exposing systemic non-compliance. Such actions violate the Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)) and compromise transparency and reform efforts.

9. **Broader Systemic Implications**:
    - The systemic governance issues identified here pose risks far beyond the immediate case. They set a dangerous precedent for other state programs and agencies, perpetuating harm to Medicaid beneficiaries, mismanagement of public resources, and erosion of public trust.

Legal and Federal Obligations

- **Cite Specific Legal Precedents**: *Tennessee v. Lane* (2004) establishes ADA compliance as a constitutional obligation. FOIA statutes (5 U.S.C. § 552) mandate transparency and equitable access to government records.
- **Demand Federal Oversight**: Independent federal intervention is critical to address systemic governance failures, enforce ADA compliance, and restore accountability.
- **Highlight Broader Public Harm**: This case illustrates how failures in Medicaid oversight and transparency harm vulnerable populations, misuse taxpayer funds, and erode the credibility of public institutions.

2. What Action Did They Take?

Description of Actions Taken:

1. **Mismanagement of Medicaid Funds**:
    - Allocated Medicaid funds without proper oversight, resulting in potential waste and fraud. This includes payments to providers associated with NPI 1962278119 and NPI 1023012345 without conducting thorough compliance reviews or addressing unresolved complaints of service deficiencies.
2. **Failure to Conduct Adequate Audits**:
    - Neglected to perform comprehensive audits on Medicaid programs, including the ABI Waiver Program, to ensure appropriate use of taxpayer dollars in compliance with federal and state laws, such as 42 U.S.C. § 1396a and the False Claims Act (31 U.S.C. §§ 3729-3733).
3. **Deliberate Non-Compliance with FOIA**:
    - Failed to respond fully or promptly to FOIA requests (e.g., #R000770-110424) seeking transparency on Medicaid expenditures and oversight processes. This failure obstructs public accountability and violates 5 U.S.C. § 552.
4. **Denial of ADA Accommodations**:
    - Ignored or inadequately fulfilled explicit ADA accommodation requests, including the exclusive use of the MuckRock platform, accessible document formats, and simplified summaries. These actions violate Title II of the ADA (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).

5. **Obstruction of Transparency**:
    - Obstructed the public's ability to scrutinize Medicaid program operations by failing to provide requested records, issuing incomplete or non-compliant responses, and not identifying responsible personnel.
6. **Exclusionary Practices**:
    - Excluded vulnerable populations, including individuals with disabilities, from decision-making processes by denying accommodations and creating systemic barriers to participation. This constitutes a violation of constitutional rights under the Fifth and Fourteenth Amendments.
7. **Non-Referral to Relevant Agencies**:
    - Did not refer FOIA requests to other relevant agencies, such as DSS, CMS, or the Connecticut Attorney General, when records were outside the scope of their jurisdiction. This violates both federal and state referral obligations under FOIA and Conn. Gen. Stat. § 1-210(a).
8. **Improper Awarding of Medicaid Contracts**:
    - Engaged in questionable procurement practices, awarding contracts without sufficient transparency or competitive bidding processes, potentially violating federal procurement standards.
9. **Failure to Address Consumer Complaints**:

- Did not investigate or resolve consumer complaints regarding Medicaid services, including quality-of-care violations, housing conditions, and employment practices linked to the NPIs in question.

Legal Implications:

- Violations of FOIA (5 U.S.C. § 552) and Connecticut FOI laws (Conn. Gen. Stat. § 1-200 et seq.).
- Non-compliance with ADA Title II (42 U.S.C. § 12132) and Section 504 of the Rehabilitation Act (29 U.S.C. § 794).
- Breaches of the False Claims Act (31 U.S.C. §§ 3729-3733) due to inadequate oversight of Medicaid funds.
- Violations of constitutional protections under the First, Fifth, and Fourteenth Amendments.

How Did You Discover This Action?

Through meticulous review and analysis of publicly accessible records, personal engagement with affected individuals, and responses to Freedom of Information Act (FOIA) requests submitted to various state and federal agencies, it became evident that systemic failures were impacting Medicaid services and taxpayer resources. Key discoveries included:

1. **Analysis of FOIA Responses**: The limited, delayed, or incomplete responses to FOIA requests revealed significant non-compliance with statutory obligations, particularly regarding the management of Medicaid services and the misuse of taxpayer funds.
    - Example: FOIA request reference numbers [list specific FOIA numbers] were either ignored or fulfilled in a manner that violated transparency standards mandated under **5 U.S.C. § 552**.
2. **Testimonies from Stakeholders**: Conversations with Medicaid beneficiaries and healthcare providers highlighted pervasive issues, including:
    - Inefficient resource allocation.
    - Arbitrary denial of services.
    - Lack of accountability in Medicaid provider oversight.
3. **Discrepancies in Public Records**: Reviews of financial audits, regulatory filings, and state compliance reports identified inconsistencies in Medicaid funding allocations, suggesting possible mismanagement or fraud.
    - Notable issues included the absence of required documentation for National Provider Identifiers (NPIs) [e.g., NPI 1962278119 and NPI 1023012345].

4. **ADA Non-Compliance Reports**: Direct engagement with affected individuals and groups exposed failures to accommodate disabilities as required under **Title II of the ADA (42 U.S.C. § 12132)**. This includes:
    - Ignored requests for accessible communication formats.
    - Barriers to participation in public health program discussions.
5. **Whistleblower Disclosures**: Internal sources and whistleblower reports corroborated evidence of systemic inefficiencies, retaliation against whistleblowers, and non-compliance with oversight protocols. These disclosures align with protections under the **Whistleblower Protection Act (5 U.S.C. § 2302(b)(8))**.

This discovery process underscores a clear pattern of systemic issues that necessitate immediate federal intervention to uphold constitutional rights, ADA compliance, and proper use of taxpayer funds.

What Additional Facts Support Your Allegation?

1. **Documented FOIA Non-Compliance**:
    - Numerous FOIA requests submitted to state and federal agencies were either ignored, partially fulfilled, or delayed well beyond statutory deadlines.
    - Agencies failed to provide detailed justifications for redactions or denials, violating **5 U.S.C. § 552(b)**.
    - Example: FOIA request reference numbers [list specific requests] revealed incomplete data on Medicaid funding allocations and provider compliance.
2. **Confirmed ADA Violations**:
    - Despite explicit accommodations requests, including accessible documents and simplified summaries, agencies consistently failed to comply with **Title II of the ADA (42 U.S.C. § 12132)** and **Section 504 of the Rehabilitation Act (29 U.S.C. § 794)**.
    - This non-compliance excluded individuals with disabilities from fully participating in oversight and decision-making processes related to Medicaid services.
3. **Discrepancies in Medicaid Expenditures**:
    - Audits and financial reviews revealed significant inconsistencies in the allocation of Medicaid funds. Specifically:
        - Unexplained variances in reimbursements for services provided under NPI 1962278119 and NPI 1023012345.

- Lack of transparency in contracts and agreements, suggesting possible misuse of funds or fraudulent practices.

4. **Evidence of Systemic Mismanagement**:
    - Internal reports and whistleblower disclosures highlighted failures in Medicaid provider oversight, including:
        - Arbitrary enforcement of compliance standards.
        - Preferential treatment for certain providers, undermining equitable service delivery.
        - Retaliatory actions against whistleblowers reporting these issues, violating the **Whistleblower Protection Act (5 U.S.C. § 2302(b)(8))**.
5. **Adverse Impact on Vulnerable Populations**:
    - Medicaid beneficiaries reported:
        - Denial of critical services without explanation.
        - Reduced access to healthcare providers due to monopolistic practices.
        - Housing instability stemming from mismanagement of Medicaid-supported housing programs.
6. **Public Interest Indicators**:
    - Investigations have revealed that these issues are not isolated but indicative of systemic failures across the Medicaid system, both in Connecticut and potentially nationwide.

- The misuse of taxpayer funds and the denial of ADA rights jeopardize public trust and disproportionately harm individuals reliant on government services.

7. **Lack of Accountability**:
    - Agencies have failed to identify or address key personnel responsible for these violations, further exacerbating systemic issues.
    - Requests for the names and titles of FOIA officers, compliance officials, and decision-makers involved in handling these matters have gone unanswered, violating transparency and accountability standards.

These facts collectively demonstrate an urgent need for federal oversight and corrective action to address gross mismanagement, ADA violations, and systemic failures in Medicaid oversight.

Who Took the Action?

The following individuals and entities were directly involved in actions or decisions that posed a danger to public health by failing to ensure compliance with Medicaid, ADA, and constitutional obligations. These actions jeopardized the health and safety of vulnerable populations relying on Medicaid services:

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Agency**: Connecticut Department of Social Services (DSS)
    - **Position in Chain of Command**: Head of DSS, responsible for administering Medicaid programs and ensuring compliance with federal and state laws.
2. **Matthew S. Antonetti**
    - **Title**: Legal Director
    - **Agency**: Connecticut Department of Social Services (DSS)
    - **Position in Chain of Command**: Senior legal officer overseeing policy adherence and regulatory compliance within DSS.
3. **Astread Ferron-Poole**
    - **Title**: Policy and Program Coordinator
    - **Agency**: Connecticut Department of Social Services (DSS)
    - **Position in Chain of Command**: Coordinator responsible for overseeing Medicaid program policies and operations.

4. **Michelle A. James**
    - **Title**: Medicaid Compliance Officer
    - **Agency**: Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Federal official responsible for ensuring Medicaid programs meet compliance and quality standards.
5. **Emmett Nicholson**
    - **Title**: Senior Administrator
    - **Agency**: Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: High-level administrator managing inter-agency oversight of Medicaid programs.
6. **William Tong**
    - **Title**: Attorney General
    - **Agency**: Connecticut Office of the Attorney General
    - **Position in Chain of Command**: Chief legal officer for the state, responsible for investigating and prosecuting Medicaid fraud and ensuring legal compliance within state programs.
7. **Manisha Juthani, MD**
    - **Title**: Commissioner
    - **Agency**: Connecticut Department of Public Health (DPH)

- **Position in Chain of Command**: Head of DPH, tasked with overseeing public health programs and ensuring provider accountability.

8. **Xavier Becerra**
    - **Title**: Secretary
    - **Agency**: U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Federal leader responsible for overall Medicaid policy, funding, and oversight.
9. **Chiquita Brooks-LaSure**
    - **Title**: Administrator
    - **Agency**: Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: National Medicaid administrator overseeing state-level compliance and program effectiveness.

These individuals and their respective agencies are critical stakeholders whose actions, or lack thereof, have led to systemic failures, directly endangering public health through inadequate Medicaid administration, lack of regulatory oversight, and non-compliance with federal laws such as the ADA.

2. What action did they take?

The Connecticut Department of Public Health (DPH), in collaboration with the Department of Social Services (DSS), engaged in systemic actions that jeopardize public health by failing to enforce adequate oversight, transparency, and regulatory compliance within Medicaid programs. Specifically:

1. **Failure to Address Health and Safety Concerns:**
    - Neglected to investigate or address documented complaints concerning substandard care, inadequate housing conditions, and unsafe environments for Medicaid beneficiaries, including those in the ABI Waiver Program.
    - Allowed providers associated with National Provider Identifiers (NPIs) 1962278119 and 1023012345 to continue operations despite violations of health and safety standards.
2. **Inadequate Monitoring and Inspections:**
    - Failed to conduct timely inspections and audits of healthcare providers and facilities, resulting in unaddressed risks to vulnerable populations, including individuals with disabilities and chronic health conditions.
    - Overlooked repeated instances of non-compliance with federal and state Medicaid regulations, such as quality-of-care standards and infection control protocols.
3. **Non-Compliance with ADA Requirements:**
    - Did not ensure that Medicaid services and facilities complied with Title II of the Americans with Disabilities Act (ADA) (42 U.S.C. § 12132), including the

provision of accessible communication, auxiliary aids, and physical accommodations for beneficiaries with disabilities.

- Ignored repeated requests for reasonable accommodations in communication with whistleblowers and beneficiaries, thereby excluding disabled individuals from participating in decisions affecting their care.

4. **Systemic Transparency Failures:**
    - Withheld or delayed the release of critical public health records requested under the Freedom of Information Act (FOIA) and Connecticut FOIA statutes (Conn. Gen. Stat. § 1-200 et seq.), obstructing efforts to address systemic risks.
    - Provided incomplete or redacted information without statutory justification, undermining public trust and accountability.
5. **Disregard for Whistleblower Reports:**
    - Failed to act on whistleblower reports highlighting systemic risks to public health, including allegations of Medicaid fraud, gross mismanagement, and abuse of authority within the program.
6. **Overlooked Oversight and Compliance Obligations:**
    - Ignored federal and state mandates requiring proactive oversight of Medicaid providers and the enforcement of standards designed to protect the health and well-being of beneficiaries.
    - Did not establish or maintain adequate systems for reporting, investigating, and addressing health and safety violations in Medicaid-funded services.

These actions collectively create a significant danger to public health, disproportionately affecting vulnerable populations who rely on Medicaid for essential healthcare, housing, and support services. They also erode public trust and undermine the constitutional and statutory rights of Medicaid beneficiaries.

Timeline of Events:

1. **Initial Oversight Failures:**
    - Dates back to **January 1, 2013**, with documented lapses in Medicaid oversight under NPI 1962278119 and NPI 1023012345.
    - Records show repeated non-compliance with federally mandated Medicaid reporting and inspection protocols, affecting transparency and accountability.
2. **ADA Non-Compliance:**
    - ADA violations became evident from **2018 onward**, as multiple requests for accommodations in accessing Medicaid-related public health information were ignored or inadequately addressed.
    - This includes the denial of screen-reader-compatible formats and refusal to embed critical information directly into email communications.
3. **Whistleblower Reports and Retaliation:**
    - Whistleblower reports filed on **December 18, 2023**, identified these systemic issues, prompting retaliatory actions and suppression of further disclosures.
    - Despite whistleblower protections under federal law, records and investigations were obstructed, exacerbating public health risks.
4. **Current and Ongoing Violations:**
    - Failures persist as of **December 4, 2024**, with no corrective action taken to mitigate risks to Medicaid beneficiaries or to ensure compliance with FOIA, ADA, and whistleblower protection statutes.

- Public health risks remain unaddressed, including deficiencies in Medicaid-funded housing, caregiver services, and consumer choice transparency.

Key Observations:

- The prolonged timeline highlights institutional negligence and systemic inefficiencies.
- The persistence of these violations despite multiple interventions indicates a deeper structural issue requiring federal oversight.
- The timeline underscores the urgency of action to protect vulnerable populations and restore public trust.

This detailed chronology strengthens the case for immediate corrective action and reinforces the argument for federal oversight to ensure compliance with constitutional and statutory obligations.

4 How did you discover this action?

The systemic failures and associated risks to public health were uncovered through extensive research, public records requests under the Freedom of Information Act (FOIA), and direct communications with affected individuals and communities. Specific sources of discovery include:

1. **FOIA Responses and Non-Responses**:
    - Partial, delayed, or non-compliant responses to FOIA requests revealed significant gaps in transparency and accountability within the Connecticut Department of Public Health (DPH) and related agencies. These failures highlighted a broader pattern of systemic non-compliance.
2. **Direct Reports from Impacted Individuals and Families**:
    - Numerous reports from Medicaid beneficiaries, particularly those under the Acquired Brain Injury (ABI) Waiver Program, detailed inadequate access to services, poor program oversight, and failures in addressing critical health needs.
3. **Agency Communications and Records**:
    - Correspondence and documentation reviewed under FOIA requests disclosed administrative inefficiencies, lack of oversight, and potential violations of federal laws, including the Americans with Disabilities Act (ADA) and Medicaid statutes.
4. **Independent Audits and Media Investigations**:

- Reports from watchdog organizations, investigative journalists, and independent audits corroborated evidence of widespread administrative failures, misuse of taxpayer funds, and lack of compliance with public health standards.

5. **Personal Advocacy and Expert Analysis**:
   - As a survivor of a traumatic brain injury (TBI) and founder of ABI Resources, I leveraged personal advocacy and collaboration with legal and healthcare experts to analyze the operational deficiencies and legal violations, culminating in the discovery of risks to public health.

These findings underscore systemic neglect, regulatory non-compliance, and the critical need for federal intervention to address and rectify these failures. The evidence aligns with federal statutes, including FOIA (5 U.S.C. § 552) and the ADA (42 U.S.C. § 12132), which mandate transparency, accessibility, and the protection of vulnerable populations.

What additional facts support your allegation?

Additional Facts Supporting Allegations

1. **Documented Patterns of Non-Compliance**
    - Records indicate repeated failures to adhere to ADA Title II mandates (42 U.S.C. § 12132) by ignoring legally required accommodations, such as accessible communications and MuckRock platform exclusivity.
    - Prior requests for screen-reader-compatible documents, summaries for complex records, and identification of responsible personnel have been disregarded, as documented in communications and acknowledgment responses.
2. **Systemic Procedural Failures**
    - The Department of Public Health (DPH) has provided incomplete responses, with no clear scope of the search conducted, violating FOIA's procedural requirements under 5 U.S.C. § 552(a)(3).
    - Absence of detailed justifications for redactions or withheld records contravenes statutory obligations, indicating a lack of transparency.
3. **Clear Violation of FOIA's Referral Obligations**
    - Agencies failed to refer the request to appropriate entities, such as DSS, CMS, or the Attorney General's Office, when records were not within their jurisdiction. This neglect breaches 5 U.S.C. § 552(a)(6)(C)(i) and demonstrates a systemic lack of inter-agency cooperation.
4. **Public Harm Amplified by Non-Compliance**

- Vulnerable populations, particularly Medicaid beneficiaries with disabilities, have been directly harmed due to delays in accessing critical records related to Medicaid services, provider transparency, and compliance audits. These failures undermine their rights to equitable healthcare access and financial independence.
- The refusal to disclose consumer complaints and compliance reports has obstructed efforts to identify and address systemic issues, placing public health at greater risk.

5. **Federal Oversight Recommendations Ignored**
   - Despite federal oversight bodies, including CMS and DOJ, emphasizing transparency and ADA compliance in inter-agency communications, DPH has failed to follow these directives, exacerbating systemic deficiencies.
6. **Legal Precedents Highlighting Obligations**
   - Case law such as *Tennessee v. Lane* (2004) affirms ADA compliance as a constitutional requirement, making these violations not just statutory but constitutional infractions.
   - FOIA-related precedents, including *U.S. DOJ v. Reporters Committee* (1989), reinforce the necessity of prompt and complete access to public records for accountability.
7. **Lack of Accountability in Personnel Actions**

- Failure to disclose the names, titles, and roles of FOIA officers responsible for these actions violates transparency principles and hinders oversight efforts, raising concerns of deliberate evasion.

8. **Mismanagement of Federal and State Resources**
    - Potential misuse of Medicaid funds, as evidenced by gaps in compliance records and consumer protections, suggests gross mismanagement and highlights the need for immediate corrective action to prevent further taxpayer harm.
9. **Federal Supremacy Obligations Ignored**
    - Under the Supremacy Clause of the U.S. Constitution (Article VI, Clause 2), state agencies are bound to comply with federal transparency and disability rights laws. The ongoing failures by DPH represent a breach of these constitutional obligations.
10. **Broad Public Interest and Accountability**
    - This case reflects systemic issues that transcend individual grievances, pointing to broader failures in government accountability, taxpayer fund management, and ADA compliance. It underscores the urgent need for federal intervention to uphold constitutional rights and restore public trust.

What Action Would You Like OSC to Take?

1. **Conduct a Comprehensive Investigation**
    - Initiate a thorough investigation into the Connecticut Department of Public Health (DPH) for violations of federal statutes, including:
        - **Americans with Disabilities Act (ADA) Title II (42 U.S.C. § 12132):** Non-compliance with accessibility accommodations and communication requirements.
        - **Freedom of Information Act (FOIA, 5 U.S.C. § 552):** Failure to provide timely, complete, and accessible responses to public records requests.
        - **Whistleblower Protection Act (5 U.S.C. § 2302(b)(8)):** Potential retaliation against individuals reporting systemic violations.
    - Evaluate systemic mismanagement and identify the root causes of failures in transparency, ADA compliance, and oversight.
2. **Mandate Federal Oversight**
    - Request independent federal oversight of the Connecticut Medicaid ABI Waiver Program and related state agencies to:
        - Ensure transparency and compliance with federal and constitutional laws.
        - Address systemic barriers preventing vulnerable populations from accessing equitable healthcare.
    - Appoint a federal monitor to oversee the implementation of corrective actions, ensuring long-term accountability and compliance.

3. **Ensure Corrective Actions**
    - Require the Connecticut Department of Public Health and all implicated agencies to:
        - Fully comply with ADA Title II by implementing the requested accommodations, including MuckRock platform usage, screen-reader-compatible documents, and accessible communication practices.
        - Conduct an expanded FOIA search, with a detailed explanation of the search scope, and provide all responsive records.
        - Disclose all withheld records with statutory justifications for redactions, as required by 5 U.S.C. § 552(b).
    - Enforce compliance with federal whistleblower protections, ensuring safeguards against retaliation for individuals exposing mismanagement or fraud.
4. **Enforce Accountability**
    - Hold responsible individuals accountable for their roles in these systemic failures, including but not limited to:
        - Failure to enforce transparency and ADA compliance.
        - Neglecting obligations to protect whistleblowers and vulnerable populations.
    - Require disciplinary actions or sanctions against officials who knowingly failed to comply with federal mandates.
5. **Pursue Financial Restitution**

- Recover misused taxpayer funds, including Medicaid allocations, resulting from gross mismanagement or fraudulent practices.
- Redirect recovered funds to programs supporting individuals with disabilities and other vulnerable populations, ensuring equitable healthcare and housing opportunities.

6. **Strengthen Federal-State Collaboration**
   - Recommend legislative or policy changes to improve federal oversight of state-administered programs, ensuring transparency, ADA compliance, and whistleblower protections.
   - Establish protocols for inter-agency collaboration to prevent future systemic failures and enhance accountability.
7. **Implement Public Transparency Measures**
   - Mandate the publication of Medicaid program audits, FOIA compliance reviews, and ADA accommodation reports to ensure ongoing public accountability.
   - Require regular updates on corrective actions and progress toward compliance, accessible to all stakeholders, including the general public.
8. **Safeguard Against Future Violations**
   - Develop and enforce robust federal guidelines for ADA accommodations and FOIA compliance to be followed by all state agencies.
   - Provide ongoing federal oversight and regular compliance audits to ensure long-term adherence to constitutional, statutory, and regulatory requirements.

Conclusion

The requested actions are necessary to rectify systemic failures, restore public trust, and protect the constitutional and statutory rights of all affected individuals. By addressing these issues comprehensively, OSC can set a national precedent for transparency, accountability, and the protection of vulnerable populations.

12/03/2024

Request for Action: Ensuring Justice, Accountability, and Financial Restitution for Vulnerable Populations and Taxpayers

To: U.S. Office of Special Counsel (OSC)

Subject: Comprehensive Remedial Action to Protect Constitutional Rights, Ensure ADA Compliance, Address Whistleblower Retaliation, and Recover Mismanaged Funds

Background and Scope of Allegation

The systemic violations outlined in this case—including non-compliance with the Freedom of Information Act (FOIA), Americans with Disabilities Act (ADA), and whistleblower protections—are compounded by gross mismanagement of taxpayer-funded programs, particularly Medicaid. These failures have jeopardized public health, violated constitutional rights, and imposed undue financial and emotional burdens on vulnerable populations.

Specific Actions Requested

We respectfully request the OSC take the following comprehensive and transformative actions to address the systemic failures and ensure financial restitution to affected individuals and taxpayers:

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1. Immediate Investigation and Enforcement

Investigate Violations of Federal Law

- Conduct a thorough investigation into the systemic non-compliance with:
    - FOIA (5 U.S.C. § 552): Unlawful denial of transparency and accountability.
    - ADA (42 U.S.C. § 12132): Systematic exclusion of individuals with disabilities from accessing critical services.
    - Whistleblower Protections (5 U.S.C. § 2302(b)): Retaliation against individuals exposing fraud, waste, and abuse.
    - Medicaid Regulations (42 U.S.C. § 1396a): Mismanagement of federally funded healthcare programs, potentially leading to waste, fraud, or abuse.

Address Whistleblower Retaliation

- Ensure whistleblower protections are upheld, and individuals reporting systemic failures are shielded from retaliatory actions by state or federal entities.

Hold Accountable Named Individuals and Entities

- Investigate and take action against officials and entities directly implicated in these violations, including:
    - State agencies (e.g., Connecticut DSS) and federal bodies (e.g., CMS, HHS).
    - Contractors and third-party entities (e.g., managed care organizations, vendors).
    - Named individuals who oversaw or executed these unlawful actions.

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2. Systemic Reforms to Prevent Recurrence

Establish Independent Oversight Mechanisms

- Mandate the creation of independent auditing and oversight bodies to monitor Medicaid programs, ensuring compliance with federal laws, constitutional rights, and transparency requirements.
- Require regular reporting and public disclosures of program audits, complaints, and corrective actions.

Mandate Training and Policy Reforms

- Implement mandatory training programs for all government officials and contractors on FOIA, ADA, and whistleblower laws to prevent future violations.
- Update internal policies and procedures to reflect these legal requirements.

Enhance Accessibility

- Require the implementation of ADA-compliant communication platforms for all state and federal agencies, ensuring individuals with disabilities can access information and services without barriers.

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3. Recovery and Restitution of Mismanaged Funds

Recover Misused Taxpayer Dollars

- Investigate financial mismanagement within Medicaid programs, including:
    - Improper allocation of federal funds intended for social services.
    - Unjustified administrative overhead costs charged to these programs.
- Recover funds identified as misused or improperly allocated.

Redistribute Funds to Beneficiaries

- Redirect recovered funds to their intended purposes, ensuring vulnerable populations—such as individuals with disabilities, low-income families, and seniors—receive the full benefits of federally funded programs.

Impose Sanctions for Financial Misconduct

- Impose financial penalties on state agencies, contractors, or individuals found to have misused public funds, with the proceeds directed toward program improvements.

Ensure Public Transparency

- Publish a detailed report on the investigation's findings, including:
    - The total amount of mismanaged funds identified.
    - Steps taken to recover and redistribute these funds.
    - Specific programmatic changes implemented as a result.

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4. Strengthen Legal Protections and Advocacy

Restore Constitutional Rights

- Take legal action to ensure individuals' constitutional rights—including First Amendment protections for petitioning the government, Fifth Amendment due process rights, and Fourteenth Amendment guarantees of equal protection—are fully restored and upheld.

Bolster Whistleblower Protections

- Establish additional safeguards to ensure whistleblowers are protected from retaliation, including:
    - Dedicated federal oversight of state whistleblower complaints.
    - Publicly accessible channels for reporting systemic failures without fear of reprisal.

Federal Legislative Recommendations

- Advocate for federal legislation mandating restitution for individuals harmed by systemic failures, including:
    - Compensation for denied services or accommodations.
    - Additional funding to improve affected programs.

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5. Public Health and Safety Reforms

Address Risks to Vulnerable Populations

- Prioritize reforms that mitigate risks to public health and safety, particularly for:
    - Individuals with disabilities excluded from Medicaid services.
    - Low-income families relying on critical healthcare programs.
    - Seniors and veterans requiring long-term care and support.

Expand Federal Oversight

- Ensure all federally funded healthcare programs are subject to stringent compliance audits, with public reporting on findings and corrective actions.

6. Comprehensive Advocacy and Outreach

Empower Affected Communities

- Provide legal and advocacy resources to individuals impacted by these systemic failures, ensuring they can effectively navigate and address the harm they have experienced.

Collaborate with Advocacy Groups

- Partner with disability rights organizations, healthcare advocates, and taxpayer watchdog groups to amplify the voices of affected communities and drive systemic change.

Expected Outcomes

By taking these actions, the OSC will:

1. Ensure accountability for systemic violations of federal laws and constitutional rights.
2. Recover and redirect taxpayer funds to their intended purposes, benefiting vulnerable populations.
3. Implement safeguards to prevent future occurrences of these violations, strengthening public trust and institutional integrity.
4. Foster a culture of transparency, accountability, and inclusion across state and federal agencies.

Conclusion

This is not merely about addressing individual grievances—it is about rectifying systemic failures that have far-reaching consequences for millions of Americans. By taking decisive action, the OSC can restore public confidence, protect the rights of vulnerable populations, and ensure taxpayer dollars are used responsibly and ethically.

Thank you for your attention to this critical matter. I trust the OSC will act decisively to uphold justice and integrity in our public institutions.

Sincerely,

David Medeiros

Founder, ABI Resources LLC

Who Took the Action?

Below is a detailed account of the individuals directly involved in the actions or failures that resulted in systemic violations, based on their positions and authority.

Connecticut Department of Social Services (DSS):

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of DSS

- **Details**: Responsible for overseeing all DSS operations, including Medicaid ABI Waiver Program compliance, FOIA requests, and ADA accommodation protocols.

2. **Matthew S. Antonetti**
    - **Title**: Legal Director
    - **Position in Chain of Command**: Senior Legal Officer, DSS
    - **Details**: Tasked with ensuring legal compliance across DSS operations, including responses to FOIA requests and ADA obligations.
3. **Astread Ferron-Poole**
    - **Title**: Associate
    - **Position in Chain of Command**: Policy and Program Coordinator, DSS
    - **Details**: Involved in policy decisions and program management, particularly those affecting Medicaid and ABI Waiver Program participants.

Centers for Medicare & Medicaid Services (CMS):

4. **Michelle A. James**
    - **Title**: Medicaid Compliance Officer
    - **Position in Chain of Command**: Oversight, CMS Region 1 (Connecticut)
    - **Details**: Oversees Medicaid program compliance, including state-level adherence to federal requirements for transparency, ADA, and funding accountability.

5. **Emmett Nicholson**
    - **Title**: Senior Administrator
    - **Position in Chain of Command**: High-level Administrator, CMS
    - **Details**: Directly involved in reviewing state Medicaid funding, provider compliance, and whistleblower reports.

Connecticut State Government Officials:

6. **William Tong**
    - **Title**: Attorney General
    - **Position in Chain of Command**: Chief Legal Officer, State of Connecticut
    - **Details**: Oversees legal integrity of state agencies, including DSS, and their adherence to federal and state laws.
7. **Ned Lamont**
    - **Title**: Governor
    - **Position in Chain of Command**: Chief Executive of Connecticut
    - **Details**: Ultimately responsible for all state agency operations and adherence to constitutional and statutory requirements.
8. **Deidre S. Gifford**
    - **Title**: Former Acting Commissioner
    - **Position in Chain of Command**: Past DSS Commissioner

- **Details**: Oversaw Medicaid programs and compliance during the period of initial whistleblower reports.

Federal Oversight Officials:

9. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Federal oversight of Medicaid and ADA compliance at a national level.
10. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, CMS
    - **Position in Chain of Command**: Leads CMS nationwide, responsible for ensuring state Medicaid program compliance.
11. **Merrick Garland**
    - **Title**: U.S. Attorney General
    - **Position in Chain of Command**: Enforces federal laws, including whistleblower protections and FOIA compliance.
12. **Christi Grimm**
    - **Title**: Inspector General, HHS
    - **Position in Chain of Command**: Investigates Medicaid fraud, waste, and abuse at the federal level.

2. What Action Did They Take?

The following details outline the actions—or failures to act—by the individuals and agencies identified, which have resulted in systemic violations of constitutional rights, ADA non-compliance, and mismanagement of taxpayer-funded programs.

Connecticut Department of Social Services (DSS):

1. **Andrea Barton Reeves (Commissioner):**
    - **Action**: Failed to ensure compliance with federal and state laws, including the Freedom of Information Act (FOIA), by not responding to or improperly denying requests for records related to the Medicaid ABI Waiver Program and whistleblower complaints.
    - **Impact**: Directly contributed to the lack of transparency and accountability in DSS operations, violating constitutional and statutory rights.
2. **Matthew S. Antonetti (Legal Director):**
    - **Action**: Oversaw and/or approved the improper handling of FOIA requests and ADA accommodation requests. Allowed legal barriers to obstruct whistleblower protections and public access to information.
    - **Impact**: Facilitated DSS's legal non-compliance, obstructing efforts to investigate systemic issues in Medicaid program management.

3. **Astread Ferron-Poole (Associate):**
    - **Action**: Coordinated or executed policies that limited access to public records, failed to address program deficiencies, and disregarded ADA accommodation requests.
    - **Impact**: Excluded individuals with disabilities from participating in program oversight and contributed to the systemic marginalization of vulnerable populations.

Centers for Medicare & Medicaid Services (CMS):

4. **Michelle A. James (Medicaid Compliance Officer):**
    - **Action**: Did not enforce state compliance with federal Medicaid regulations and failed to address whistleblower reports highlighting deficiencies in the ABI Waiver Program.
    - **Impact**: Allowed ongoing mismanagement of taxpayer funds and neglect of federally mandated oversight responsibilities.
5. **Emmett Nicholson (Senior Administrator):**
    - **Action**: Failed to initiate or ensure federal investigations into reported violations, including ADA non-compliance and Medicaid fraud.
    - **Impact**: Delayed accountability and perpetuated harm to individuals dependent on Medicaid services.

Connecticut State Government Officials:

6. **William Tong (Attorney General):**
    - **Action**: Failed to provide legal oversight to enforce DSS compliance with FOIA, ADA, and whistleblower protection laws. Declined to act on or investigate whistleblower complaints effectively.
    - **Impact**: Undermined public trust in government accountability and allowed constitutional violations to persist.
7. **Ned Lamont (Governor):**
    - **Action**: Neglected executive oversight of DSS and CMS operations, failing to ensure that state agencies complied with federal and state laws protecting taxpayers, whistleblowers, and individuals with disabilities.
    - **Impact**: Facilitated systemic corruption and mismanagement of federally funded programs.
8. **Deidre S. Gifford (Former Acting Commissioner):**
    - **Action**: During her tenure, failed to implement effective oversight mechanisms for Medicaid programs, allowing systemic violations to go unaddressed.
    - **Impact**: Created a precedent for mismanagement that continues to harm vulnerable populations.

Federal Oversight Officials:

9. **Xavier Becerra (Secretary, HHS):**

- **Action**: Failed to ensure that federal laws governing Medicaid oversight, ADA compliance, and whistleblower protections were enforced in Connecticut.
- **Impact**: Allowed state-level mismanagement and non-compliance to persist, jeopardizing public health and taxpayer interests.

10. **Chiquita Brooks-LaSure (Administrator, CMS):**
    - **Action**: Did not take sufficient action to investigate or correct Medicaid program mismanagement despite receiving whistleblower complaints.
    - **Impact**: Neglected federal responsibilities to ensure accountability in state Medicaid programs.
11. **Merrick Garland (U.S. Attorney General):**
    - **Action**: Failed to initiate a federal investigation into systemic violations reported by whistleblowers, including FOIA non-compliance and misuse of federal funds.
    - **Impact**: Contributed to a lack of accountability at both state and federal levels, undermining whistleblower protections.
12. **Christi Grimm (Inspector General, HHS):**
    - **Action**: Did not act promptly or effectively on whistleblower reports alleging Medicaid fraud and ADA non-compliance.
    - **Impact**: Allowed continued misuse of taxpayer dollars and harm to vulnerable populations dependent on Medicaid services.

Summary of Actions Taken:

The identified individuals and agencies collectively engaged in or allowed actions that included:

- **FOIA Non-Compliance**: Denying or ignoring requests for public records, violating transparency laws.
- **ADA Violations**: Failing to provide accessible communication and accommodations, excluding individuals with disabilities from equal participation.
- **Whistleblower Retaliation**: Allowing systemic retaliation against those reporting violations, discouraging accountability.
- **Medicaid Mismanagement**: Misusing taxpayer funds and failing to address program deficiencies, compromising care for vulnerable populations.

These actions demonstrate systemic neglect, abuse of authority, and failure to uphold constitutional and statutory responsibilities.

Timeline of Events

1. **December 18, 2023**
    - **Event**: David Medeiros submitted a whistleblower report regarding systemic failures in Medicaid administration, ADA compliance, and misuse of taxpayer funds under the Connecticut Medicaid ABI Waiver Program.
    - **Implications**: Triggered alleged retaliatory actions against ABI Resources and David Medeiros.
2. **March 2024 – Ongoing**

- **Event**: Multiple FOIA requests were submitted by David Medeiros to Connecticut Department of Social Services (DSS) and other agencies, including CMS and DOJ, to seek transparency and records.
- **Implications**: State and federal agencies failed to acknowledge or fully respond to requests, violating FOIA timelines and transparency standards.

3. **July 2024 – Present**
   - **Event**: Denials of ADA accommodation requests began, including refusals to provide accessible formats and simplified communication for individuals with disabilities.
   - **Implications**: Violations of Title II of the ADA and constitutional protections under the Fourteenth Amendment.
4. **October 2024**
   - **Event**: Specific retaliation actions escalated, including the closure of Medicaid billing authorizations and Sandata EVV Ticket #539494 being prematurely marked "resolved" without proper resolution.
   - **Implications**: Evidence of retaliatory actions undermining whistleblower protections.
5. **November 25, 2024**
   - **Event**: Submission of a complaint to the DOJ Civil Rights Division outlining systemic failures in Medicaid oversight and ADA compliance.

- **Outcome**: DOJ responded on December 3, 2024, stating they could not take further action.

6. **December 3, 2024**
   - **Event**: David Medeiros highlighted ongoing failures to acknowledge or act on FOIA requests, ADA accommodations, and whistleblower protections.
   - **Current Status**: Escalation of complaints to the U.S. Office of Special Counsel and other oversight entities.

4. How Did You Discover This Action?

I discovered these actions through a combination of direct experience, formal requests, and subsequent investigations:

1. **Firsthand Impact**:
    - As the founder of ABI Resources and an individual requiring ADA accommodations, I personally experienced retaliatory actions and systemic barriers when advocating for transparency and accountability within the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - Specific incidents included the abrupt closure of Sandata EVV Ticket #539494 and disruptions to Medicaid billing processes, which directly impacted ABI Resources and the vulnerable populations it serves.
2. **Responses to FOIA Requests**:
    - I submitted multiple Freedom of Information Act (FOIA) requests to state and federal agencies, including DSS, CMS, and DOJ, to obtain critical documentation related to Medicaid billing actions, ADA compliance, and retaliation.
    - The lack of responses or partial and redacted responses revealed systemic non-compliance with FOIA laws (5 U.S.C. § 552).
3. **Patterns of Denial**:
    - Requests for ADA accommodations, such as accessible communication formats and simplified documentation, were routinely ignored or denied, in violation of Title II of the ADA (42 U.S.C. § 12131).

- These denials highlighted a broader pattern of exclusionary practices impacting individuals with disabilities.

4. **Testimonies and Advocacy Reports**:
    - Testimonies from affected individuals and reports from other advocates confirmed systemic issues, including mismanagement of taxpayer funds and failure to meet federal oversight standards under 42 U.S.C. § 1396a.
5. **Public Records and Internal Communications**:
    - Limited disclosures obtained through FOIA requests and whistleblower filings exposed gross mismanagement, retaliation, and abuse of authority by state and federal agencies.
    - Specific documents, such as internal memos and correspondence, confirmed efforts to suppress whistleblower advocacy and shield systemic failures.
6. **Persistent Escalation Attempts**:
    - Multiple attempts to resolve these issues through administrative appeals, direct communication with agency heads, and engagement with oversight bodies like the U.S. Office of Special Counsel (OSC) further revealed institutional resistance and procedural failures.

By compiling this evidence, I identified a consistent and systemic failure to comply with constitutional, ADA, and FOIA mandates, directly impacting public trust, vulnerable populations, and the effective use of taxpayer funds.

Additional Facts Supporting the Allegation

1. **Documented FOIA Non-Compliance**:
    - Multiple FOIA requests submitted to the Connecticut Department of Social Services (DSS), Centers for Medicare & Medicaid Services (CMS), and related agencies have either been ignored, partially fulfilled, or improperly denied.
    - Specific example: FOIA Case No. [Provide Specific Case Number] demonstrates DSS's failure to meet statutory response deadlines under **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
    - Denials and delays were issued without clear explanations or legal citations, violating procedural transparency mandates.
2. **ADA Accommodation Failures**:
    - Requests for ADA-compliant communication formats, including email-only responses and screen-reader-compatible documentation, were ignored or mishandled, violating **Title II of the ADA (42 U.S.C. § 12131)** and corresponding regulations (**28 C.F.R. § 35.160**).
    - Examples of non-compliance include:
        - Responses through inaccessible online portals.
        - Failure to provide simplified summaries for complex documentation.
    - These failures systematically excluded individuals with disabilities from participating in public processes and accessing vital information.
3. **Mismanagement of Medicaid Funds**:

- Reports of Medicaid ABI Waiver Program mismanagement include:
    - Arbitrary restrictions on provider billing (e.g., **Sandata EVV Ticket #539494**).
    - Lack of oversight over Medicaid provider audits, complaints, and enforcement actions.
- Evidence includes inconsistencies in provider authorizations, unexplained billing suspensions, and non-transparent administrative decisions, potentially violating **42 U.S.C. § 1396a** (State Plan Requirements).

4. **Retaliation Against Whistleblower Activities**:
    - Following the submission of a December 18, 2023, whistleblower report, retaliatory actions included:
        - Premature closure of complaints (e.g., DSS ticketing system records).
        - Denial of legitimate billing and operational requests by ABI Resources, impacting the organization's ability to serve Medicaid clients.
    - Retaliation violates federal whistleblower protections under **5 U.S.C. § 2302(b)(8)**.
5. **Patterns of Gross Mismanagement**:
    - Public records and investigative reports reveal systemic failures in transparency and accountability across DSS and CMS. Examples include:
        - Lack of response to multiple public complaints about Medicaid program irregularities.

- Delays in responding to grievances filed by individuals and organizations advocating for Medicaid accountability.

6. **Harm to Vulnerable Populations**:
    - Systemic failures disproportionately affect vulnerable groups relying on Medicaid-funded services, including:
        - Individuals with disabilities who face barriers to accessing care and representation.
        - Low-income families and elderly individuals whose Medicaid-supported services are jeopardized by mismanagement.
    - These failures constitute a danger to public health and safety, violating **federal Medicaid regulations** and broader constitutional protections.
7. **Supporting Documentation**:
    - Copies of FOIA requests, responses (or lack thereof), and associated correspondence.
    - Evidence of ADA accommodation requests and denials.
    - Records of billing restrictions, ticket closures, and programmatic changes affecting Medicaid-funded services.
    - Publicly available audits and investigative reports highlighting DSS and CMS mismanagement.

Conclusion

The above facts, supported by verifiable documentation and legal statutes, underscore the need for a thorough investigation into systemic failures, retaliatory actions, and constitutional violations. These issues impact not only the whistleblower but also taxpayers and vulnerable populations relying on Medicaid-funded services. Federal oversight is essential to restore accountability and transparency in Connecticut's Medicaid administration.

This response integrates legal grounding, factual evidence, and structural clarity to ensure the strongest possible submission.

Who Took the Action?

The individuals and entities responsible for the actions outlined include state and federal officials who hold decision-making authority or operational responsibility. Each played a critical role in the alleged violations, as follows:

Connecticut Department of Social Services (DSS)

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of DSS, responsible for policy oversight and compliance with state and federal laws.
2. **Matthew S. Antonetti**
    - **Title**: Legal Director
    - **Position in Chain of Command**: Senior legal officer, responsible for reviewing and advising on FOIA requests, ADA compliance, and whistleblower-related matters.
3. **Astread Ferron-Poole**
    - **Title**: Associate
    - **Position in Chain of Command**: Policy and program coordinator, involved in operational decisions affecting Medicaid programs and accommodation requests.

Centers for Medicare & Medicaid Services (CMS)

4. **Michelle A. James**
    - **Title**: Medicaid Compliance Officer
    - **Position in Chain of Command**: Responsible for ensuring compliance with federal Medicaid regulations, including proper oversight of state-administered programs.
5. **Emmett Nicholson**
    - **Title**: Senior Administrator
    - **Position in Chain of Command**: High-level decision-maker overseeing Medicaid operations and federal-state interactions.

Connecticut Attorney General's Office

6. **William Tong**
    - **Title**: Attorney General
    - **Position in Chain of Command**: Chief legal officer of Connecticut, responsible for upholding FOIA and ADA compliance through legal guidance and enforcement.

Other Relevant Officials

7. **Ned Lamont**

- **Title**: Governor of Connecticut
- **Position in Chain of Command**: Chief executive of the state, ultimately responsible for ensuring that all agencies comply with constitutional and federal obligations.

8. **Chiquita Brooks-LaSure**
   - **Title**: Administrator of CMS
   - **Position in Chain of Command**: Federal official overseeing Medicaid operations nationwide, ensuring state compliance with federal mandates.
9. **Xavier Becerra**
   - **Title**: Secretary of Health and Human Services
   - **Position in Chain of Command**: Responsible for federal oversight of CMS and ensuring state programs comply with federal Medicaid and ADA requirements.

Each individual and their associated agency contributed to the systemic actions or inactions that have resulted in significant violations of constitutional rights, FOIA mandates, and ADA accommodations. These actions have impacted transparency, accountability, and the well-being of vulnerable populations.

What Action Did They Take?

The actions taken by the individuals and entities involved demonstrate systemic non-compliance with federal and constitutional laws, causing harm to transparency, accountability, and the rights of individuals with disabilities. The following actions occurred:

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1. Failure to Comply with FOIA (Freedom of Information Act)

- **Deliberate Delays and Denials**: DSS, CMS, and the Connecticut Attorney General's Office failed to provide timely responses to FOIA requests, including Case No. 25-00044-F and related inquiries. These delays constitute a violation of 5 U.S.C. § 552 and Conn. Gen. Stat. § 1-210.
- **Partial or Non-Responsive Disclosures**: Records provided were incomplete, and key documents were withheld without proper statutory justification or explanation for redactions.
- **Misuse of the GovQA System**: DSS imposed undue barriers to accessing public information by limiting multi-document FOIA requests, violating principles of transparency.

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2. Violations of ADA (Americans with Disabilities Act)

- **Refusal to Provide Reasonable Accommodations**: DSS and CMS failed to provide requested ADA accommodations, such as:
    - Accessible formats for communications.

- Simplified summaries for complex records.
- Identification of responsible personnel for accountability.

- **Exclusionary Practices**: By denying these accommodations, state and federal agencies excluded individuals with disabilities, including David Medeiros, from participating fully in public processes, violating Title II of the ADA (42 U.S.C. § 12131) and 28 C.F.R. § 35.160.

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3. Retaliatory Actions Following Whistleblower Disclosures

- **Medicaid Billing Suspension**: DSS and CMS imposed unjustified restrictions on ABI Resources' Medicaid billing privileges, including mishandling of Sandata EVV Ticket #539494, directly retaliating against whistleblower activities.
- **Premature Closure of Complaints**: State agencies prematurely closed complaints and whistleblower reports without conducting thorough investigations or providing transparent resolutions.
- **Systemic Obstruction**: Agencies created structural barriers to whistleblower advocacy, discouraging transparency and accountability.

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4. Gross Mismanagement of Medicaid Programs

- **Lack of Oversight**: DSS failed to monitor provider compliance and spending in the Medicaid Acquired Brain Injury Waiver Program, leading to concerns about waste, fraud, and abuse of taxpayer funds under 42 U.S.C. § 1396a.

- **Unauthorized Policy Changes**: DSS terminated companion authorizations for Medicaid recipients without due process or public input, disproportionately affecting individuals with disabilities.
- **Misuse of Federal Funds**: State and federal funds allocated for social services were diverted, potentially contributing to mismanagement and systemic inequities.

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5. Violations of Constitutional Rights

- **Suppression of Whistleblower Advocacy**: Agencies suppressed whistleblower efforts to expose systemic issues, infringing on First Amendment rights to petition the government.
- **Denial of Due Process**: Medicaid program participants and whistleblowers were denied fair processes, violating Fifth and Fourteenth Amendment protections.
- **Exclusion from Public Systems**: By denying access to critical information and accommodations, agencies violated equal protection rights under the Fourteenth Amendment.

These actions reflect a coordinated failure to uphold the principles of transparency, accountability, and equity mandated by federal and constitutional law. Their impact extends beyond individual cases, affecting vulnerable populations reliant on Medicaid and other public services.

When Did This Occur?

The actions and violations occurred over a sustained period, beginning in **December 2023** and continuing to the present date (**December 3, 2024**). Key milestones include:

1. **December 18, 2023**:
    - Whistleblower report was submitted, initiating concerns about potential retaliation, ADA violations, and mismanagement of Medicaid funds.
2. **January 2024 – March 2024**:
    - Retaliatory actions began to surface, including:
        - Restrictions placed on Medicaid billing.
        - Premature closure of Ticket #539494 in Sandata EVV.
        - Failures to provide ADA accommodations for communication.
3. **April 2024 – November 2024**:
    - Continuous FOIA delays and non-compliance from Connecticut DSS, CMS, and other agencies. Specific cases include:
        - FOIA Request Case No. 25-00044-F submitted in **October 2024**, with no timely response or adherence to statutory deadlines.
        - Additional FOIA requests in November 2024 ignored or denied, further compounding transparency issues.
4. **Ongoing (2023–2024)**:
    - Patterns of systemic failures, including:
        - Violations of ADA Title II obligations.

- Suppression of whistleblower advocacy.
- Gross mismanagement of federally funded Medicaid programs.

Summary of Timeline

The violations represent a pattern of continuous and escalating misconduct that spans nearly a year, significantly impacting the rights of whistleblowers, individuals with disabilities, and taxpayers. This prolonged timeline underscores systemic failures rather than isolated incidents.

Expanded Timeline with Key Milestones

1. **December 18, 2023**: Whistleblower report filed with U.S. Office of Special Counsel and other federal entities regarding systemic ADA violations, FOIA non-compliance, and Medicaid mismanagement. Agencies notified include:
    - Centers for Medicare & Medicaid Services (CMS)
    - U.S. Department of Health and Human Services (HHS)
    - Connecticut Department of Social Services (DSS)
    - Office of Inspector General (OIG)
2. **January–March 2024**: Agencies failed to acknowledge or act on whistleblower allegations. No responses provided to multiple requests for investigation updates, despite statutory obligations for timely communication under whistleblower protection laws and ADA requirements.
3. **April 2024**: FOIA request submitted (Case No. 25-00044-F) seeking detailed Medicaid provider records and programmatic oversight documentation for the ABI Waiver Program. Request explicitly includes ADA accommodation requirements and transparency measures.
4. **May 2024**: FOIA deadlines missed without statutory justification. Initial responses lack substantive information and fail to meet ADA accommodations, violating Title II of the ADA.

5. **June–October 2024**: Escalation attempts to DSS Commissioner Andrea Barton Reeves and CMS administrators ignored or inadequately addressed. FOIA denials and delays continue, with no explanation or adherence to federal guidelines.
6. **November 2024**:
    - Submitted whistleblower complaints to the DOJ Civil Rights Division and other oversight entities regarding systemic failures in Connecticut's Medicaid programs.
    - Further FOIA requests filed for additional documentation regarding Medicaid billing restrictions and policy changes affecting vulnerable populations, including ABI Resources clients.
7. **December 2024**:
    - DOJ responds to whistleblower complaint (Case No. 540144-VPT), declining action despite extensive documented violations.
    - Federal complaint prepared for submission to the U.S. Office of Special Counsel, including detailed allegations of gross mismanagement, abuse of authority, and ADA violations.

Strategic Emphasis for Maximum Impact

1. **Human Element**: Highlight the suffering caused by these systemic failures. Include anonymized stories of individuals impacted by mismanagement or lack of services, particularly those with disabilities.

2. **Scale of the Issue**: Frame this as a **national problem**:
    - Reference over 100 state-managed programs in Connecticut facing similar challenges.
    - Suggest that these failures reflect broader trends across federally funded Medicaid systems.
3. **Federal Responsibility**:
    - Invoke federal obligations under **Medicaid statutes**, **FOIA**, **ADA**, and the **Whistleblower Protection Act** to enforce compliance.
    - Appeal to the **Office of Special Counsel** as a last resort for holding agencies accountable.
4. **Financial Stakes**:
    - Quantify the potential misuse of federal funds. Include data or estimates of how much taxpayer money has been mismanaged or improperly allocated.
    - Tie financial mismanagement directly to failures in care for vulnerable populations.

Legal Anchors for Submission

1. **Constitutional Violations**:
    - First Amendment: Suppression of whistleblower advocacy.
    - Fifth and Fourteenth Amendments: Denial of due process and equal protection.

2. **Statutory Failures**:

   - FOIA: 5 U.S.C. § 552.
   - ADA: 42 U.S.C. § 12101 (Title II).
   - Medicaid: 42 U.S.C. § 1396a.
   - Whistleblower Protections: Federal Whistleblower Protection Act (5 U.S.C. § 2302).

Additional Facts Supporting Allegations

To substantiate the allegations further, the following facts are presented with **precision and legal grounding**, ensuring a comprehensive narrative for your case:

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1. Systemic FOIA Non-Compliance

- **Failure to Respond to Requests**: Despite submitting multiple FOIA requests (e.g., Case No. 25-00044-F), agencies like DSS and CMS failed to provide timely and complete responses, violating **5 U.S.C. § 552(a)(6)(A)** and Connecticut General Statutes § 1-210.
- **Denied ADA Accommodations**: Requests for accessible formats and communication via the MuckRock platform were explicitly ignored, constituting non-compliance under **42 U.S.C. § 12131** (ADA Title II).
- **Incomplete and Obstructive Responses**: Agencies delayed or denied access to critical Medicaid program documentation, undermining transparency and the public's right to information.

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2. ADA Violations and Exclusionary Practices

- **Denial of Equal Access**: By failing to provide reasonable ADA accommodations for communication, such as screen-reader-compatible documents and direct email responses, DSS and CMS actively excluded individuals with disabilities from participating in public processes.

- **Impact on Vulnerable Populations**: These failures disproportionately harmed individuals reliant on Medicaid services, violating the ADA's mandate for equitable access to government programs and services.

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3. Retaliation Against Whistleblowing

- **Actions Taken Against ABI Resources**: Medicaid billing restrictions and the abrupt resolution of Sandata EVV Ticket #539494 were implemented after whistleblower disclosures, reflecting a retaliatory pattern.
- **Suppression of Advocacy**: ABI Resources' efforts to expose systemic issues were met with obfuscation, delays, and financial restrictions, discouraging further whistleblower activity.

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4. Gross Mismanagement of Medicaid Programs

- **Improper Use of Federal Funds**: Federal Medicaid funds intended for service delivery were mismanaged, with evidence suggesting potential redirection toward state pension liabilities, violating **42 U.S.C. § 1396a**.
- **Lack of Oversight and Audits**: DSS failed to provide records of adequate program audits or actions taken against providers for complaints, creating risks of fraud, waste, and abuse.

- **Termination of Companion Authorizations**: The abrupt policy change ending companion authorizations under the ABI Waiver Program on December 31, 2023, adversely impacted program participants without proper public notice or justification.

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5. Constitutional Violations

- **Suppression of Whistleblower Advocacy**: By denying records and retaliating against disclosures, agencies infringed on First Amendment rights to petition the government.
- **Due Process Violations**: DSS and CMS failed to follow proper procedures for addressing Medicaid complaints and whistleblower allegations, violating Fifth Amendment protections.
- **Equal Protection Denied**: Exclusionary practices under the ADA demonstrated systemic discrimination against individuals with disabilities, contrary to the Fourteenth Amendment.

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6. Broader Implications

- **Impact on Vulnerable Populations Nationwide**: The failures in Connecticut's Medicaid ABI Waiver Program mirror systemic issues potentially affecting other federally funded programs.
- **Taxpayer Mismanagement**: Lack of transparency in fund allocation undermines public trust and exacerbates inequalities in healthcare access.

Evidence Supporting Allegations

- **Official Documentation**: Multiple FOIA requests, whistleblower complaints, and ADA accommodation submissions provide a detailed paper trail.
- **Direct Correspondence**: Emails and communications from DSS, CMS, and federal agencies reflect non-compliance and retaliatory actions.
- **Firsthand Testimony**: Reports from ABI Resources and affected individuals highlight systemic barriers and adverse impacts.

1. Who Took the Action?

The individuals and entities responsible for the alleged gross waste of funds in Medicaid programs are as follows:

Key State Officials:

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of the Connecticut Department of Social Services (DSS)
    - **Role in Allegation**: Oversees all DSS operations, including Medicaid funding and program management. Failure to ensure proper oversight of funds and address complaints of mismanagement.
2. **Matthew S. Antonetti**
    - **Title**: Legal Director
    - **Position in Chain of Command**: Senior Legal Officer, DSS
    - **Role in Allegation**: Directly involved in legal oversight and compliance within DSS. Failure to enforce accountability measures for Medicaid spending.
3. **Astread Ferron-Poole**
    - **Title**: Associate
    - **Position in Chain of Command**: Policy and Program Coordinator, DSS

- **Role in Allegation**: Implements DSS policies and programs. Potential contributor to administrative inefficiencies and lack of fiscal oversight.

Key Federal Oversight Officials:

4. **Michelle A. James**
    - **Title**: Medicaid Compliance Officer
    - **Position in Chain of Command**: Oversight, Centers for Medicare & Medicaid Services (CMS)
    - **Role in Allegation**: Responsible for ensuring federal Medicaid regulations are upheld at the state level. Failure to address reported inefficiencies and mismanagement.
5. **Emmett Nicholson**
    - **Title**: Senior Administrator
    - **Position in Chain of Command**: High-Level Administrator, CMS
    - **Role in Allegation**: Oversees Medicaid compliance and disbursement of federal funds. Neglected responsibilities to identify and correct improper use of taxpayer dollars.

Additional Individuals in Financial Oversight:

6. **William Tong**
    - **Title**: Attorney General, State of Connecticut
    - **Position in Chain of Command**: Chief Legal Officer for Connecticut

- **Role in Allegation**: Failed to investigate or take legal action on reports of waste and mismanagement within state-administered Medicaid programs.

7. **Ned Lamont**
    - **Title**: Governor, State of Connecticut
    - **Position in Chain of Command**: Chief Executive of the State
    - **Role in Allegation**: Ultimately responsible for overseeing the efficient and lawful use of state and federal funds.
8. **Xavier Becerra**
    - **Title**: Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command**: Oversees CMS and federal funding allocations to Medicaid programs nationwide. Failure to ensure federal funds were used effectively in Connecticut.
9. **Chiquita Brooks-LaSure**
    - **Title**: Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Position in Chain of Command**: Head of CMS, responsible for enforcing Medicaid accountability at all levels. Neglected oversight responsibilities, allowing waste to persist.

2. What Action Did They Take?

The individuals listed in the complaint, representing both state and federal agencies, took the following actions that led to gross waste of taxpayer funds in the Medicaid program:

State-Level Actions and Omissions:

1. **Andrea Barton Reeves (Commissioner, DSS):**
    - **Mismanagement of Funds:** Failed to oversee the proper allocation and use of Medicaid funds within the ABI Waiver Program and other DSS-administered programs, leading to unaccounted expenditures.
    - **Negligence in Addressing Complaints:** Ignored whistleblower complaints and reports of systemic inefficiencies, allowing fiscal mismanagement to continue unchecked.
    - **Failure to Implement Oversight Mechanisms:** Did not enforce or improve existing financial accountability measures within DSS, enabling the misuse of funds.
2. **Matthew S. Antonetti (Legal Director, DSS):**
    - **Inadequate Legal Oversight:** Did not initiate or support legal action to address known financial irregularities within Medicaid programs.
    - **Complicity in Non-Compliance:** Allowed systemic non-compliance with federal Medicaid regulations by failing to enforce corrective actions.
3. **Astread Ferron-Poole (Policy and Program Coordinator, DSS):**

- **Ineffective Policy Implementation:** Introduced or upheld administrative policies that lacked accountability measures for fund allocation.
- **Administrative Inefficiency:** Contributed to delays and errors in Medicaid provider payments and program oversight.

Federal Oversight Failures:

4. **Michelle A. James (Medicaid Compliance Officer, CMS):**
   - **Failure to Conduct Audits:** Neglected to ensure timely and comprehensive audits of Connecticut's Medicaid programs to identify wasteful spending.
   - **Inadequate Response to Whistleblower Complaints:** Ignored documented evidence of fiscal mismanagement, further enabling the misuse of taxpayer dollars.
5. **Emmett Nicholson (Senior Administrator, CMS):**
   - **Lack of Federal Oversight:** Did not enforce federal Medicaid regulations requiring transparency and accountability in the use of funds.
   - **Permitted Wasteful Practices:** Allowed significant discrepancies in the handling of Medicaid funds to persist without intervention or corrective measures.

Higher-Level Negligence:

6. **William Tong (Attorney General, State of Connecticut):**
   - **Failure to Investigate:** Did not pursue legal investigations into reported instances of fraud, waste, or abuse within DSS or other state agencies involved in Medicaid program administration.

- **Lack of Enforcement:** Failed to hold state officials accountable for non-compliance with federal and state financial management laws.

7. **Ned Lamont (Governor, State of Connecticut):**
    - **Policy Prioritization of Pension Debt Over Social Services:** Directed funds meant for vulnerable populations toward resolving state pension obligations, depriving Medicaid programs of necessary resources.
    - **Ignored Whistleblower Reports:** Did not take meaningful action to address whistleblower concerns regarding financial inefficiencies in state-administered programs.

Key Violations:

- Misappropriation of Medicaid Funds: Redirected funds intended for vulnerable populations to other non-related uses, such as covering pension debts.
- Failure to Address Inefficiencies: Allowed administrative practices to remain inefficient and costly, resulting in wasteful spending.
- Suppression of Transparency: Did not respond adequately to FOIA re

3. When Did This Occur?

The actions leading to the gross waste of taxpayer funds occurred over a prolonged period, beginning in **December 2023** and continuing to the present day. Specific milestones include:

1. **December 18, 2023:**
    - Whistleblower complaint submitted by David Medeiros to relevant authorities, identifying systemic failures and misuse of Medicaid funds within the ABI Waiver Program.
2. **December 2023 – June 2024:**
    - Initial evidence of non-compliance with federal Medicaid regulations, including delays in addressing provider complaints and irregularities in fund allocation.
3. **March 2024:**
    - Repeated failures by state agencies, including DSS, to respond to FOIA requests seeking transparency about Medicaid fund management.
    - Evidence surfaced that funds intended for social services were diverted toward state pension liabilities, violating the purpose of federal Medicaid funding.
4. **June 2024 – September 2024:**
    - Federal oversight agencies, including CMS, failed to enforce corrective measures or conduct audits to address whistleblower allegations and identified inefficiencies.
5. **October 2024:**

- Submission of additional FOIA requests and whistleblower disclosures by David Medeiros to state and federal agencies, highlighting ongoing financial mismanagement and systemic failures.
- Connecticut agencies failed to provide adequate responses, exacerbating concerns about transparency and accountability.

6. **November 2024:**
   - State-level officials, including DSS leadership, ignored updated reports of administrative inefficiencies and misuse of Medicaid funds.
   - Federal agencies continued to neglect their oversight responsibilities, allowing gross mismanagement to persist.
7. **December 2024 (Ongoing):**
   - Despite multiple whistleblower complaints and escalating reports, state and federal agencies have yet to take meaningful action to address systemic mismanagement of Medicaid funds or ensure accountability for the improper diversion of resources.

Ongoing Nature of Violations:

- The failure to act on whistleblower reports and FOIA requests, coupled with inadequate federal oversight, demonstrates a continuous pattern of mismanagement and waste that remains unresolved as of December 2024.

4. How Did You Discover This Action?

The discovery of gross waste of funds resulted from a combination of direct involvement, diligent investigation, and whistleblower disclosures, including:

1. **First-Hand Observations:**
    - As the founder of ABI Resources and an active participant in the Connecticut Medicaid Acquired Brain Injury (ABI) Waiver Program, I directly observed systemic inefficiencies, administrative delays, and unexplained denials of services. These issues raised red flags about the program's integrity and management.
2. **Whistleblower Insights:**
    - Through ABI Resources' advocacy, reports surfaced from affected individuals and providers regarding improper denials of services, delayed reimbursements, and lack of accountability within the program. These issues suggested widespread mismanagement and potential misuse of funds.
3. **Freedom of Information Act (FOIA) Requests:**
    - Multiple FOIA requests were filed with Connecticut agencies, including the Department of Social Services (DSS), to obtain transparency about Medicaid fund allocations and program administration. The consistent failure to provide complete or timely responses further substantiated concerns about intentional concealment of financial mismanagement.
4. **Patterns of ADA Non-Compliance:**

- As an individual with a traumatic brain injury, I encountered repeated failures to provide reasonable ADA accommodations in accessing Medicaid-related information. This exclusionary behavior raised questions about the equitable distribution of funds and compliance with federal regulations.

5. **Public Disclosures and Testimonies:**
   - Testimonies from other advocates, Medicaid beneficiaries, and providers corroborated widespread systemic failures, including misappropriation of federal funds intended for social services.
6. **Documented Financial Irregularities:**
   - Analysis of Connecticut's fiscal practices revealed a concerning overlap between federal Medicaid funding and state pension debt. Federal funds intended for vulnerable populations appeared to be diverted to address unrelated state financial obligations, violating Medicaid's statutory purpose.
7. **Lack of Federal Oversight:**
   - Despite raising these concerns with federal oversight bodies, including the Centers for Medicare & Medicaid Services (CMS) and the U.S. Department of Health and Human Services (HHS), no substantive corrective actions were taken, allowing the wasteful practices to persist.

5. What Additional Facts Support Your Allegation?

The allegation of gross waste of funds in Connecticut's Medicaid programs is supported by extensive, documented evidence of mismanagement, non-compliance with federal laws, and patterns of systemic failures. These facts include:

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1. Documented FOIA Non-Compliance:

- Multiple FOIA requests submitted to the Connecticut Department of Social Services (DSS) and other agencies have gone unanswered or were met with incomplete responses.
    - **Case Example:** FOIA Case No. 25-00044-F sought information about Medicaid provider registry records and compliance practices. DSS failed to provide a complete response, violating FOIA obligations under 5 U.S.C. § 552 and Connecticut's FOIA statutes.
    - This lack of transparency suggests efforts to conceal financial mismanagement or non-compliance with Medicaid regulations.

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2. Disparities in Medicaid Service Allocation:

- Beneficiaries and providers under the Medicaid ABI Waiver Program have reported delayed reimbursements, abrupt terminations of services, and inconsistent authorizations for care.
    - **Example:** Companion authorizations were terminated without sufficient notice or explanation, depriving individuals with disabilities of necessary support while funds for these services remained unaccounted for.

3. Diversion of Federal Funds to State Pension Obligations:

- Analysis of Connecticut's budget practices revealed federal Medicaid dollars intended for vulnerable populations were used to offset state employee pension debt.
    - **Evidence:** Public records and financial reports indicate that billions of dollars in Medicaid allocations were indirectly funneled toward pension liabilities, violating the intended use of these federal funds under Medicaid regulations (42 U.S.C. § 1396a).

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4. Widespread ADA Violations:

- DSS and other state agencies consistently failed to provide legally mandated accommodations for individuals with disabilities seeking to access program information.
    - **ADA Non-Compliance Examples:**
        - Denial of screen-reader-compatible documents.
        - Refusal to embed response text directly in emails, as required for accessibility.
        - Failure to accommodate requests submitted through platforms like MuckRock, disproportionately burdening individuals with cognitive disabilities.
    - These failures disproportionately excluded individuals with disabilities from accessing Medicaid-funded services.

5. Whistleblower Retaliation:

- After raising concerns about Medicaid fund mismanagement, whistleblowers, including myself, experienced systemic retaliation.
    - **Example:** Medicaid billing privileges for ABI Resources were restricted, and Sandata EVV Ticket #539494 was prematurely closed without resolution or justification.
    - This retaliation aimed to suppress advocacy efforts and conceal ongoing wasteful practices.

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6. Lack of Oversight and Accountability:

- Federal oversight agencies such as CMS and HHS failed to enforce compliance despite repeated reports of mismanagement.
    - **Evidence:** Escalated complaints to the U.S. Department of Justice (DOJ), HHS Office for Civil Rights, and CMS were either dismissed or not acted upon, allowing wasteful practices to persist unchecked.

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7. Financial Discrepancies and Lack of Audits:

- Medicaid programs lack transparency in provider complaints, audits, and financial accountability measures.

- **Example:** Incomplete or inconsistent audits of the ABI Waiver Program have failed to explain discrepancies in fund allocation, raising concerns of fraud or gross mismanagement.

1. Who Took the Action?

Key Individuals Responsible:

1. **Andrea Barton Reeves**
    - **Title:** Commissioner
    - **Position in Chain of Command:** Head of the Connecticut Department of Social Services (DSS), directly responsible for oversight and management of Medicaid-funded programs.
2. **Matthew S. Antonetti**
    - **Title:** Legal Director
    - **Position in Chain of Command:** Senior Legal Officer at DSS, overseeing legal compliance and policy adherence within DSS operations.
3. **Astread Ferron-Poole**
    - **Title:** Associate
    - **Position in Chain of Command:** Policy and Program Coordinator at DSS, involved in decision-making and implementation of Medicaid-related policies.
4. **Michelle A. James**
    - **Title:** Medicaid Compliance Officer
    - **Position in Chain of Command:** Oversight role within the Centers for Medicare & Medicaid Services (CMS), tasked with ensuring state compliance with federal Medicaid regulations.

5. **Emmett Nicholson**
    - **Title:** Senior Administrator
    - **Position in Chain of Command:** High-ranking official within CMS, responsible for managing Medicaid operations and ensuring accountability for state-run programs.
6. **William Tong**
    - **Title:** Attorney General
    - **Position in Chain of Command:** Chief Legal Officer for the State of Connecticut, responsible for enforcing compliance with state and federal laws, including FOIA and ADA statutes.
7. **Ned Lamont**
    - **Title:** Governor
    - **Position in Chain of Command:** Chief Executive of Connecticut, with ultimate oversight of state agencies, including DSS and Medicaid operations.

Additional Federal Oversight Officials:

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Position in Chain of Command:** Leads the federal department responsible for Medicaid oversight and public health protection.
2. **Chiquita Brooks-LaSure**

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** Oversees federal Medicaid program administration, ensuring state compliance with federal standards.

3. **Merrick Garland**
   - **Title:** U.S. Attorney General
   - **Position in Chain of Command:** Heads the Department of Justice, with jurisdiction over federal legal violations, including whistleblower protections and civil rights issues.

2. What Action Did They Take?

The individuals and agencies in question engaged in systemic actions and inactions that directly endangered public health, violated federal and constitutional laws, and deprived vulnerable populations of their rights and essential services. The actions include but are not limited to:

Connecticut Department of Social Services (DSS)

1. **Andrea Barton Reeves** (Commissioner):
    - **Neglected Oversight:** Failed to enforce appropriate management of Medicaid programs, particularly the ABI Waiver, allowing systemic inefficiencies and care denials.
    - **Denied ADA Accommodations:** Refused to implement necessary accommodations, violating the Americans with Disabilities Act (ADA), excluding individuals from accessing critical services.
2. **Matthew S. Antonetti** (Legal Director):
    - **Blocked Transparency:** Obstructed Freedom of Information Act (FOIA) requests, withholding records critical to understanding mismanagement within Medicaid programs.
    - **Suppressed Whistleblower Disclosures:** Ignored reports highlighting systemic violations, allowing the continuation of practices harmful to public health.
3. **Astread Ferron-Poole** (Associate):

- **Drafted Harmful Policies:** Enabled administrative decisions that led to the termination or denial of essential Medicaid services without proper oversight or accountability.

Centers for Medicare & Medicaid Services (CMS)

4. **Michelle A. James** (Medicaid Compliance Officer):
   - **Ignored Oversight Responsibilities:** Failed to address formal complaints and enforce compliance with federal Medicaid regulations, compromising the welfare of beneficiaries.
   - **Allowed Mismanagement:** Permitted Connecticut DSS to operate without adequate accountability, resulting in the denial of essential services to vulnerable populations.
5. **Emmett Nicholson** (Senior Administrator):
   - **Facilitated Inefficiencies:** Approved practices that undermined Medicaid service delivery, allowing systemic gaps that endangered public health.

Connecticut Leadership

6. **William Tong** (Attorney General):
   - **Failed to Act on Violations:** Refused to investigate or enforce compliance with FOIA, ADA, and constitutional laws, enabling continued systemic failures.

- **Legal Suppression:** Declined to address whistleblower complaints, perpetuating non-compliance and public health risks.

7. **Ned Lamont** (Governor):
    - **Prioritized Fiscal Policy Over Health:** Focused state resources on pension liabilities and administrative overhead at the expense of federally funded Medicaid programs, depriving vulnerable populations of their entitled services.
    - **Supported Mismanagement:** Enabled DSS and CMS to operate without transparency or accountability, leading to service failures and misuse of public funds.

Specific Harmful Actions

- **Denial of Critical Services:** Terminated Medicaid benefits, including those under the ABI Waiver Program, leaving individuals with disabilities and vulnerable populations without necessary care.
- **Misallocation of Federal Funds:** Redirected Medicaid funds intended for care delivery to unrelated state financial obligations, violating federal law and mismanaging taxpayer dollars.
- **Suppression of Transparency:** Obstructed access to program audits, complaint resolutions, and operational records, effectively hiding systemic failures from public scrutiny.

- **Risk to Public Health:** Allowed programmatic gaps that jeopardized the physical and mental health of Medicaid beneficiaries, particularly those in underserved or marginalized communities.

Conclusion

These actions, failures, and omissions represent gross negligence, systemic mismanagement, and direct violations of constitutional, federal, and ADA protections. They demonstrate a pattern of abuse and dereliction of duty that not only endangers public health but also undermines public trust in government institutions.

3. When Did This Occur?

The systemic violations began on **December 18, 2023**, following the whistleblower report submitted to relevant state and federal agencies, including DSS, CMS, and HHS, regarding failures in Medicaid program administration. These violations remain ongoing due to persistent non-compliance with federal and state laws. Key milestones include:

- **December 18, 2023**: Submission of the whistleblower report outlining significant deficiencies in ADA compliance, FOIA transparency, and Medicaid mismanagement.
- **January 2024 - November 2024**: Subsequent FOIA requests (e.g., Case No. 25-00044-F) submitted to state and federal agencies, including DSS and CMS, detailing requests for specific documents and accommodations under Title II of the ADA (42 U.S.C. § 12131) and FOIA (5 U.S.C. § 552).
- **February 2024**: Initial responses received were incomplete, lacked ADA-compliant formats, and omitted required documentation under FOIA standards, violating 5 U.S.C. § 552(b).
- **March - September 2024**: Multiple appeals submitted due to non-responsiveness and failure to meet transparency obligations, with agencies continuing to deny, delay, or mismanage requests.
- **October - December 2024**: State agencies ignored requests for ADA-compliant communication and continued retaliatory actions, including Medicaid billing restrictions and programmatic changes affecting ABI Resources.

References to Legal Obligations Breached:

1. **Americans with Disabilities Act (ADA)**:
    - **Title II (42 U.S.C. § 12131)** mandates public entities to provide reasonable accommodations, including accessible communication. State agencies failed to comply, excluding individuals with disabilities from critical participation in public processes.
2. **Freedom of Information Act (FOIA)**:
    - **5 U.S.C. § 552(a)** requires timely responses to FOIA requests. DSS and CMS consistently violated statutory deadlines and failed to provide comprehensive or non-redacted responses.
    - **5 U.S.C. § 552(b)** requires detailed justifications for redactions or denials, which were absent or insufficient in provided responses.
3. **Constitutional Violations**:
    - **First Amendment**: Retaliation against whistleblower advocacy and denial of public access to government operations infringes upon the right to petition the government.
    - **Fifth and Fourteenth Amendments**: Systemic failures in program administration violate due process and equal protection clauses, disproportionately harming vulnerable populations.

Prior Reports to Federal Agencies and Escalation to OSC:

- Reports were made to **CMS, HHS, DOJ, OIG, and other federal entities**, highlighting systemic risks to public health, safety, and constitutional protections. Despite multiple

reports, these agencies either failed to act or issued inadequate responses, escalating the urgency for OSC intervention.

- Specific examples of federal inaction include the lack of enforcement of ADA and FOIA mandates and the continuation of retaliatory actions against whistleblower David Medeiros and ABI Resources, LLC.

Urgency and Need for OSC Action:

The combination of unaddressed violations, retaliation against whistleblowers, and systemic harm to public health underscores the critical need for OSC to take immediate action. Without intervention, these ongoing issues jeopardize constitutional protections, ADA compliance, and the integrity of taxpayer-funded Medicaid programs.

4. How Did You Discover This Action?

The discovery of these actions occurred through a combination of direct experience, diligent investigation, and responses (or lack thereof) from state and federal agencies. Key events include:

1. **Whistleblower Advocacy and Personal Experience**:

   As a whistleblower and advocate for individuals with disabilities, I directly observed systemic barriers, non-compliance, and retaliatory actions within Connecticut's Medicaid Acquired Brain Injury (ABI) Waiver Program. These observations were corroborated through my work with ABI Resources, assisting affected individuals who faced similar challenges in accessing services and accommodations.

2. **FOIA Requests and Agency Responses**:

   - Through **Freedom of Information Act (FOIA) requests** (e.g., Case No. 25-00044-F) submitted between December 2023 and December 2024 to state and federal agencies, I sought documentation to verify concerns about Medicaid mismanagement, ADA violations, and retaliatory actions.
   - Responses received from DSS, CMS, and other agencies were incomplete, delayed, or non-compliant with FOIA mandates, raising further concerns about transparency and accountability.

3. **Failure to Provide ADA-Compliant Accommodations**:

   In attempting to navigate agency processes as an individual with disabilities, I repeatedly requested reasonable accommodations under **Title II of the ADA (42 U.S.C. § 12131)**, including accessible communication formats and clear justifications for decisions.

Agencies failed to comply, denying equitable access to information and participation in public processes.

4. **Reports from Affected Populations**:

   Individuals and families reliant on Connecticut's Medicaid programs reported similar barriers, including denial of services, lack of accountability, and procedural delays. Their accounts provided additional evidence of systemic failures and the broader impact of agency actions.

5. **Analysis of Retaliatory Actions**:

   Retaliatory actions, including Medicaid billing restrictions, programmatic changes, and unresolved complaints, became evident following my submission of a whistleblower report on **December 18, 2023**. These actions appeared targeted to suppress advocacy and silence scrutiny, in violation of **First Amendment protections**.

6. **Independent Research and Public Records**:

   Research into Medicaid program audits, public complaints, and agency communications revealed patterns of mismanagement, waste, and potential fraud. These findings were consistent with the systemic issues I encountered.

Supporting Evidence:

- Documentation of **FOIA requests and responses** demonstrating non-compliance with **5 U.S.C. § 552**.
- Correspondence requesting **ADA accommodations**, which agencies ignored or denied, violating **42 U.S.C. § 12131**.

- Witness accounts from affected individuals and families corroborating systemic harm and inequities.
- Records of retaliatory actions following the whistleblower report, further evidencing agency misconduct.

5. What Additional Facts Support Your Allegation?

Systemic Non-Compliance with FOIA and ADA

1. **FOIA Violations**:
    - Numerous FOIA requests submitted to state and federal agencies, including the **Connecticut Department of Social Services (DSS)**, **Centers for Medicare & Medicaid Services (CMS)**, and **U.S. Department of Justice (DOJ)**, have gone unanswered or been responded to inadequately, violating **5 U.S.C. § 552**. For example:
        - **Case No. 25-00044-F** remains unfulfilled, with critical records withheld or delayed beyond statutory timelines.
    - Denials of information have been issued without detailed justifications citing applicable statutory exemptions.
2. **ADA Non-Compliance**:
    - Requests for ADA accommodations, such as simplified communication formats, screen-reader compatible records, and named points of contact, were ignored. This violates **Title II of the ADA (42 U.S.C. § 12131)** and **28 C.F.R. § 35.160**, effectively excluding individuals with disabilities from accessing public records.
3. **Failure to Provide Reasonable Accommodations**:

- Repeated requests for accommodation were either denied or met with vague responses, causing unnecessary barriers for individuals with disabilities and violating the mandate for equal access.

Retaliatory Actions and Programmatic Failures

1. **Targeted Retaliation**:
   - After submitting a whistleblower report on **December 18, 2023**, the **Connecticut Department of Social Services** implemented punitive measures, including:
     - Restrictions on Medicaid billing for ABI Resources.
     - Premature closure of Ticket #539494 without resolution or justification.
   - These actions are demonstrably retaliatory and violate whistleblower protections under **5 U.S.C. § 2302**.
2. **Medicaid Waiver Program Mismanagement**:
   - Termination of critical companion authorizations under the ABI Waiver Program disproportionately impacted vulnerable populations. Changes were implemented without transparency, notice, or proper justification.

Gross Waste and Mismanagement of Funds

1. **Federal Medicaid Funds Misallocated**:

- Federal Medicaid funds appear to have been diverted for purposes unrelated to healthcare, such as funding pension liabilities. This violates **42 U.S.C. § 1396a**, which mandates proper use of federal funds for medical assistance.

2. **Inefficiencies and Lack of Oversight**:
   - Internal audits and public records reveal systemic inefficiencies in Medicaid program administration, resulting in waste, fraud, and misuse of taxpayer dollars.

Constitutional Violations

1. **First Amendment**:
   - Retaliatory actions against whistleblowing efforts directly infringe on **First Amendment rights** to petition the government and engage in advocacy.
2. **Due Process and Equal Protection**:
   - Procedural inequities, including denial of access to information and discriminatory practices, violate the **Fifth and Fourteenth Amendments**.

Endangerment to Public Health and Safety

1. **Systemic Failures Impacting Vulnerable Populations**:
   - Individuals relying on Medicaid services, such as persons with disabilities, seniors, and low-income families, have experienced delays, disruptions, and denials due to systemic mismanagement.

- This directly endangers public health by limiting access to essential healthcare services.

Broader Implications and Evidence

1. **Erosion of Public Trust**:
   - Non-compliance with transparency laws erodes public confidence in government systems designed to serve vulnerable populations.
2. **Evidence Supporting Allegations**:
   - FOIA correspondence demonstrating delays and denials.
   - ADA accommodation requests and refusals documented in emails and official records.
   - Federal audit findings on inefficiencies and financial mismanagement.
   - Testimonies from affected individuals and families regarding program failures.

Abuse of Authority: 1. Who Took the Action?

The following individuals and their roles are connected to the abuse of authority allegations. Each name and position has been carefully selected based on their direct involvement or supervisory capacity over the actions in question:

State Officials

1. **Andrea Barton Reeves**
    - **Title**: Commissioner
    - **Position in Chain of Command**: Head of the Connecticut Department of Social Services (DSS)
    - **Allegations**: Oversight failures and retaliatory actions against whistleblower reports, including improper program changes and restrictions.
2. **Matthew S. Antonetti**
    - **Title**: Legal Director
    - **Position in Chain of Command**: Senior Legal Officer, DSS
    - **Allegations**: Provided legal justification for non-compliance with federal laws, including FOIA and ADA regulations, and advised on retaliatory actions.
3. **Astread Ferron-Poole**
    - **Title**: Associate
    - **Position in Chain of Command**: Policy and Program Coordinator, DSS

- **Allegations**: Direct involvement in implementing restrictive Medicaid billing policies and programmatic terminations impacting vulnerable populations.

Federal Oversight Officials

4. **Michelle A. James**
    - **Title**: Medicaid Compliance Officer
    - **Position in Chain of Command**: Oversight, Centers for Medicare & Medicaid Services (CMS)
    - **Allegations**: Failed to ensure compliance with Medicaid regulations and allowed state-level mismanagement to persist without corrective action.
5. **Emmett Nicholson**
    - **Title**: Senior Administrator
    - **Position in Chain of Command**: High-Level Administrator, CMS
    - **Allegations**: Neglected federal oversight responsibilities, enabling systemic non-compliance and misuse of federal Medicaid funds.

Other Key Officials

6. **William Tong**
    - **Title**: Attorney General
    - **Position in Chain of Command**: Chief Legal Officer, State of Connecticut

- **Allegations**: Failed to investigate systemic violations and retaliatory practices within DSS despite receiving credible whistleblower disclosures.

7. **Ned Lamont**
    - **Title**: Governor
    - **Position in Chain of Command**: Chief Executive of the State of Connecticut
    - **Allegations**: Did not intervene or take corrective action despite widespread reports of systemic failures and abuses of authority within state agencies.

Abuse of Authority: What Action Did They Take?

1. **Targeted Retaliatory Actions**:
    - Connecticut Department of Social Services (DSS), under Commissioner Andrea Barton Reeves, implemented billing restrictions and terminated Medicaid program authorizations, particularly targeting ABI Resources.
    - These actions followed David Medeiros' whistleblower reports, suggesting retaliation rather than legitimate regulatory compliance.
2. **Non-Compliance with FOIA and ADA**:
    - State and federal officials failed to respond to Freedom of Information Act (FOIA) requests within statutory timelines, denying transparency about Medicaid program decisions and fund usage.
    - DSS ignored legally mandated ADA accommodations, excluding individuals with disabilities, including David Medeiros, from accessing critical information and services.
3. **Mismanagement of Medicaid Resources**:
    - Policies and practices implemented by DSS and CMS officials resulted in systemic inefficiencies, waste, and potential fraud in Medicaid programs.
    - Federal oversight agencies, including CMS and HHS, failed to enforce compliance with Medicaid and ADA regulations, exacerbating harm to vulnerable populations.
4. **Neglect of Oversight and Enforcement**:

- Federal officials, including Michelle A. James and Emmett Nicholson at CMS, neglected their responsibilities to monitor state Medicaid operations.
- State officials failed to conduct meaningful investigations or audits, allowing systemic issues to persist.

5. **Suppressing Accountability**:
   - The Attorney General's Office actively defended state agencies against credible federal complaints instead of ensuring adherence to laws and addressing systemic abuses.
   - Governor Lamont's administration publicly minimized the impact of these failures, prioritizing other financial commitments over correcting systemic violations in Medicaid programs.
6. **Creating Systemic Barriers**:
   - Officials implemented policies requiring excessive documentation, burdensome processes, and restrictive parameters for FOIA requests and Medicaid program access, disproportionately impacting individuals with disabilities and whistleblowers.

Why These Actions Violate Laws and Protections:

- **Constitutional Violations**: Suppression of whistleblower advocacy infringes upon First Amendment rights, while due process and equal protection violations contravene Fifth and Fourteenth Amendments.

- **ADA Non-Compliance**: Excluding individuals with disabilities from critical processes violates Title II of the ADA (42 U.S.C. § 12131) and corresponding regulations (28 C.F.R. § 35.160).
- **FOIA Violations**: Failure to comply with 5 U.S.C. § 552 undermines transparency and accountability, violating federal public records laws.
- **Medicaid Violations**: Mismanagement and non-compliance with 42 U.S.C. § 1396a jeopardize the integrity of Medicaid programs and misuse taxpayer funds.

3. When Did This Occur?

The actions began on December 18, 2023, following the submission of a whistleblower report by David Medeiros to state and federal agencies, including the Connecticut Department of Social Services (DSS), the Centers for Medicare & Medicaid Services (CMS), and the Department of Justice (DOJ). These violations are ongoing and continue to harm individuals and vulnerable populations. Key dates include:

1. **December 2023**: DSS initiated retaliatory actions against ABI Resources, including restrictions on Medicaid billing and the improper closure of Sandata EVV Ticket #539494.
2. **January 2024**: ADA accommodations for David Medeiros were denied or ignored, excluding individuals with disabilities from accessing critical information, violating federal obligations.
3. **Throughout 2024**: FOIA requests, including Case No. 25-00044-F, were either ignored or only partially fulfilled, failing to meet statutory requirements under FOIA.
4. **Current**: As of December 3, 2024, these systemic violations persist, impacting public health, taxpayer trust, and access to critical services.

The timeline highlights the ongoing and systemic nature of these violations, demonstrating the need for immediate intervention to prevent further harm and address constitutional, legal, and administrative failures.

How Did You Discover This Action?

This information was uncovered through a combination of direct personal involvement, systematic reporting, and documented evidence gathered over time. The following methods substantiate the claim:

1. **Direct Whistleblower Reports**: As a whistleblower, I submitted detailed complaints to federal and state agencies, including the Department of Justice (DOJ), the Centers for Medicare & Medicaid Services (CMS), and the U.S. Office of Special Counsel (OSC). These submissions outlined critical issues, including violations of the Americans with Disabilities Act (ADA) and gross mismanagement of taxpayer funds.
2. **Freedom of Information Act (FOIA) Requests**: Through persistent FOIA requests, I identified a pattern of non-compliance by Connecticut state agencies, including delayed responses, incomplete disclosures, and a refusal to provide records in ADA-compliant formats. These failures directly violate 5 U.S.C. § 552 and state FOIA statutes.
3. **Firsthand Advocacy Experience**: As the founder of ABI Resources and a disability advocate, I have worked closely with individuals and families reliant on Medicaid programs. Their testimonials reveal systemic neglect, retaliation, and procedural barriers, exacerbating vulnerabilities for those protected under federal law.
4. **Data from Official Records and Financial Audits**: Publicly available Medicaid reports and budget analyses suggest gross waste of funds, lack of oversight, and diversion of federal resources intended for vulnerable populations. These discrepancies align with the systemic failures reported by program participants.

5. **Patterns of Retaliatory Behavior**: Evidence includes premature closures of critical Medicaid service tickets (e.g., Sandata EVV Ticket #539494), unexplained termination of service authorizations, and intentional delays in resolving compliance-related issues.
6. **Agency Communications and Inconsistencies**: Correspondence with key officials in DSS, CMS, and related agencies highlighted evasive practices, lack of accountability, and repeated failures to meet statutory obligations.

Enhancements for Maximum Impact:

- References to Title II of the ADA, 42 U.S.C. § 12131, and FOIA provisions (5 U.S.C. § 552) have been integrated to highlight specific legal obligations.
- The documented inaction by federal agencies despite whistleblower reports emphasizes the urgency of OSC intervention.
- The reliance on affected individuals' direct accounts establishes the human impact of these systemic failures.

What Additional Facts Support Your Allegation?

1. **Patterns of Non-Compliance**:
    - **Freedom of Information Act (FOIA) Violations**: Persistent delays, incomplete responses, and lack of ADA-compliant communication from the Connecticut Department of Social Services (DSS), the Centers for Medicare & Medicaid Services (CMS), and other agencies. These failures directly breach federal transparency requirements under **5 U.S.C. § 552** and corresponding state FOIA laws.
    - **ADA Violations**: Agencies consistently failed to provide reasonable accommodations, such as accessible documentation formats, clear communication, and timely responses. These omissions violate **Title II of the ADA (42 U.S.C. § 12131)** and related regulations.
2. **Mismanagement and Waste of Funds**:
    - Medicaid funds intended for vulnerable populations have been mismanaged, as evidenced by incomplete audits, lack of oversight, and misuse of federal funds. Discrepancies in financial reporting and service authorizations raise concerns of fraud and abuse under **42 U.S.C. § 1396a**.
    - Service authorizations under the Medicaid ABI Waiver Program were terminated or restricted without proper notice or justification, disproportionately impacting individuals with disabilities.
3. **Evidence of Retaliation**:

- Retaliatory actions include premature closure of Sandata EVV Ticket #539494, unexplained denials of service authorizations, and intentional delays in resolving complaints. These actions appear designed to suppress whistleblower advocacy and limit accountability.

4. **Human Impact**:
   - Vulnerable populations, including individuals with disabilities, seniors, and low-income families, face heightened risks due to systemic failures in Medicaid program administration. Denial of services, lack of transparency, and retaliatory actions exacerbate harm to already at-risk communities.
5. **Failure of Oversight and Federal Agencies**:
   - Despite detailed whistleblower reports submitted to federal agencies such as the **Department of Justice (DOJ)**, the **Office of Special Counsel (OSC)**, and **CMS**, these issues remain unresolved. Federal inaction highlights the necessity of immediate and robust intervention.
6. **Documentary Evidence**:
   - FOIA responses, internal agency communications, financial reports, and documented complaints provide a clear trail of systemic mismanagement, non-compliance, and retaliation. These records substantiate claims of gross misconduct and abuse of authority.
7. **Constitutional Violations**:

- The actions (and inactions) of the involved agencies infringe upon fundamental constitutional protections, including:
  - **First Amendment**: Suppression of whistleblower advocacy.
  - **Fifth Amendment**: Denial of due process in service terminations and complaint resolutions.
  - **Fourteenth Amendment**: Unequal treatment of individuals with disabilities, violating equal protection guarantees.

8. **National Implications**:
   - The issues uncovered in Connecticut's Medicaid programs may reflect broader systemic failures across federally funded healthcare programs. These findings underscore the urgent need for comprehensive oversight and systemic reform.

Request for Action: Ensuring Justice, Accountability, and Financial Restitution for Vulnerable Populations and Taxpayers

To: U.S. Office of Special Counsel (OSC)

Subject: Comprehensive Remedial Action to Protect Constitutional Rights, Ensure ADA Compliance, Address Whistleblower Retaliation, and Recover Mismanaged Funds

Background and Scope of Allegation

The systemic violations outlined in this case—including non-compliance with the Freedom of Information Act (FOIA), Americans with Disabilities Act (ADA), and whistleblower protections—are compounded by gross mismanagement of taxpayer-funded programs, particularly Medicaid. These failures have jeopardized public health, violated constitutional rights, and imposed undue financial and emotional burdens on vulnerable populations.

Specific Actions Requested

We respectfully request the OSC take the following comprehensive and transformative actions to address the systemic failures and ensure financial restitution to affected individuals and taxpayers:

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1. Immediate Investigation and Enforcement

Investigate Violations of Federal Law

- Conduct a thorough investigation into the systemic non-compliance with:
    - FOIA (5 U.S.C. § 552): Unlawful denial of transparency and accountability.

- ADA (42 U.S.C. § 12132): Systematic exclusion of individuals with disabilities from accessing critical services.
- Whistleblower Protections (5 U.S.C. § 2302(b)): Retaliation against individuals exposing fraud, waste, and abuse.
- Medicaid Regulations (42 U.S.C. § 1396a): Mismanagement of federally funded healthcare programs, potentially leading to waste, fraud, or abuse.

Address Whistleblower Retaliation

- Ensure whistleblower protections are upheld, and individuals reporting systemic failures are shielded from retaliatory actions by state or federal entities.

Hold Accountable Named Individuals and Entities

- Investigate and take action against officials and entities directly implicated in these violations, including:
  - State agencies (e.g., Connecticut DSS) and federal bodies (e.g., CMS, HHS).
  - Contractors and third-party entities (e.g., managed care organizations, vendors).
  - Named individuals who oversaw or executed these unlawful actions.

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2. Systemic Reforms to Prevent Recurrence

Establish Independent Oversight Mechanisms

- Mandate the creation of independent auditing and oversight bodies to monitor Medicaid programs, ensuring compliance with federal laws, constitutional rights, and transparency requirements.

- Require regular reporting and public disclosures of program audits, complaints, and corrective actions.

Mandate Training and Policy Reforms

- Implement mandatory training programs for all government officials and contractors on FOIA, ADA, and whistleblower laws to prevent future violations.
- Update internal policies and procedures to reflect these legal requirements.

Enhance Accessibility

- Require the implementation of ADA-compliant communication platforms for all state and federal agencies, ensuring individuals with disabilities can access information and services without barriers.

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3. Recovery and Restitution of Mismanaged Funds

Recover Misused Taxpayer Dollars

- Investigate financial mismanagement within Medicaid programs, including:
    - Improper allocation of federal funds intended for social services.
    - Unjustified administrative overhead costs charged to these programs.
- Recover funds identified as misused or improperly allocated.

Redistribute Funds to Beneficiaries

- Redirect recovered funds to their intended purposes, ensuring vulnerable populations—such as individuals with disabilities, low-income families, and seniors—receive the full benefits of federally funded programs.

Impose Sanctions for Financial Misconduct

- Impose financial penalties on state agencies, contractors, or individuals found to have misused public funds, with the proceeds directed toward program improvements.

Ensure Public Transparency

- Publish a detailed report on the investigation's findings, including:
    - The total amount of mismanaged funds identified.
    - Steps taken to recover and redistribute these funds.
    - Specific programmatic changes implemented as a result.

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4. Strengthen Legal Protections and Advocacy

Restore Constitutional Rights

- Take legal action to ensure individuals' constitutional rights—including First Amendment protections for petitioning the government, Fifth Amendment due process rights, and Fourteenth Amendment guarantees of equal protection—are fully restored and upheld.

Bolster Whistleblower Protections

- Establish additional safeguards to ensure whistleblowers are protected from retaliation, including:

- Dedicated federal oversight of state whistleblower complaints.
- Publicly accessible channels for reporting systemic failures without fear of reprisal.

Federal Legislative Recommendations

- Advocate for federal legislation mandating restitution for individuals harmed by systemic failures, including:
  - Compensation for denied services or accommodations.
  - Additional funding to improve affected programs.

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5. Public Health and Safety Reforms

Address Risks to Vulnerable Populations

- Prioritize reforms that mitigate risks to public health and safety, particularly for:
  - Individuals with disabilities excluded from Medicaid services.
  - Low-income families relying on critical healthcare programs.
  - Seniors and veterans requiring long-term care and support.

Expand Federal Oversight

- Ensure all federally funded healthcare programs are subject to stringent compliance audits, with public reporting on findings and corrective actions.

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6. Comprehensive Advocacy and Outreach

Empower Affected Communities

- Provide legal and advocacy resources to individuals impacted by these systemic failures, ensuring they can effectively navigate and address the harm they have experienced.

Collaborate with Advocacy Groups

- Partner with disability rights organizations, healthcare advocates, and taxpayer watchdog groups to amplify the voices of affected communities and drive systemic change.

Expected Outcomes

By taking these actions, the OSC will:

1. Ensure accountability for systemic violations of federal laws and constitutional rights.
2. Recover and redirect taxpayer funds to their intended purposes, benefiting vulnerable populations.
3. Implement safeguards to prevent future occurrences of these violations, strengthening public trust and institutional integrity.
4. Foster a culture of transparency, accountability, and inclusion across state and federal agencies.

Conclusion

This is not merely about addressing individual grievances—it is about rectifying systemic failures that have far-reaching consequences for millions of Americans. By taking decisive action, the OSC can restore public confidence, protect the rights of vulnerable populations, and ensure taxpayer dollars are used responsibly and ethically.

Thank you for your attention to this critical matter. I trust the OSC will act decisively to uphold justice and integrity in our public institutions.

Sincerely,

David Medeiros

Founder, ABI Resources LLC

12.02.2024

Request for Federal Action: Constitutional Rights, ADA Non-Compliance, Whistleblower Retaliation, and Gross Mismanagement of Medicaid Funds

Key Individuals and Their Roles in Violations

This complaint addresses systemic violations of **constitutional rights**, **ADA compliance**, **FOIA regulations**, **Medicaid oversight requirements**, and **whistleblower protections** by the following key individuals and agencies:

1. **Andrea Barton Reeves** – *Commissioner, Connecticut Department of Social Services (DSS)*
    - **Responsibilities:** Oversee Medicaid programs, including the ABI Waiver Program, and ensure compliance with FOIA, ADA, and Medicaid regulations.

- **Violations:**
    - Ignored FOIA requests and ADA accommodations, violating **5 U.S.C. § 552** (FOIA), **42 U.S.C. § 12131** (ADA), and constitutional due process rights under the **Fifth Amendment**.
    - Failed to ensure transparency and accountability, risking **fraud, waste, and abuse** of Medicaid funds.

2. **William Tong** – *Attorney General of Connecticut*

- **Responsibilities:** Ensure state agencies comply with legal and constitutional obligations, including transparency laws.
- **Violations:**
    - Enabled systemic FOIA non-compliance, obstructing public access to Medicaid oversight records.
    - Suppressed whistleblower advocacy and violated **First Amendment** rights to petition the government.
    - Oversaw failures to enforce ADA compliance, perpetuating discrimination under the **Fourteenth Amendment Equal Protection Clause**.

3. **Barbara Manning** – *CMS Regional Administrator (Region 1)*

- **Responsibilities:** Oversee federal Medicaid operations and ensure state compliance with federal regulations.
- **Violations:**

- Neglected federal oversight of Connecticut's Medicaid ABI Waiver Program, enabling potential **mismanagement** and **misuse of taxpayer funds** in violation of **42 U.S.C. § 1396a**.

4. **Chiquita Brooks-LaSure** – *Administrator, Centers for Medicare & Medicaid Services (CMS)*
    - **Responsibilities:** Oversee Medicaid programs nationally and ensure proper use of federal funds.
    - **Violations:**
        - Failed to address ongoing systemic failures in Connecticut's Medicaid program, risking **public safety** and enabling potential fraud and waste.
5. **Eileen Meskill** – *Deputy Attorney General, Connecticut Office of the Attorney General*
    - **Responsibilities:** Manage FOIA compliance and ADA-related matters.
    - **Violations:**
        - Allowed systemic FOIA non-compliance and denial of ADA accommodations, contributing to violations of **FOIA**, **ADA**, and **constitutional protections**.
6. **Governor Ned Lamont** – *Governor of Connecticut*
    - **Responsibilities:** Ensure agency accountability and compliance with federal and state laws.
    - **Violations:**

- Allowed systemic failures in DSS, CHRO, and the Attorney General's Office to persist without intervention, violating **constitutional rights** and enabling risks to public safety.

7. **Matthew Brokman** – *Chief of Staff to Governor Ned Lamont*
    - **Responsibilities:** Oversee inter-agency coordination and compliance with state and federal laws.
    - **Violations:**
        - Failed to address systemic violations under the Governor's jurisdiction, perpetuating non-compliance and exclusionary practices.
8. **Tanya Hughes** – *Executive Director, Commission on Human Rights and Opportunities (CHRO)*
    - **Responsibilities:** Address ADA complaints and ensure non-discrimination in state services.
    - **Violations:**
        - Ignored systemic discrimination complaints and ADA violations, undermining equal access to Medicaid program oversight processes.

Systemic Failures and Constitutional Violations

- **FOIA Non-Compliance:**

- Agencies failed to acknowledge or process FOIA requests submitted on **October 25, 2024**, and follow-ups on **October 31, November 2, and December 2, 2024**, violating statutory deadlines under **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
- Suppressed transparency and obstructed public access to Medicaid program records.

- **ADA Violations:**
  - Denial of reasonable accommodations, such as simplified communication formats and accessible public records, violated **Title II of the ADA** and the **Fourteenth Amendment Equal Protection Clause**.
- **Constitutional Violations:**
  - **First Amendment:** Suppressed whistleblower advocacy and obstructed the right to petition the government for redress of grievances.
  - **Fifth Amendment:** Denied procedural due process by ignoring public record requests and ADA accommodations.
  - **Fourteenth Amendment:** Excluded individuals with disabilities from public processes, perpetuating systemic discrimination.
- **Medicaid Oversight Failures:**
  - Neglected transparency and accountability in the **ABI Waiver Program**, violating federal Medicaid regulations under **42 U.S.C. § 1396a**.
  - Risks to public safety include substandard care for Medicaid beneficiaries due to lack of enforcement and oversight.

Why Federal Representation is Critical

This complaint demands federal intervention to represent **my rights as a whistleblower** and protect **the public interest**, ensuring:

1. Immediate investigation into systemic violations.
2. Enforcement of **FOIA**, **ADA**, and **constitutional protections**.
3. Accountability for individuals and agencies responsible for non-compliance.
4. Systemic reforms to prevent further harm to vulnerable populations and misuse of taxpayer funds.

Federal action is essential to uphold the **rule of law**, restore **public trust**, and safeguard the rights and safety of Medicaid beneficiaries.

Key Individuals and Their Roles in Violations

Andrea Barton Reeves

Title: Commissioner, Connecticut Department of Social Services (DSS)

Responsibilities: Oversee DSS operations, including Medicaid programs such as the Acquired Brain Injury (ABI) Waiver Program, and ensure compliance with FOIA and ADA requirements.

Violations:

DSS failed to respond to FOIA requests submitted on October 25, 2024, and follow-ups on October 31, November 2, and December 2, violating statutory deadlines under 5 U.S.C. § 552 and Conn. Gen. Stat. § 1-210.

Ignored explicit requests for ADA accommodations, including simplified communication formats, violating 42 U.S.C. § 12131 (ADA Title II).

Excluded me from accessing critical Medicaid program information, violating Fifth Amendment due process and Fourteenth Amendment equal protection rights.

Attorney General William Tong

Title: Connecticut Attorney General

Responsibilities: Ensure legal compliance across state agencies, uphold transparency laws, and enforce accountability mechanisms.

Violations:

As head of the Attorney General's Office, William Tong is responsible for the refusal to acknowledge or process FOIA requests. This constitutes a violation of First Amendment rights to petition the government and Fifth Amendment due process protections.

Enabled systemic obstruction of transparency, potentially covering mismanagement of federally funded Medicaid programs, violating federal Medicaid regulations (42 U.S.C. § 1396a).

Barbara Manning

Title: CMS Regional Administrator (Region 1)

Responsibilities: Oversee CMS operations in Connecticut and ensure state compliance with federal Medicaid regulations.

Violations:

Failed to enforce federal oversight of the Medicaid ABI Waiver Program, despite systemic non-compliance with transparency and accountability mandates.

By neglecting to investigate Connecticut's violations, CMS contributed to potential misuse of federal Medicaid funds.

Chiquita Brooks-LaSure

Title: Administrator, Centers for Medicare & Medicaid Services (CMS)

Responsibilities: Oversee national Medicaid programs and ensure state compliance with federal funding conditions.

Violations:

Failed to address systemic issues in Connecticut's Medicaid ABI Waiver Program, despite federal obligations under 42 U.S.C. § 1396a.

Oversight failures under her leadership have enabled potential fraud, waste, and abuse of taxpayer funds.

Eileen Meskill

Title: Deputy Attorney General, Connecticut Office of the Attorney General

Responsibilities: Manage FOIA compliance and oversee ADA-related legal matters.

Violations:

Operationally responsible for ensuring FOIA compliance; her failure to act perpetuated violations of 5 U.S.C. § 552.

Enabled systemic denial of ADA accommodations, contributing to discrimination under 42 U.S.C. § 12131.

Governor Ned Lamont

Title: Governor of Connecticut

Responsibilities: Ensure state agencies comply with federal and state laws, including FOIA and ADA, and oversee the performance of agency leadership.

Violations:

Allowed systemic failures within DSS, CHRO, and the Attorney General's Office to persist without intervention.

Failed to exercise executive authority to enforce accountability, enabling constitutional violations under the First, Fifth, and Fourteenth Amendments.

Matthew Brokman

Title: Chief of Staff to Governor Ned Lamont

Responsibilities: Oversee the Governor's agenda, coordinate policy enforcement across state agencies, and ensure compliance with federal laws.

Violations:

Failed to address systemic violations reported within DSS and the Attorney General's Office, contributing to ongoing FOIA and ADA non-compliance.

Tanya Hughes

Title: Executive Director, Connecticut Commission on Human Rights and Opportunities (CHRO)

Responsibilities: Address discrimination complaints and ensure ADA compliance in state agencies.

Violations:

Failed to act on ADA violations and discrimination complaints related to systemic barriers in DSS and the Attorney General's Office.

Neglected oversight responsibilities, perpetuating discrimination against individuals with disabilities.

Systemic Failures and Constitutional Violations

FOIA Non-Compliance (First and Fifth Amendments):

Refusal to acknowledge or process FOIA requests violated my First Amendment right to petition the government and my Fifth Amendment due process rights by obstructing access to public records.

ADA Violations (Fourteenth Amendment):

Denial of reasonable accommodations excluded me from public processes, violating Title II of the ADA (42 U.S.C. § 12131) and the Fourteenth Amendment's Equal Protection Clause.

Abuse of Authority:

Systemic failures across DSS, CHRO, and the Attorney General's Office represent an abuse of state power, suppressing whistleblower advocacy and perpetuating discriminatory practices.

Gross Mismanagement of Federal Funds:

Failure to ensure Medicaid ABI Waiver Program compliance raises concerns of fraud, waste, and abuse, violating federal Medicaid regulations (42 U.S.C. § 1396a).

When Did This Occur?

The violations began with my **initial FOIA request**, submitted on **October 25, 2024**, to the Connecticut Attorney General's Office, and are ongoing. Despite explicit statutory obligations under **5 U.S.C. § 552** (FOIA) and **Conn. Gen. Stat. § 1-210**, no acknowledgment or response has been provided, constituting both procedural and constitutional violations.

Key Dates and Events

1. **October 25, 2024:**
    - Submitted a FOIA request to the Connecticut Attorney General's Office seeking records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - The request included specific ADA accommodation requests, such as simplified communication formats and accessible records, due to my traumatic brain injury (TBI).
2. **October 31, 2024:**
    - Sent the first follow-up communication to request acknowledgment of my FOIA submission and an estimated timeline for compliance. No response was received, violating the **four-business-day acknowledgment requirement** under Connecticut FOIA law (**Conn. Gen. Stat. § 1-210**).
3. **November 2, 2024:**

- Submitted a second follow-up, emphasizing the urgency of ADA compliance and statutory deadlines for FOIA responses under **5 U.S.C. § 552(a)(6)**. The agency failed to respond or address the accommodation requests.

4. **December 2, 2024:**

   - Sent a final follow-up communication, highlighting the systemic nature of the non-compliance and its broader implications for constitutional and federal law violations.

5. **Ongoing Exclusion and Retaliation:**

   - The systemic violations are **continuous and ongoing**, including:
     - Refusal to process FOIA requests.
     - Denial of ADA accommodations.
     - Exclusion from public forums and discussions related to Medicaid oversight.
   - These failures demonstrate deliberate and systemic obstruction, directly impacting my ability to advocate as a whistleblower and participate as a person with disabilities.

Why This Timeline is Critical

1. **Statutory Deadlines Violated:**

- Under **5 U.S.C. § 552(a)(6)(A)**, agencies must respond to FOIA requests within **20 business days**, and Connecticut law mandates acknowledgment within **four business days**. These deadlines were disregarded without explanation.

2. **ADA Non-Compliance:**

   - Reasonable accommodation requests, required under **Title II of the Americans with Disabilities Act (42 U.S.C. § 12131)**, were ignored, constituting discrimination and exclusion from public processes.

3. **Constitutional Violations:**

   - These actions infringe upon my **First Amendment right to petition**, my **Fifth Amendment due process rights**, and my **Fourteenth Amendment right to equal protection** as a person with disabilities.

4. **Ongoing Nature:**

   - The refusal to acknowledge, process, or comply with my requests continues, reflecting a pattern of systemic neglect and obstruction that requires immediate federal intervention.

How Did You Discover This Action?

I discovered the violations through my direct involvement as a whistleblower and advocate for transparency and accountability within Connecticut's Medicaid Acquired Brain Injury (ABI) Waiver Program. My discovery occurred as follows:

1. **FOIA Request Submission and Lack of Response:**

    - On **October 25, 2024**, I submitted a FOIA request to the Connecticut Attorney General's Office seeking records related to the Medicaid ABI Waiver Program. When no acknowledgment or response was received, I initiated follow-ups on **October 31, 2024**, **November 2, 2024**, and **December 2, 2024**, all of which were ignored. The failure to respond within the statutory timeframe alerted me to systemic non-compliance with **5 U.S.C. § 552** (FOIA) and **Conn. Gen. Stat. § 1-210**.

2. **ADA Accommodation Requests Ignored:**

    - I included explicit requests for reasonable ADA accommodations to address my cognitive challenges as a traumatic brain injury (TBI) survivor, such as simplified communication formats and accessible records. The failure to acknowledge or fulfill these accommodations violated the **Americans with Disabilities Act (ADA)** and highlighted a pattern of exclusion and discrimination.

3. **Ongoing Exclusion from Public Processes:**

    - I was excluded from public forums and discussions related to Medicaid oversight, despite being a stakeholder directly impacted by these programs. This exclusion,

combined with procedural barriers such as non-responsiveness, demonstrated a deliberate effort to suppress whistleblower advocacy and prevent accountability.

4. **Research into Oversight Failures:**

    - In investigating the lack of response, I discovered broader systemic issues within the Connecticut Attorney General's Office, the Department of Social Services (DSS), and the Commission on Human Rights and Opportunities (CHRO), including failures to uphold transparency laws, ADA requirements, and federal Medicaid regulations.

5. **Corroborating Evidence:**

    - The lack of records, unexplained delays, and continued procedural barriers confirm systemic failures in transparency, ADA compliance, and oversight, prompting me to escalate the matter to federal authorities.

1. **2. What Action Did They Take?**

Here is a detailed breakdown of the actions (or inactions) taken by each individual listed, highlighting their role in the violations:

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1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command:** Head of DSS
- **Actions Taken:**
    - Ignored FOIA requests submitted on **October 25, 2024**, and subsequent follow-ups on **October 31, November 2, and December 2, 2024**, violating statutory obligations under **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
    - Failed to ensure ADA compliance by denying reasonable accommodations, such as simplified communication formats and accessible records, in violation of **Title II of the ADA (42 U.S.C. § 12131)**.
    - Excluded me from public forums related to Medicaid oversight, violating my constitutional **Fourteenth Amendment right** to equal protection.

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2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Position in Chain of Command:** Head of the Connecticut Office of the Attorney General
- **Actions Taken:**

- Failed to enforce FOIA compliance within his office, allowing requests to go unanswered, violating the **First Amendment right to petition** and **Fifth Amendment due process rights**.
- Oversaw systemic non-compliance with transparency laws, withholding critical records about the Medicaid ABI Waiver Program.
- Enabled a culture of non-responsiveness and procedural barriers, obstructing my advocacy as a whistleblower.

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3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)
- **Position in Chain of Command:** Oversees CMS operations in Connecticut and neighboring states
- **Actions Taken:**
  - Failed to enforce oversight of Connecticut's Medicaid ABI Waiver Program, despite federal obligations under **42 U.S.C. § 1396a**.
  - Neglected to investigate systemic violations of Medicaid compliance, allowing potential misuse of federal funds.

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4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** National head of CMS
- **Actions Taken:**
    - Failed to address systemic Medicaid mismanagement in Connecticut, allowing violations to persist without accountability.
    - Did not ensure state compliance with federal transparency and oversight requirements, undermining public trust in Medicaid programs.

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5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Position in Chain of Command:** Second-in-command to Attorney General William Tong
- **Actions Taken:**
    - Failed to operationalize FOIA compliance or ensure ADA accommodations were provided under the Attorney General's Office.
    - Allowed systemic delays and non-responsiveness, contributing to ongoing violations of transparency and accessibility laws.

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6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Position in Chain of Command:** Chief Executive of the State of Connecticut
- **Actions Taken:**
    - Failed to intervene or hold DSS, CHRO, and the Attorney General's Office accountable for systemic violations.
    - Allowed continued non-compliance with federal and state laws, including FOIA, ADA, and constitutional protections, despite public awareness of these issues.

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7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Position in Chain of Command:** Oversees executive operations and ensures policy enforcement across state agencies
- **Actions Taken:**
    - Failed to ensure agencies under the Governor's jurisdiction complied with federal and state obligations.
    - Allowed procedural barriers and systemic violations to persist without oversight or correction.

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8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Position in Chain of Command:** Head of CHRO
- **Actions Taken:**
    - Failed to act on complaints of ADA violations and systemic discrimination.
    - Did not address exclusionary practices by DSS and the Attorney General's Office, perpetuating barriers for individuals with disabilities.

Summary of Actions

- The listed individuals and agencies took actions (or inactions) that collectively demonstrate systemic non-compliance with FOIA, ADA, and federal Medicaid regulations.
- These failures violated statutory deadlines, denied my constitutional rights, and perpetuated discriminatory practices, resulting in significant harm to transparency, accountability, and public trust.

This response provides a detailed, bulletproof account of actions taken by each key individual.

Let me know if you need additional refinements!

2. **You said:**

make sure list all the constitutional medicaid foia whistleblower ada taxpayer laws rights violations.

2. What Action Did They Take?

Here is the enhanced and **bulletproof response**, listing all key constitutional, Medicaid, FOIA, ADA, whistleblower, and taxpayer violations for each individual. This version ties their actions (or inactions) directly to legal and constitutional principles, ensuring a comprehensive and actionable explanation.

Key Individuals and Their Actions

1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command:** Head of DSS
- **Actions Taken and Violations:**
    - **FOIA Violations:** Ignored legally submitted FOIA requests (October 25, 2024, and follow-ups), violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
    - **ADA Violations:** Denied requests for reasonable accommodations (simplified communication formats, accessible records), violating **Title II**

of the ADA (42 U.S.C. § 12131) and associated regulations (**28 C.F.R. § 35.130, § 35.160**).

- **Medicaid Violations:** Failed to ensure transparency and accountability in the Medicaid ABI Waiver Program, violating **42 U.S.C. § 1396a(a)(30)(A)**, which requires states to administer Medicaid efficiently and transparently.
- **Constitutional Violations:**
    - **First Amendment:** Obstructed my right to petition the government for redress of grievances.
    - **Fifth Amendment:** Denied procedural due process by refusing access to public records.
    - **Fourteenth Amendment:** Excluded me from public processes due to my disability, violating equal protection rights.

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2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Position in Chain of Command:** Head of the Connecticut Office of the Attorney General
- **Actions Taken and Violations:**

- **FOIA Violations:** Oversaw systemic failure to comply with FOIA obligations, obstructing public access to Medicaid program records.
- **Constitutional Violations:**
    - **First Amendment:** Suppressed transparency and advocacy efforts by ignoring lawful FOIA requests.
    - **Fifth Amendment:** Obstructed due process rights by failing to respond to requests within statutory deadlines.
    - **Fourteenth Amendment:** Enabled discriminatory practices by failing to enforce ADA compliance.
- **Whistleblower Retaliation:** Procedural barriers and inaction hindered my efforts to expose systemic Medicaid mismanagement, violating **whistleblower protections** under federal law.

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3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)
- **Position in Chain of Command:** Oversees CMS operations in Connecticut and neighboring states
- **Actions Taken and Violations:**

- **Medicaid Violations:** Failed to investigate Connecticut's Medicaid ABI Waiver Program for compliance with federal regulations (**42 U.S.C. § 1396a**).
- **Taxpayer Rights Violations:** Allowed potential misuse of taxpayer-funded Medicaid resources due to lack of oversight, undermining public trust and fiscal accountability.

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4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** National Administrator of CMS
- **Actions Taken and Violations:**
  - **Medicaid Violations:** Failed to ensure Connecticut's Medicaid program adhered to federal oversight and accountability standards under **42 U.S.C. § 1396a**.
  - **Taxpayer Rights Violations:** Neglected systemic issues in Connecticut's Medicaid administration, enabling potential fraud and waste of federal funds.

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5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Position in Chain of Command:** Second-in-command to Attorney General William Tong
- **Actions Taken and Violations:**
    - **FOIA Violations:** Operationally responsible for FOIA compliance but failed to address systemic non-compliance within the Attorney General's Office.
    - **ADA Violations:** Enabled systemic exclusion by not enforcing ADA accommodations, violating **Title II of the ADA**.

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6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Position in Chain of Command:** Chief Executive of the State of Connecticut
- **Actions Taken and Violations:**
    - **Constitutional Violations:**
        - Failed to ensure compliance with FOIA and ADA requirements across state agencies, violating my **First, Fifth, and Fourteenth Amendment rights**.

- Allowed systemic exclusion from public forums and decision-making processes, perpetuating inequities.

- **Medicaid and Taxpayer Violations:** Did not address systemic failures in DSS and Medicaid programs, enabling potential fraud, waste, and abuse of taxpayer funds.

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7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Position in Chain of Command:** Oversees Governor's agenda and inter-agency coordination
- **Actions Taken and Violations:**
  - Failed to address systemic violations reported under the Governor's jurisdiction, contributing to ongoing FOIA and ADA non-compliance.

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8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Position in Chain of Command:** Head of CHRO
- **Actions Taken and Violations:**

- **ADA Violations:** Neglected to act on complaints of systemic exclusion and ADA non-compliance.
- **Constitutional Violations:** Enabled discrimination and systemic barriers, violating my **Fourteenth Amendment rights** to equal protection.

Summary of Violations

Constitutional Violations

25. **First Amendment:** Obstructed my right to petition the government for redress of grievances through FOIA inaction and procedural barriers.

26. **Fifth Amendment:** Denied procedural due process by refusing access to public records and ignoring accommodation requests.

27. **Fourteenth Amendment:** Discriminated against me as a person with disabilities, excluding me from public processes and denying equal protection.

Statutory Violations

28. **FOIA (5 U.S.C. § 552):** Ignored lawful FOIA requests, violating federal and state transparency laws.

29. **ADA (42 U.S.C. § 12131):** Denied reasonable accommodations and excluded me from public participation.

30. **Medicaid (42 U.S.C. § 1396a):** Failed to ensure transparency and accountability in federally funded Medicaid programs.

Taxpayer and Whistleblower Rights

31. **Taxpayer Rights:** Enabled potential fraud, waste, and abuse of federally allocated funds, undermining public trust.

32. **Whistleblower Protections:** Retaliated against my advocacy by imposing procedural barriers and suppressing transparency efforts.

When Did This Occur?

The violations began with my **initial FOIA request on October 25, 2024**, and remain **ongoing**. Below is a detailed timeline of events tied directly to statutory and constitutional violations, demonstrating a systemic and deliberate pattern of non-compliance.

Timeline of Events

1. **October 25, 2024:**
    - I submitted a FOIA request to the Connecticut Attorney General's Office requesting records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - This request explicitly included **ADA accommodation requests**, such as simplified communication formats and accessible records, due to my traumatic brain injury (TBI).
    - **Violations:**
        - The Attorney General's Office failed to acknowledge the FOIA request within the statutory **four-business-day deadline** required under **Conn. Gen. Stat. § 1-210**.
        - Ignoring ADA accommodations violates **Title II of the ADA (42 U.S.C. § 12131)** and associated regulations (**28 C.F.R. § 35.130, § 35.160**).
2. **October 31, 2024:**

- I submitted a **follow-up communication** to the Attorney General's Office and the Department of Social Services (DSS), requesting acknowledgment of my FOIA request and compliance with ADA requirements.
- **Violations:**
    - No acknowledgment was provided, violating statutory deadlines under both **federal FOIA (5 U.S.C. § 552)** and Connecticut state law.
    - The continued failure to provide accommodations exacerbated the ADA violation.

3. **November 2, 2024:**
    - A second follow-up was submitted to both agencies, emphasizing the urgency of my request and its relevance to Medicaid transparency and public accountability.
    - **Violations:**
        - No response was provided, continuing the violations of **FOIA deadlines**, **ADA requirements**, and constitutional due process protections under the **Fifth Amendment**.

4. **December 2, 2024:**
    - I submitted a **final follow-up communication**, highlighting the systemic nature of these failures, the broader implications for federal Medicaid compliance, and the violation of constitutional rights.
    - **Violations:**

- The agencies failed to act on repeated requests, demonstrating systemic obstruction of transparency, ADA non-compliance, and suppression of whistleblower advocacy.

5. **Ongoing and Continuous Violations:**

- To date, the Attorney General's Office, DSS, and associated entities have failed to:

  - Provide the requested public records, violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.

  - Address ADA accommodation requests, violating **42 U.S.C. § 12131**.

  - Ensure transparency and accountability in Medicaid program oversight, violating **42 U.S.C. § 1396a**.

- These failures persist, constituting ongoing violations of **constitutional rights**, federal statutes, and taxpayer protections.

Key Legal Violations and Constitutional Implications

1. **FOIA Violations:**

- **Federal FOIA (5 U.S.C. § 552):** Agencies failed to acknowledge or respond to my requests within the statutory deadlines of **20 business days**, impeding public access to information.

- **State FOIA (Conn. Gen. Stat. § 1-210):** Agencies ignored the **four-business-day acknowledgment deadline**, demonstrating systemic non-compliance with transparency laws.

2. **ADA Violations:**

   - **Title II of the ADA (42 U.S.C. § 12131):** Agencies failed to provide reasonable accommodations for my disability, excluding me from participating in public processes.
   - **28 C.F.R. § 35.160:** Agencies denied effective communication, further violating ADA mandates.

3. **Constitutional Violations:**

   - **First Amendment:** Suppression of my FOIA requests and procedural barriers infringed upon my **right to petition** the government for redress of grievances.
   - **Fifth Amendment:** Denial of access to public records and accommodations violated my **due process rights**.
   - **Fourteenth Amendment:** Exclusion due to my disability constitutes discrimination, violating my **equal protection rights**.

4. **Medicaid and Taxpayer Violations:**

   - **42 U.S.C. § 1396a:** Refusal to provide transparency in Medicaid oversight undermines federal regulations requiring efficient and accountable program administration.

- Potential misuse or mismanagement of taxpayer-funded Medicaid programs raises concerns of **fraud, waste, and abuse**, violating public trust.

Conclusion

The violations began with my **initial FOIA request on October 25, 2024**, and remain ongoing. These failures to comply with federal and state laws, combined with ADA and constitutional violations, demonstrate systemic neglect and deliberate obstruction, necessitating immediate federal intervention to uphold legal and constitutional rights.

How Did You Discover This Action?

I discovered the violations through my direct engagement as a whistleblower and advocate for transparency, accountability, and accessibility within Connecticut's Medicaid Acquired Brain Injury (ABI) Waiver Program. My discovery unfolded as follows:

1. **Submission of FOIA Requests:**
    - On **October 25, 2024**, I submitted a Freedom of Information Act (FOIA) request to the Connecticut Attorney General's Office seeking transparency into the Medicaid ABI Waiver Program.
    - When the statutory deadlines for acknowledgment and response passed without action, I initiated follow-up communications on **October 31**, **November 2**, and **December 2, 2024**. These requests were ignored, indicating potential non-compliance with **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.

2. **Denial of ADA Accommodations:**
    - Along with my FOIA request, I explicitly requested reasonable accommodations under the **Americans with Disabilities Act (ADA)** due to my traumatic brain injury (TBI). These accommodations included simplified communication formats and accessible records.

- The failure to acknowledge or fulfill these accommodation requests alerted me to systemic non-compliance with **Title II of the ADA (42 U.S.C. § 12131)** and its implementing regulations (**28 C.F.R. § 35.130, § 35.160**).

3. **Repeated Exclusion from Public Processes:**

- My exclusion from public forums and discussions related to Medicaid oversight, despite being directly affected by the Medicaid ABI Waiver Program, further demonstrated systemic discrimination and suppression of my advocacy efforts.
- These barriers highlighted ongoing violations of my **First Amendment right to petition the government**, **Fifth Amendment due process rights**, and **Fourteenth Amendment equal protection rights**.

4. **Research into Broader Failures:**

- As I investigated the lack of response to my FOIA requests and ADA accommodations, I identified broader systemic issues within the Connecticut Attorney General's Office, the Department of Social Services (DSS), and the Commission on Human Rights and Opportunities (CHRO).
- This included evidence of widespread non-compliance with transparency laws, ADA requirements, and federal Medicaid regulations (**42 U.S.C. § 1396a**).

5. **Corroborating Evidence from Procedural Barriers:**

    - The continued lack of transparency, repeated procedural barriers, and exclusionary practices pointed to systemic mismanagement and potential misuse of taxpayer funds. These failures were compounded by the refusal to disclose records critical to Medicaid oversight.

Conclusion

I discovered these actions through direct engagement as a whistleblower and advocate, uncovering systemic non-compliance with FOIA, ADA, and Medicaid regulations. My efforts to seek transparency and accountability revealed deliberate obstruction, exclusionary practices, and potential fraud or waste of federally allocated Medicaid funds.

What Additional Facts Support Your Allegation?

The following facts substantiate my allegations of systemic violations of FOIA, ADA, constitutional rights, Medicaid oversight requirements, and taxpayer protections:

1. FOIA Violations

- **Unanswered Requests:**
    - I submitted a FOIA request on **October 25, 2024**, to the Connecticut Attorney General's Office, followed by additional communications on **October 31**, **November 2**, and **December 2, 2024**. None of these were acknowledged or processed, violating statutory deadlines under **5 U.S.C. § 552(a)(6)** and **Conn. Gen. Stat. § 1-210**.
    - The complete lack of response demonstrates systemic non-compliance and obstruction of transparency.
- **Deliberate Obstruction:**
    - The agencies' inaction suggests intentional efforts to suppress information related to the Medicaid ABI Waiver Program, hindering public oversight of federally funded programs.

2. ADA Violations

- **Ignored Accommodation Requests:**
    - Along with my FOIA request, I explicitly requested reasonable accommodations under **Title II of the ADA (42 U.S.C. § 12131)** due to my traumatic brain injury (TBI). These included simplified communication formats and accessible records.
    - The agencies failed to provide accommodations, violating **28 C.F.R. § 35.130** and **§ 35.160**, which require public entities to ensure effective communication and prohibit discrimination based on disability.
- **Exclusion from Public Processes:**
    - I was systematically excluded from public forums and discussions related to Medicaid oversight, further marginalizing my voice as a whistleblower and disability advocate.
    - This exclusion violates the **Fourteenth Amendment's Equal Protection Clause** and ADA protections.

3. Whistleblower Retaliation

- **Procedural Barriers:**
    - After raising concerns about systemic failures in Medicaid oversight, I encountered procedural barriers, including delayed responses, public ridicule, and outright exclusion.

- These actions constitute retaliation, violating federal **whistleblower protections** aimed at safeguarding individuals who expose fraud, waste, or abuse in federally funded programs.

4. Gross Mismanagement of Federal Medicaid Funds

- **Lack of Transparency:**
  - Refusal to disclose records related to the Medicaid ABI Waiver Program raises concerns of fraud, waste, and abuse of taxpayer dollars.
  - Transparency in Medicaid program administration is mandated under **42 U.S.C. § 1396a(a)(30)(A)**, and failure to provide oversight jeopardizes compliance with federal funding requirements.
- **Absence of Accountability Measures:**
  - Despite my FOIA requests, no records of audits, enforcement actions, or disciplinary measures against providers in the ABI Waiver Program have been disclosed.
  - This lack of accountability endangers the program's integrity and the vulnerable populations it serves.

5. Documentary Evidence

- **FOIA Submission Records:**
    - Copies of my FOIA request (October 25, 2024) and follow-ups (October 31, November 2, and December 2, 2024) provide a clear timeline of agency non-compliance.
    - These records show repeated violations of statutory deadlines and transparency obligations.
- **ADA Accommodation Requests:**
    - Documented requests for reasonable accommodations demonstrate the agencies' failure to comply with ADA mandates.
- **Exclusion and Retaliation Evidence:**
    - Correspondence with DSS, CHRO, and the Attorney General's Office highlights procedural barriers and exclusionary practices aimed at suppressing my advocacy.
- **Medicaid Transparency Deficiencies:**
    - The absence of publicly available records on Medicaid ABI Waiver Program oversight supports allegations of systemic mismanagement.

6. Broader Implications

- **Harm to Public Trust:**

- The systemic failure to comply with FOIA, ADA, and Medicaid regulations undermines public confidence in federally funded programs.
- Excluding whistleblowers and disability advocates perpetuates a culture of non-accountability and inequity.

- **Risk to Vulnerable Populations:**
  - The lack of transparency and oversight jeopardizes the quality and accessibility of services for individuals with acquired brain injuries, one of the most vulnerable populations relying on Medicaid.

Conclusion

These facts demonstrate systemic violations of federal and state laws, including FOIA, ADA, Medicaid oversight requirements, and constitutional protections. Immediate federal intervention is necessary to address these failures and restore transparency, accountability, and compliance.

1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command:** Head of DSS
- **Abuse of Authority:**

- Ignored FOIA requests (October 25, 2024, and subsequent follow-ups), failing to provide transparency about the Medicaid ABI Waiver Program, violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
- Denied ADA accommodations for simplified communication formats and accessible records, violating **Title II of the ADA (42 U.S.C. § 12131)** and **28 C.F.R. § 35.130**.
- Oversaw a culture of exclusion by failing to include stakeholders, such as individuals with acquired brain injuries, in public processes critical to Medicaid oversight, violating the **Fourteenth Amendment Equal Protection Clause**.
- Allowed systemic non-accountability for Medicaid providers, raising concerns about fraud, waste, and abuse of taxpayer-funded programs, violating **42 U.S.C. § 1396a**.

2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Position in Chain of Command:** Head of the Connecticut Office of the Attorney General
- **Abuse of Authority:**
    - Refused to enforce FOIA compliance within his office, suppressing public access to critical information about Medicaid programs, violating the **First**

Amendment right to petition the government and **Fifth Amendment** due process rights.

- Ignored ADA compliance within the Attorney General's Office, enabling systemic exclusion of individuals with disabilities, violating **42 U.S.C. § 12131** and the **Fourteenth Amendment Equal Protection Clause**.
- Obstructed transparency efforts, perpetuating a culture of secrecy regarding public programs funded by taxpayers.

3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)
- **Position in Chain of Command:** Oversees CMS operations in Connecticut and neighboring states
- **Abuse of Authority:**
  - Failed to investigate and address systemic non-compliance in Connecticut's Medicaid ABI Waiver Program, violating federal Medicaid regulations (**42 U.S.C. § 1396a**).
  - Neglected federal oversight responsibilities, enabling potential fraud, waste, and abuse of taxpayer-funded Medicaid dollars.

4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** National Administrator of CMS
- **Abuse of Authority:**
    - Allowed systemic issues in Connecticut's Medicaid ABI Waiver Program to persist without intervention, violating federal oversight responsibilities under **42 U.S.C. § 1396a**.
    - Failed to ensure compliance with federal transparency and accountability standards, jeopardizing taxpayer funds and the integrity of Medicaid services.

5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Position in Chain of Command:** Second-in-command to Attorney General William Tong
- **Abuse of Authority:**
    - Neglected operational oversight of FOIA and ADA compliance within the Attorney General's Office, contributing to systemic transparency failures.
    - Enabled exclusionary practices and the suppression of whistleblower advocacy, violating federal whistleblower protections and the **First Amendment**.

6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Position in Chain of Command:** Chief Executive of the State of Connecticut
- **Abuse of Authority:**
    - Allowed systemic violations within DSS, CHRO, and the Attorney General's Office to continue unchecked, failing to exercise executive authority to enforce compliance with FOIA, ADA, and constitutional protections.
    - Failed to address systemic issues despite public awareness, perpetuating a culture of neglect and non-accountability, violating the public trust.

7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Position in Chain of Command:** Oversees executive operations and ensures policy enforcement across state agencies
- **Abuse of Authority:**
    - Failed to ensure that state agencies under the Governor's jurisdiction complied with federal and state obligations, contributing to ongoing FOIA and ADA non-compliance.

8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Position in Chain of Command:** Head of CHRO
- **Abuse of Authority:**
    - Failed to act on complaints of ADA violations and systemic discrimination, enabling exclusionary practices within DSS and the Attorney General's Office.
    - Allowed systemic violations of civil rights protections for individuals with disabilities, undermining the mission of CHRO.

Summary of Violations

1. **FOIA Violations:** Refusal to respond to or process FOIA requests constitutes a suppression of transparency and an abuse of authority.
2. **ADA Violations:** Systemic denial of reasonable accommodations excluded individuals with disabilities from public participation.
3. **Constitutional Violations:**
    - **First Amendment:** Obstructed transparency and advocacy efforts, suppressing whistleblower rights.

- **Fifth Amendment:** Denied due process through procedural barriers and non-compliance.
- **Fourteenth Amendment:** Engaged in discriminatory practices, excluding individuals with disabilities.

4. **Medicaid Oversight Failures:** Allowed potential fraud, waste, and abuse of taxpayer funds by failing to ensure transparency and accountability in federally funded Medicaid programs.

2. What Action Did They Take?

Here's a detailed, bulletproof breakdown of the actions (or inactions) taken by each key individual that resulted in violations of FOIA, ADA, constitutional rights, and federal Medicaid regulations. This response ensures clarity, legal precision, and actionable details.

1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Position in Chain of Command:** Head of DSS
- **Actions Taken:**
    - Ignored FOIA requests submitted on **October 25, 2024**, and follow-ups on **October 31, November 2, and December 2, 2024**, violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
    - Denied ADA accommodation requests for simplified communication formats and accessible records, violating **Title II of the ADA (42 U.S.C. § 12131)** and associated regulations (**28 C.F.R. § 35.130, § 35.160**).
    - Allowed systemic exclusion of individuals with disabilities from public processes, violating the **Fourteenth Amendment's Equal Protection Clause**.
    - Failed to conduct or disclose audits and accountability measures for Medicaid ABI Waiver Program providers, raising concerns of fraud, waste, and abuse of taxpayer-funded Medicaid programs, violating **42 U.S.C. § 1396a**.

2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Position in Chain of Command:** Head of the Connecticut Office of the Attorney General
- **Actions Taken:**
    - Refused to acknowledge or process FOIA requests submitted to his office, suppressing transparency and violating the **First Amendment's right to petition** and **Fifth Amendment due process rights**.
    - Failed to enforce FOIA compliance and transparency across Connecticut agencies, perpetuating systemic violations of **5 U.S.C. § 552**.
    - Neglected to address ADA accommodation failures within his office, enabling discriminatory practices, violating **Title II of the ADA**.
    - Suppressed whistleblower advocacy by allowing procedural barriers and delays, undermining federal whistleblower protections.

3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)

- **Position in Chain of Command:** Oversees CMS operations in Connecticut and neighboring states
- **Actions Taken:**
    - Failed to enforce oversight of Connecticut's Medicaid ABI Waiver Program, despite clear indications of systemic non-compliance, violating **42 U.S.C. § 1396a**.
    - Neglected federal responsibilities to investigate and address mismanagement in Medicaid programs, enabling potential fraud, waste, and abuse of taxpayer funds.

4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Position in Chain of Command:** National Administrator of CMS
- **Actions Taken:**
    - Allowed systemic issues in Connecticut's Medicaid ABI Waiver Program to persist, failing to enforce federal oversight responsibilities under **42 U.S.C. § 1396a**.
    - Neglected to ensure state compliance with transparency, accountability, and effective program administration, jeopardizing public trust and Medicaid beneficiaries.

5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Position in Chain of Command:** Second-in-command to Attorney General William Tong
- **Actions Taken:**
    - Failed to operationalize FOIA compliance and ADA accommodations within the Attorney General's Office, perpetuating systemic transparency failures.
    - Neglected oversight responsibilities, enabling discriminatory practices and the suppression of whistleblower advocacy, violating **5 U.S.C. § 552**, **Title II of the ADA**, and whistleblower protection statutes.

6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Position in Chain of Command:** Chief Executive of the State of Connecticut
- **Actions Taken:**
    - Allowed systemic violations within DSS, CHRO, and the Attorney General's Office to persist, failing to exercise executive authority to enforce compliance with FOIA, ADA, and constitutional protections.

- Did not intervene or hold state agencies accountable despite public awareness of these issues, perpetuating systemic neglect and constitutional violations.

7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Position in Chain of Command:** Oversees executive operations and ensures policy enforcement across state agencies
- **Actions Taken:**
    - Failed to address systemic violations within the Governor's jurisdiction, contributing to ongoing non-compliance with FOIA, ADA, and Medicaid regulations.

8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Position in Chain of Command:** Head of CHRO
- **Actions Taken:**
    - Failed to act on complaints of ADA violations and systemic discrimination, perpetuating exclusionary practices by DSS and the Attorney General's Office.

- Neglected to address systemic civil rights violations, undermining CHRO's mission to ensure equal access and compliance with ADA protections.

Summary of Violations

1. **FOIA Violations:**
    - Agencies and officials ignored lawful FOIA requests, violating federal and state transparency laws.
2. **ADA Violations:**
    - Denied reasonable accommodations, excluding individuals with disabilities from public processes, in violation of ADA mandates.
3. **Constitutional Violations:**
    - **First Amendment:** Obstructed the right to petition the government through FOIA non-compliance.
    - **Fifth Amendment:** Denied procedural due process through delays and lack of response.
    - **Fourteenth Amendment:** Enabled discrimination and systemic exclusion of individuals with disabilities.
4. **Medicaid Oversight Failures:**

- Neglected federal and state oversight responsibilities, risking fraud, waste, and abuse of taxpayer-funded Medicaid programs.

5. **Whistleblower Retaliation:**

- Suppressed advocacy efforts by creating procedural barriers and delays, violating whistleblower protection statutes.

Timeline of Events

1. **October 25, 2024:**

    - I submitted a FOIA request to the Connecticut Attorney General's Office, requesting records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.

    - This request explicitly included ADA accommodation requests for simplified communication formats and accessible records due to my traumatic brain injury (TBI).

    - The Attorney General's Office and DSS failed to acknowledge the request within the statutory **four-business-day deadline** required under **Conn. Gen. Stat. § 1-210**, initiating the violation.

2. **October 31, 2024:**

    - I sent the first follow-up communication to both the Attorney General's Office and DSS, requesting acknowledgment of my FOIA request and compliance with ADA requirements.

    - Both agencies failed to respond, violating statutory FOIA deadlines under **5 U.S.C. § 552** and state law.

3. **November 2, 2024:**

- A second follow-up was submitted, emphasizing the urgency of my request for transparency and the legal obligation to accommodate my disability under the ADA.
- The agencies again failed to respond or acknowledge the request, compounding the violations of federal FOIA statutes and ADA requirements.

4. **December 2, 2024:**
    - A final follow-up communication was submitted, highlighting the systemic nature of these failures and their broader implications for Medicaid compliance and public accountability.
    - No acknowledgment or response was received, demonstrating ongoing systemic non-compliance.
5. **Ongoing Violations:**
    - The failure to comply with FOIA, ADA, and federal Medicaid regulations remains unresolved as of today.
    - Continued exclusion from public forums, refusal to disclose critical Medicaid information, and suppression of whistleblower advocacy reflect deliberate and systemic violations of federal law and constitutional rights.

Violations by Timeline

1. **FOIA Non-Compliance:**

- Failure to acknowledge or respond to my FOIA request violated federal FOIA deadlines under **5 U.S.C. § 552(a)(6)(A)** and state requirements under **Conn. Gen. Stat. § 1-210**.

2. **ADA Non-Compliance:**

   - Ignored requests for reasonable accommodations from October 25, 2024, onward, violating **Title II of the ADA (42 U.S.C. § 12131)** and its implementing regulations (**28 C.F.R. § 35.130, § 35.160**).

3. **Constitutional Violations:**

   - These failures infringed on my **First Amendment right** to petition the government, my **Fifth Amendment due process rights**, and my **Fourteenth Amendment right** to equal protection.

4. **Medicaid Violations:**

   - Systemic lack of transparency in Medicaid ABI Waiver Program oversight jeopardizes compliance with **42 U.S.C. § 1396a**.

Conclusion

The violations began on **October 25, 2024**, with my initial FOIA request and continue to this day, reflecting an ongoing pattern of non-compliance, exclusion, and systemic neglect. Immediate federal intervention is required to address these persistent failures.

4. How Did You Discover This Action?

I discovered the violations through my direct engagement as a whistleblower and advocate for transparency and accountability in Connecticut's Medicaid Acquired Brain Injury (ABI) Waiver Program. Below is a detailed explanation of how I identified the systemic failures:

1. Submission of FOIA Requests

- **Date:** October 25, 2024
    - I submitted a FOIA request to the Connecticut Attorney General's Office, seeking records related to the Medicaid ABI Waiver Program to evaluate the program's oversight and compliance with federal regulations.
    - Despite statutory deadlines requiring acknowledgment within **four business days (Conn. Gen. Stat. § 1-210)** and response within **20 business days (5 U.S.C. § 552(a)(6)(A))**, no response or acknowledgment was received.

2. Repeated Follow-Ups and Continued Non-Response

- **Dates:** October 31, November 2, and December 2, 2024
    - I sent follow-up communications to the Attorney General's Office and the Connecticut Department of Social Services (DSS), highlighting the lack of acknowledgment and requesting updates.

- Each follow-up was ignored, which revealed systemic procedural failures and deliberate non-compliance with transparency obligations.

3. Denial of ADA Accommodations

- Along with my FOIA requests, I explicitly requested **reasonable ADA accommodations** due to my traumatic brain injury (TBI), including:
  - Simplified communication formats.
  - Accessible records compatible with assistive technologies.
- The agencies' failure to acknowledge or address these requests revealed **violations of Title II of the ADA (42 U.S.C. § 12131)** and **28 C.F.R. § 35.130 and § 35.160**, further excluding me from public processes.

4. Exclusion from Public Processes

- My exclusion from public forums and discussions related to Medicaid program oversight—despite being a direct stakeholder—underscored systemic barriers and discriminatory practices.
- This exclusion revealed constitutional violations, including:
  - **First Amendment (right to petition):** Suppression of my advocacy efforts.

- **Fifth Amendment (due process):** Denial of access to legally mandated processes and information.
- **Fourteenth Amendment (equal protection):** Discrimination based on my disability, preventing equitable participation.

5. Broader Investigation and Analysis

- As I analyzed the lack of response, I uncovered broader systemic issues, including:
  - **Lack of Transparency:** No publicly available records or disclosures related to Medicaid ABI Waiver Program audits, provider complaints, or enforcement actions.
  - **Potential Mismanagement:** The absence of accountability measures raised concerns about fraud, waste, and abuse of taxpayer-funded Medicaid resources, violating **42 U.S.C. § 1396a**.

6. Corroborating Evidence from Procedural Barriers

- Procedural barriers, such as non-responsiveness, exclusionary practices, and delays, confirmed deliberate obstruction and systemic failures across the Attorney General's Office, DSS, and other agencies.
- These actions directly impeded my ability to advocate as a whistleblower and obtain transparency into federally funded programs.

Conclusion

I discovered these actions through my direct engagement with the FOIA process, my ADA accommodation requests, and my broader advocacy efforts. These experiences revealed systemic non-compliance with federal and state transparency laws, ADA mandates, and constitutional protections, necessitating immediate federal intervention.

5. What Additional Facts Support Your Allegation?

Here is a comprehensive response with specific supporting facts tied to the allegations of systemic violations of FOIA, ADA, Medicaid regulations, constitutional rights, and taxpayer protections:

1. FOIA Non-Compliance

- **Unanswered FOIA Requests:**
    - I submitted a FOIA request on **October 25, 2024**, to the Connecticut Attorney General's Office, with follow-ups on **October 31, November 2, and December 2, 2024**. None of these communications were acknowledged or answered, violating statutory requirements under **5 U.S.C. § 552** (FOIA) and **Conn. Gen. Stat. § 1-210**.

- This deliberate inaction reflects a systemic failure to uphold transparency and accountability in Medicaid program oversight.

- **Pattern of Obstruction:**

  - The lack of acknowledgment, communication, or documentation in response to lawful FOIA requests demonstrates intentional suppression of public information about the Medicaid ABI Waiver Program.

2. ADA Violations

- **Ignored ADA Accommodation Requests:**

  - Along with my FOIA request, I explicitly requested ADA accommodations due to my traumatic brain injury (TBI). These included simplified communication formats and accessible records.

  - The refusal to address these accommodation requests constitutes a violation of **Title II of the ADA (42 U.S.C. § 12131)** and its implementing regulations (**28 C.F.R. § 35.130, § 35.160**), further excluding me from participating in government processes.

- **Exclusionary Practices:**

  - My exclusion from public forums and discussions related to Medicaid oversight underscores systemic discrimination and deliberate marginalization of individuals

with disabilities, violating the **Fourteenth Amendment Equal Protection Clause**.

3. Constitutional Violations

- **First Amendment Violations:**
    - By obstructing FOIA requests and suppressing my ability to advocate as a whistleblower, the Connecticut Attorney General's Office and DSS infringed upon my **First Amendment right** to petition the government for redress of grievances.
- **Fifth Amendment Violations:**
    - The refusal to provide access to legally mandated public records and processes denied my **due process rights**, as guaranteed by the Fifth Amendment.
- **Fourteenth Amendment Violations:**
    - The systemic exclusion of individuals with disabilities from public processes constitutes discrimination, violating my **Fourteenth Amendment right** to equal protection under the law.

4. Whistleblower Retaliation

- **Suppression of Advocacy:**

- Procedural barriers, non-responsiveness, and public exclusion demonstrate retaliation against my efforts to expose systemic failures in Medicaid oversight.
- These actions violate federal whistleblower protection laws designed to protect individuals advocating for transparency and accountability in federally funded programs.

5. Medicaid Oversight Failures

- **Lack of Transparency:**
  - No publicly available records or audits exist detailing the Medicaid ABI Waiver Program's administration, provider oversight, or enforcement actions.
  - This absence of accountability raises concerns about compliance with federal Medicaid regulations (**42 U.S.C. § 1396a**) and the potential for fraud, waste, and abuse of taxpayer-funded resources.
- **Program Mismanagement:**
  - The refusal to disclose records essential for evaluating Medicaid program oversight indicates systemic mismanagement and jeopardizes the integrity of services for vulnerable populations, including individuals with acquired brain injuries.

6. Corroborating Evidence

- **FOIA Submission Records:**
    - Documented FOIA requests and follow-ups provide evidence of agency non-compliance with federal and state transparency laws.
- **ADA Accommodation Requests:**
    - Written and verbal requests for reasonable accommodations substantiate violations of ADA mandates.
- **Correspondence:**
    - Communication logs with DSS, CHRO, and the Attorney General's Office demonstrate repeated procedural barriers, delays, and exclusionary practices.
- **Lack of Accountability Measures:**
    - The absence of audits, disciplinary actions, or provider accountability reports within the Medicaid ABI Waiver Program supports allegations of systemic neglect and non-compliance.

7. Broader Implications

- **Harm to Vulnerable Populations:**
    - The systemic denial of transparency and ADA accommodations harms individuals reliant on Medicaid services, exacerbating inequality and discrimination.
- **Erosion of Public Trust:**

- The refusal to comply with transparency laws and oversight obligations undermines public confidence in state and federally funded programs.

- **Taxpayer Impact:**

  - Mismanagement of federally allocated Medicaid funds risks fraud, waste, and abuse, violating public trust and federal funding requirements.

Conclusion

These additional facts provide clear and compelling evidence of systemic violations of FOIA, ADA, Medicaid oversight requirements, and constitutional rights. Immediate federal investigation is necessary to address these failures and restore accountability, transparency, and compliance.

Gross Waste of Funds Allegation

This allegation focuses on the **mismanagement or misallocation of federal Medicaid funds**, emphasizing systemic failures to ensure transparency and accountability. Below is the breakdown of how each individual's role and actions (or inactions) contributed to this gross waste of taxpayer dollars:

1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Role:** Oversees DSS operations, including Medicaid programs such as the ABI Waiver Program.
- **Actions Contributing to Gross Waste of Funds:**
    - Failed to provide transparency into Medicaid ABI Waiver Program administration, violating **42 U.S.C. § 1396a**.
    - Neglected to ensure oversight of providers, including audits, accountability measures, and responses to complaints, increasing the risk of fraud, waste, and abuse.
    - Refused to disclose requested records through FOIA, preventing public accountability for the program's expenditures and operations.
    - Enabled systemic inefficiency by ignoring ADA accommodation requests, creating barriers to stakeholder advocacy and oversight.

2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Role:** Responsible for ensuring legal compliance and transparency across state agencies, including Medicaid program operations.
- **Actions Contributing to Gross Waste of Funds:**
    - Oversaw the obstruction of FOIA requests, suppressing public access to information necessary for holding DSS and Medicaid programs accountable.
    - Failed to enforce transparency and accountability laws, enabling potential misuse of Medicaid funds allocated to the ABI Waiver Program.
    - Allowed systemic non-compliance, risking financial mismanagement of taxpayer-funded programs.

3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)
- **Role:** Oversees CMS operations in Connecticut and neighboring states, ensuring compliance with federal Medicaid regulations.
- **Actions Contributing to Gross Waste of Funds:**

- Failed to investigate systemic failures in Connecticut's Medicaid ABI Waiver Program, despite ongoing non-compliance and lack of transparency.
- Neglected oversight responsibilities, allowing the potential misallocation of federally allocated Medicaid funds.

4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Role:** National Administrator of Medicaid programs.
- **Actions Contributing to Gross Waste of Funds:**
  - Allowed systemic issues in Medicaid program oversight in Connecticut to persist without intervention.
  - Failed to ensure Connecticut adhered to federal Medicaid regulations, enabling potential misuse or mismanagement of funds.

5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Role:** Second-in-command to the Connecticut Attorney General, responsible for operational oversight of transparency laws.
- **Actions Contributing to Gross Waste of Funds:**

- Failed to enforce FOIA compliance within the Attorney General's Office, contributing to a lack of transparency in Medicaid program expenditures.
- Enabled procedural barriers that shielded DSS and Medicaid programs from public scrutiny, increasing the risk of financial mismanagement.

6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Role:** Chief Executive of the State of Connecticut, responsible for ensuring state agency compliance with federal laws.
- **Actions Contributing to Gross Waste of Funds:**
  - Did not intervene or address systemic failures in DSS, CHRO, and the Attorney General's Office, despite being aware of ongoing issues.
  - Allowed mismanagement of federally allocated Medicaid funds to continue unchecked, undermining public trust and fiscal accountability.

7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Role:** Oversees executive operations and ensures agency compliance with the Governor's agenda.

- **Actions Contributing to Gross Waste of Funds:**
    - Failed to address the systemic lack of transparency and accountability in Medicaid programs under the Governor's jurisdiction.

8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Role:** Head of CHRO, responsible for addressing systemic discrimination and ensuring equitable access to government services.
- **Actions Contributing to Gross Waste of Funds:**
    - Did not act on complaints of ADA violations and procedural barriers, which excluded individuals with disabilities from participating in Medicaid program oversight.
    - Enabled a culture of non-accountability that increased the risk of financial mismanagement.

Systemic Implications of Gross Waste of Funds

1. **Transparency Failures:**
    - FOIA non-compliance prevented public oversight of Medicaid expenditures, enabling inefficiency and potential fraud.

2. **ADA Violations:**

    - Excluding individuals with disabilities from public processes denied critical stakeholder input, exacerbating inequitable and inefficient program administration.

3. **Medicaid Non-Compliance:**

    - Violations of **42 U.S.C. § 1396a** demonstrate systemic mismanagement, risking loss of federal funding and harm to Medicaid beneficiaries.

4. **Taxpayer Impact:**

    - The systemic lack of transparency and accountability undermines public trust and creates opportunities for waste and abuse of taxpayer-funded resources.

Conclusion

The gross waste of funds stems from systemic failures at multiple levels of state and federal oversight, highlighting the urgent need for federal intervention to restore accountability, ensure proper Medicaid fund allocation, and protect taxpayer resources.

3. When Did This Occur?

The violations began on **October 25, 2024**, with the submission of my initial FOIA request to the Connecticut Attorney General's Office and continue to this day. Below is a detailed timeline of key events:

Timeline of Events

1. **October 25, 2024:**
    - I submitted a FOIA request to the Connecticut Attorney General's Office, requesting records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - This request explicitly included ADA accommodation requests for simplified communication formats and accessible records due to my traumatic brain injury (TBI).
    - The Attorney General's Office and the Department of Social Services (DSS) failed to acknowledge the request within the statutory **four-business-day deadline** required under **Conn. Gen. Stat. § 1-210**, initiating the first violation.

2. **October 31, 2024:**

- I sent the first follow-up communication to the Attorney General's Office and DSS, requesting acknowledgment of my FOIA request and compliance with ADA requirements.
- Neither agency responded, violating statutory FOIA deadlines under both **5 U.S.C. § 552** (FOIA) and **Conn. Gen. Stat. § 1-210**.

3. **November 2, 2024:**
   - I sent a second follow-up to both agencies, reiterating the urgency of my request and the legal obligation to provide reasonable accommodations under the ADA.
   - The agencies again failed to respond or acknowledge my request, demonstrating systemic non-compliance.

4. **December 2, 2024:**
   - I submitted a final follow-up communication, highlighting the broader implications of these failures, including violations of federal Medicaid regulations (**42 U.S.C. § 1396a**) and constitutional protections.
   - The agencies failed to provide any response, further solidifying the ongoing violations.

5. **Ongoing and Continuous Violations:**

    - As of **December 2, 2024**, the Attorney General's Office, DSS, and other related agencies continue to:

        - Refuse to respond to FOIA requests or provide ADA accommodations.

        - Exclude me from public forums and discussions critical to Medicaid oversight.

        - Obstruct access to public records, transparency, and accountability in the Medicaid ABI Waiver Program.

    - These failures demonstrate a pattern of systemic neglect, deliberate non-compliance, and suppression of whistleblower advocacy.

Violations by Timeline

1. **FOIA Violations:**

    - Agencies failed to meet statutory deadlines for acknowledgment (**4 business days under Conn. Gen. Stat. § 1-210**) and response (**20 business days under 5 U.S.C. § 552(a)(6)(A)**).

2. **ADA Violations:**

- Agencies ignored ADA accommodation requests beginning on **October 25, 2024**, and continuing to this day, violating **42 U.S.C. § 12131** and **28 C.F.R. § 35.130 and § 35.160**.

3. **Constitutional Violations:**
    - These ongoing failures infringe on my:
        - **First Amendment right to petition** the government for redress of grievances.
        - **Fifth Amendment due process rights**, as agencies denied access to mandated public records and processes.
        - **Fourteenth Amendment equal protection rights**, by discriminating against me as a person with disabilities.
4. **Medicaid Oversight Failures:**
    - Lack of transparency and accountability violates federal Medicaid regulations (**42 U.S.C. § 1396a**) and jeopardizes compliance with funding requirements.

Conclusion

The violations began on **October 25, 2024**, with my initial FOIA request and persist to this day. These ongoing failures demonstrate deliberate systemic neglect and non-compliance, necessitating immediate federal intervention.

4. How Did You Discover This Action?

I discovered these violations through direct engagement with the Freedom of Information Act (FOIA) process, my role as a whistleblower advocating for transparency in the Medicaid Acquired Brain Injury (ABI) Waiver Program, and repeated attempts to secure reasonable ADA accommodations. Below is a detailed account of how I uncovered these systemic issues:

1. Submission of FOIA Requests

- **Date:** October 25, 2024
    - I submitted a FOIA request to the Connecticut Attorney General's Office, seeking records related to the Medicaid ABI Waiver Program. This request was intended to ensure transparency and accountability in a federally funded program.
    - The agency's failure to meet statutory deadlines for acknowledgment and response alerted me to a potential systemic issue with transparency and FOIA compliance.

2. Follow-Up Communications

- **Dates:** October 31, November 2, and December 2, 2024
    - I sent follow-up communications to both the Attorney General's Office and the Department of Social Services (DSS), highlighting their failure to acknowledge or respond to my request.

- The consistent lack of response, combined with procedural delays, suggested deliberate non-compliance with transparency laws, violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.

3. Denial of ADA Accommodations

- I included requests for **reasonable ADA accommodations**, such as simplified communication formats and accessible records, due to my traumatic brain injury (TBI).
- The agencies ignored these requests, which revealed systemic non-compliance with **Title II of the ADA (42 U.S.C. § 12131)** and its implementing regulations (**28 C.F.R. § 35.130, § 35.160**).
- The denial of accommodations further excluded me from participating in oversight processes, underscoring a pattern of discrimination and systemic barriers.

4. Exclusion from Public Processes

- Despite being a direct stakeholder in the Medicaid ABI Waiver Program, I was excluded from public forums and decision-making processes critical to Medicaid program oversight.
- This exclusion revealed violations of my:
    - **First Amendment right to petition** the government.

- **Fifth Amendment due process rights**, as I was denied access to legally mandated processes.
- **Fourteenth Amendment right to equal protection**, as a person with disabilities.

5. Broader Investigations and Findings

- As I sought to understand the lack of response to my FOIA requests and ADA accommodations, I uncovered broader systemic issues, including:
  - **Lack of Transparency:** No publicly available records on Medicaid program oversight, provider accountability, or program audits.
  - **Potential Mismanagement:** Absence of disclosures about enforcement actions against providers or corrective measures raises concerns about fraud, waste, and abuse of taxpayer-funded resources.

6. Corroborating Evidence

- **FOIA Submission Records:** Copies of my FOIA request and follow-up communications provide evidence of agency non-compliance.
- **ADA Accommodation Requests:** Documented requests for accommodations demonstrate the agencies' failure to comply with ADA mandates.

- **Procedural Barriers:** Exclusionary practices and delays confirm systemic efforts to suppress transparency and advocacy.

Conclusion

I discovered these violations through my direct interactions with the FOIA process, repeated denials of ADA accommodations, and exclusion from public forums. These experiences revealed systemic non-compliance with transparency laws, ADA requirements, and constitutional protections, necessitating immediate federal intervention.

5. What Additional Facts Support Your Allegation?

The following facts substantiate the systemic violations of FOIA, ADA, Medicaid regulations, constitutional rights, and taxpayer protections. These facts highlight a pattern of non-compliance, gross waste of funds, and deliberate exclusion of individuals with disabilities from public processes.

1. FOIA Non-Compliance

- **Ignored FOIA Requests:**
    - My initial FOIA request, submitted on **October 25, 2024**, and follow-ups on **October 31, November 2, and December 2, 2024**, were ignored by the Connecticut Attorney General's Office and the Department of Social Services (DSS).
    - Both agencies violated statutory deadlines under **5 U.S.C. § 552** (FOIA) and **Conn. Gen. Stat. § 1-210**, failing to acknowledge or respond to legally submitted requests.
- **Pattern of Obstruction:**
    - The refusal to disclose public records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program reveals systemic suppression of transparency, violating federal and state laws designed to ensure public accountability.

2. ADA Violations

- **Denied Accommodation Requests:**
    - Along with my FOIA request, I submitted explicit requests for reasonable accommodations due to my traumatic brain injury (TBI). These included simplified communication formats and accessible records, as mandated under **Title II of the ADA (42 U.S.C. § 12131)**.
    - The agencies failed to provide these accommodations, violating **28 C.F.R. § 35.130 and § 35.160**, which require public entities to ensure effective communication and equitable access.
- **Exclusionary Practices:**
    - By ignoring ADA accommodation requests, DSS and the Attorney General's Office excluded me from participating in Medicaid program oversight processes.
    - This exclusion violates the **Fourteenth Amendment's Equal Protection Clause** and perpetuates systemic discrimination against individuals with disabilities.

3. Constitutional Violations

- **First Amendment (Right to Petition):**

- FOIA non-compliance obstructed my ability to petition the government for redress of grievances, violating my constitutional right to advocate for transparency and accountability.

- **Fifth Amendment (Due Process):**
  - The agencies' refusal to provide public records and accommodations denied me access to public processes mandated by law, violating my procedural due process rights.

- **Fourteenth Amendment (Equal Protection):**
  - Systemic exclusion from public forums and decision-making processes due to my disability constitutes discrimination, violating my equal protection rights under the law.

4. Medicaid Oversight Failures

- **Lack of Transparency:**
  - No publicly available records or audits exist detailing the Medicaid ABI Waiver Program's administration, provider accountability, or enforcement actions.
  - This absence of oversight violates **42 U.S.C. § 1396a**, which requires Medicaid programs to operate transparently and effectively.

- **Potential Mismanagement:**

- The lack of disclosure regarding complaints, violations, or corrective actions against Medicaid providers raises concerns about fraud, waste, and abuse of taxpayer-funded resources.

5. Whistleblower Retaliation

- **Procedural Barriers:**
  - The agencies imposed procedural barriers, such as non-responsiveness and exclusion from public processes, to suppress my efforts as a whistleblower.
  - These actions constitute retaliation against protected advocacy, violating federal whistleblower protection laws.

6. Corroborating Evidence

- **FOIA Submission Records:**
  - Copies of my FOIA request (October 25, 2024) and follow-ups (October 31, November 2, and December 2, 2024) demonstrate a clear pattern of agency non-compliance.
- **ADA Accommodation Requests:**
  - Documented requests for reasonable accommodations highlight systemic failures to provide equitable access and effective communication.

- **Communication Logs:**
    - Email and written correspondence with DSS and the Attorney General's Office confirm repeated procedural barriers and lack of responsiveness.
- **Program Oversight Deficiencies:**
    - The absence of provider audits, enforcement actions, or corrective measures within the Medicaid ABI Waiver Program underscores systemic neglect.

7. Broader Implications

- **Harm to Vulnerable Populations:**
    - The lack of transparency and accountability jeopardizes the quality of care for Medicaid beneficiaries, particularly individuals with acquired brain injuries.
- **Gross Waste of Funds:**
    - Systemic failures to oversee Medicaid programs risk fraud, waste, and abuse of taxpayer-funded resources, undermining public trust.
- **Public Trust Erosion:**
    - Continued non-compliance with federal and state laws damages confidence in the government's ability to operate programs equitably and effectively.

Conclusion

These additional facts substantiate systemic violations of FOIA, ADA, Medicaid regulations, and constitutional protections. They demonstrate a deliberate pattern of non-compliance and exclusion, necessitating immediate federal intervention to restore transparency, accountability, and equitable program administration.

Danger to Public Health or Safety

The lack of transparency, accountability, and oversight in Connecticut's Medicaid programs, specifically the Acquired Brain Injury (ABI) Waiver Program, poses a significant danger to public health and safety. Vulnerable populations, including individuals with acquired brain injuries, rely on these services for essential care, and systemic failures jeopardize their well-being. Below is a breakdown of how each individual contributed to this danger:

1. Andrea Barton Reeves

- **Title:** Commissioner, Connecticut Department of Social Services (DSS)
- **Role:** Oversees DSS operations, including the Medicaid ABI Waiver Program.
- **Actions Contributing to Danger:**
    - **Lack of Oversight:** Failed to ensure transparency in program operations, including audits, complaints, and enforcement actions, increasing risks of substandard care.
    - **FOIA Non-Compliance:** Refused to disclose information critical to evaluating the program's effectiveness and safety, violating **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
    - **Impact on Vulnerable Populations:** Without accountability, Medicaid beneficiaries, including those with acquired brain injuries, face risks of neglect, mistreatment, or inadequate care.

2. Attorney General William Tong

- **Title:** Connecticut Attorney General
- **Role:** Responsible for ensuring legal compliance across state agencies.
- **Actions Contributing to Danger:**
    - **FOIA Obstruction:** Suppressed transparency efforts by ignoring FOIA requests, obstructing access to vital Medicaid oversight information.
    - **Failure to Enforce Accountability:** Did not hold DSS or other agencies accountable for systemic non-compliance, perpetuating unsafe practices in Medicaid programs.

3. Barbara Manning

- **Title:** CMS Regional Administrator (Region 1)
- **Role:** Oversees CMS operations in Connecticut and other New England states.
- **Actions Contributing to Danger:**
    - **Lack of Federal Oversight:** Neglected to investigate or address systemic failures in Connecticut's Medicaid ABI Waiver Program, despite its federally funded nature.

- **Risk to Public Health:** By failing to ensure program accountability, Barbara Manning allowed unsafe conditions and risks to persist for vulnerable Medicaid populations.

4. Chiquita Brooks-LaSure

- **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
- **Role:** National Administrator of Medicaid programs.
- **Actions Contributing to Danger:**
  - **Failure to Intervene:** Did not address ongoing issues in Connecticut's Medicaid program, allowing risks to public health and safety to escalate.
  - **Jeopardized Beneficiary Care:** Lax oversight contributed to systemic failures that directly impact the quality and accessibility of care for Medicaid beneficiaries.

5. Eileen Meskill

- **Title:** Deputy Attorney General
- **Role:** Second-in-command to Attorney General William Tong.
- **Actions Contributing to Danger:**

- **Neglected Legal Oversight:** Failed to enforce transparency and ADA compliance, preventing stakeholders from ensuring the safety and efficacy of Medicaid programs.

6. Governor Ned Lamont

- **Title:** Governor of Connecticut
- **Role:** Chief Executive of the State of Connecticut.
- **Actions Contributing to Danger:**
  - **Inaction on Systemic Failures:** Despite being aware of the systemic issues in DSS and other agencies, Governor Lamont failed to intervene or address the lack of accountability.
  - **Harm to Public Trust:** This inaction undermines public confidence in programs meant to serve vulnerable populations, further endangering their health and safety.

7. Matthew Brokman

- **Title:** Chief of Staff to Governor Ned Lamont
- **Role:** Oversees executive operations and ensures compliance with the Governor's agenda.
- **Actions Contributing to Danger:**

- **Lack of Executive Oversight:** Failed to ensure that state agencies complied with federal and state requirements for Medicaid program transparency and safety.

8. Tanya Hughes

- **Title:** Executive Director, Commission on Human Rights and Opportunities (CHRO)
- **Role:** Ensures equitable access and compliance with ADA requirements in public services.
- **Actions Contributing to Danger:**
  - **Neglected ADA Complaints:** Did not address exclusionary practices or ensure reasonable accommodations for stakeholders advocating for Medicaid program improvements.
  - **Risk to Vulnerable Groups:** Failure to address ADA violations perpetuates systemic inequities and endangers Medicaid beneficiaries.

Systemic Implications of Danger

1. **Transparency Failures:**
   - FOIA non-compliance and lack of public accountability prevent scrutiny of Medicaid program operations, jeopardizing care quality and safety.
2. **Impact on Vulnerable Populations:**

- Medicaid beneficiaries, particularly those with acquired brain injuries, face increased risks of neglect, mistreatment, or harm due to inadequate oversight.

3. **Erosion of Public Trust:**

    - Lack of accountability undermines confidence in the integrity of public health programs and exposes taxpayers to fraud, waste, and abuse.

4. **Broader Public Health Risk:**

    - Systemic failures in Medicaid administration can set a precedent for unsafe practices in other programs, posing a wider threat to public health and safety.

Conclusion

The systemic lack of transparency and accountability in the Medicaid ABI Waiver Program poses an ongoing danger to public health and safety. Immediate federal intervention is required to protect vulnerable populations, restore program integrity, and ensure compliance with federal oversight requirements.

3. When Did This Occur?

The violations began on **October 25, 2024**, with my initial FOIA request to the Connecticut Attorney General's Office, and continue to this day. Below is a detailed timeline of events that illustrate the systemic and ongoing nature of these violations:

Timeline of Events

1. **October 25, 2024:**
    - I submitted a FOIA request to the Connecticut Attorney General's Office seeking records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - This request also included ADA accommodation requests for simplified communication formats and accessible records due to my traumatic brain injury (TBI).
    - The Attorney General's Office and the Department of Social Services (DSS) failed to acknowledge the request within the statutory **four-business-day deadline** required under **Conn. Gen. Stat. § 1-210**, initiating the first violation.

2. **October 31, 2024:**
    - I submitted a follow-up communication to both the Attorney General's Office and DSS, requesting acknowledgment of my FOIA submission and compliance with ADA requirements.

- Neither agency provided a response, violating FOIA's federal **20-business-day response deadline** under **5 U.S.C. § 552(a)(6)(A)**.

3. **November 2, 2024:**

   - I sent a second follow-up communication reiterating the urgency of my requests for transparency and ADA compliance.
   - Both agencies ignored this communication, compounding the FOIA and ADA violations and demonstrating systemic non-compliance.

4. **December 2, 2024:**

   - I submitted a final follow-up communication highlighting the broader implications of these failures, including violations of Medicaid regulations (**42 U.S.C. § 1396a**) and constitutional rights.
   - No response or acknowledgment was received, further confirming the deliberate and ongoing nature of these violations.

5. **Ongoing and Continuous Violations:**

   - To date, the Attorney General's Office, DSS, and other related entities continue to:
     - Fail to respond to my FOIA requests and provide ADA accommodations.

- Exclude me from public forums and discussions critical to Medicaid program oversight.
- Obstruct access to public records, transparency, and accountability for federally funded Medicaid programs.

Nature of Violations

1. **FOIA Non-Compliance:**
    - Agencies failed to meet acknowledgment and response deadlines under **5 U.S.C. § 552** and **Conn. Gen. Stat. § 1-210**.
2. **ADA Violations:**
    - Ignored requests for accommodations, excluding me from participation and access, violating **42 U.S.C. § 12131** and **28 C.F.R. § 35.130 and § 35.160**.
3. **Constitutional Violations:**
    - These actions infringe on my:
        - **First Amendment right** to petition the government for redress.
        - **Fifth Amendment due process rights**, as agencies denied access to mandated processes and records.
        - **Fourteenth Amendment equal protection rights**, as a person with disabilities.

4. **Medicaid Oversight Failures:**

    - Lack of transparency and accountability violates federal Medicaid regulations (**42 U.S.C. § 1396a**) and jeopardizes the integrity of taxpayer-funded programs.

Conclusion

The violations began on **October 25, 2024**, with my initial FOIA request and persist to this day. These ongoing failures demonstrate systemic neglect, deliberate non-compliance, and significant risks to public health and safety, necessitating immediate federal intervention.

4. How Did You Discover This Action?

I discovered these violations through direct engagement with the Freedom of Information Act (FOIA) process, my role as a whistleblower advocating for transparency in the Medicaid Acquired Brain Injury (ABI) Waiver Program, and repeated attempts to secure reasonable ADA accommodations. Below is a detailed explanation of how I uncovered these systemic failures:

1. Submission of FOIA Requests

- **Date:** October 25, 2024
    - I submitted a FOIA request to the Connecticut Attorney General's Office, seeking records related to the Medicaid ABI Waiver Program to evaluate its oversight and compliance with federal regulations.
    - The agency failed to acknowledge the request within the statutory **four-business-day deadline** under **Conn. Gen. Stat. § 1-210**, which was my first indication of potential systemic transparency issues.

2. Follow-Up Communications

- **Dates:** October 31, November 2, and December 2, 2024
    - After receiving no acknowledgment, I sent follow-up communications to both the Attorney General's Office and the Department of Social Services (DSS).

- The consistent lack of response and failure to meet statutory deadlines under **5 U.S.C. § 552** (FOIA) revealed procedural barriers and deliberate non-compliance with transparency laws.

3. Denial of ADA Accommodations

- Along with my FOIA request, I submitted **explicit ADA accommodation requests** due to my traumatic brain injury (TBI), including simplified communication formats and accessible records.
- The agencies' failure to address or fulfill these accommodations exposed systemic non-compliance with **Title II of the ADA (42 U.S.C. § 12131)** and **28 C.F.R. § 35.130 and § 35.160**.
- This denial of accommodations excluded me from participating in public processes and advocacy efforts, further confirming institutional barriers and discriminatory practices.

4. Exclusion from Public Processes

- Despite being a direct stakeholder in the Medicaid ABI Waiver Program, I was excluded from public forums and decision-making processes critical to Medicaid oversight.
- This exclusion revealed violations of my:
    - **First Amendment right** to petition the government for redress.

- **Fifth Amendment due process rights**, as I was denied access to legally mandated processes.
- **Fourteenth Amendment right to equal protection**, as a person with disabilities.

5. Broader Investigation and Findings

- As I sought to understand the lack of response and accommodations, I uncovered broader systemic issues, including:
  - **Lack of Transparency:** No publicly available records on Medicaid program oversight, provider accountability, or program audits.
  - **Potential Mismanagement:** The absence of disclosures about enforcement actions against providers or corrective measures raised concerns about fraud, waste, and abuse of taxpayer-funded resources.

6. Corroborating Evidence

- **FOIA Submission Records:** Copies of my FOIA request and follow-up communications provide evidence of non-compliance.
- **ADA Accommodation Requests:** Documented requests for accommodations highlight systemic failures to provide equitable access and effective communication.

- **Communication Logs:** Correspondence with DSS and the Attorney General's Office confirms procedural barriers and systemic non-responsiveness.

Conclusion

I discovered these actions through my direct engagement with the FOIA process, repeated denials of ADA accommodations, and exclusion from public processes. These experiences exposed systemic non-compliance with transparency laws, ADA requirements, and constitutional protections, necessitating immediate federal intervention.

Constitutional Rights Violations Contributing to Danger to Public Safety

The systemic failures in transparency, ADA compliance, and oversight within Connecticut's Medicaid programs, particularly the ABI Waiver Program, violate multiple constitutional rights and significantly endanger public safety. Below are the specific constitutional violations linked to key individuals' actions or inactions.

1. First Amendment Violations

- **Right to Petition the Government:**
    - **What Happened:**
        - FOIA non-compliance obstructed my right to petition the government for redress of grievances.
        - The Attorney General's Office and DSS suppressed my advocacy efforts by ignoring lawful FOIA requests, preventing me from addressing systemic Medicaid oversight failures.
    - **Constitutional Violation:**
        - Suppressing my ability to request information and advocate for transparency violates the **First Amendment**.

2. Fifth Amendment Violations

- **Right to Due Process:**
    - **What Happened:**
        - Denied access to public records mandated by FOIA and state law.
        - Ignored ADA accommodations, effectively excluding me from participating in Medicaid-related public processes.
        - Procedural barriers and non-responsiveness blocked my access to legal remedies.
    - **Constitutional Violation:**
        - These actions violate the **Fifth Amendment**, which guarantees procedural due process rights when engaging with government processes.

3. Fourteenth Amendment Violations

- **Equal Protection Under the Law:**
    - **What Happened:**
        - Denial of ADA accommodations excluded me, as a person with a disability, from critical forums and decision-making processes concerning Medicaid oversight.
        - Systemic neglect disproportionately impacts individuals with acquired brain injuries and disabilities, creating unequal access to public services.

- **Constitutional Violation:**
    - This exclusion constitutes discrimination, violating the **Fourteenth Amendment's Equal Protection Clause**.

- **Due Process (State-Level Applications):**
    - **What Happened:**
        - Lack of transparency and accountability in Medicaid programs directly affects beneficiaries' ability to access safe, effective care.
        - DSS and the Attorney General's Office ignored FOIA requests and procedural requirements, bypassing due process obligations.
    - **Constitutional Violation:**
        - These actions also violate the Fourteenth Amendment's **Due Process Clause**, which requires fairness in government actions impacting individuals' rights.

Specific Violations Linked to Danger to Public Safety

1. **Denial of Transparency (First and Fifth Amendments):**
    - FOIA violations obstruct public accountability, preventing timely identification of safety risks in Medicaid programs, which jeopardizes beneficiaries' lives and well-being.

2. **Exclusion of Stakeholders (Fourteenth Amendment):**

    - The exclusion of individuals with disabilities from public processes weakens program accountability and oversight, increasing risks of harm to vulnerable populations.

3. **Suppression of Advocacy (First Amendment):**

    - Retaliatory procedural barriers discourage whistleblower advocacy, allowing dangerous conditions to persist within Medicaid programs.

4. **Failure to Provide Due Process (Fifth and Fourteenth Amendments):**

    - Denying access to records and accommodations prevents individuals from engaging in legally mandated oversight, violating due process and endangering public safety.

Contributing Actions by Key Individuals

Andrea Barton Reeves (Commissioner, DSS):

- Ignored FOIA requests, violating the First and Fifth Amendments.
- Failed to provide ADA accommodations, violating the Fourteenth Amendment's Equal Protection Clause.

Attorney General William Tong:

- Suppressed transparency by allowing systemic FOIA non-compliance, violating the First Amendment.
- Failed to ensure ADA compliance, perpetuating discrimination and violating the Fourteenth Amendment.

Barbara Manning (CMS Regional Administrator):

- Neglected oversight of Medicaid programs, enabling systemic failures that endanger vulnerable populations and violate constitutional protections.

Chiquita Brooks-LaSure (CMS Administrator):

- Failed to enforce transparency and oversight within Connecticut's Medicaid programs, allowing constitutional violations to persist.

Eileen Meskill (Deputy Attorney General):

- Operationally responsible for FOIA compliance, ignored requests, and failed to address ADA violations, compounding constitutional infractions.

Governor Ned Lamont:

- As the state's chief executive, failed to intervene in systemic failures, allowing violations of constitutional rights to persist unchecked.

Systemic Impact of Constitutional Violations

1. **Public Health Risk:**

- Denying transparency and excluding stakeholders from oversight processes jeopardizes the safety and well-being of Medicaid beneficiaries.

2. **Erosion of Public Trust:**

    - Violations of constitutional rights and lack of government accountability undermine public confidence in Medicaid programs and taxpayer-funded initiatives.

3. **Increased Risks for Vulnerable Populations:**

    - Discrimination and lack of oversight disproportionately harm individuals with acquired brain injuries and disabilities, leaving them vulnerable to neglect, mistreatment, or harm.

Conclusion

The actions of key individuals and agencies violate the **First, Fifth, and Fourteenth Amendments** of the U.S. Constitution. These constitutional infractions directly contribute to systemic risks that endanger public safety and necessitate immediate federal intervention to uphold the rule of law and protect vulnerable populations.

3. When Did This Occur?

The violations began on **October 25, 2024**, with the submission of my initial FOIA request to the Connecticut Attorney General's Office, and continue to this day. Below is a detailed timeline of events, demonstrating systemic and ongoing failures.

Timeline of Events

1. **October 25, 2024:**
    - I submitted a FOIA request to the Connecticut Attorney General's Office, seeking records related to the Medicaid Acquired Brain Injury (ABI) Waiver Program.
    - This request explicitly included ADA accommodation requests for simplified communication formats and accessible records, as required under **Title II of the ADA (42 U.S.C. § 12131)**.
    - The Attorney General's Office and the Department of Social Services (DSS) failed to acknowledge this request within the statutory **four-business-day deadline** required under **Conn. Gen. Stat. § 1-210**, initiating the first violation.

2. **October 31, 2024:**
    - I sent a follow-up communication to the Attorney General's Office and DSS, requesting acknowledgment of my FOIA submission and compliance with ADA requirements.

- Neither agency responded, violating federal FOIA response deadlines under **5 U.S.C. § 552(a)(6)(A)**.

3. **November 2, 2024:**

   - I submitted a second follow-up communication reiterating the urgency of my requests for transparency and ADA compliance.
   - Both agencies ignored this communication, compounding FOIA and ADA violations and demonstrating systemic neglect.

4. **December 2, 2024:**

   - I submitted a final follow-up communication highlighting the broader implications of these failures, including violations of federal Medicaid regulations (**42 U.S.C. § 1396a**) and constitutional rights.
   - Neither agency provided any acknowledgment or response, confirming deliberate non-compliance and ongoing violations.

5. **Ongoing and Continuous Violations:**

   - As of today, the Attorney General's Office, DSS, and other related entities continue to:

- Refuse to respond to my FOIA requests or provide ADA accommodations.
- Exclude me from public forums and discussions critical to Medicaid program oversight.
- Obstruct access to public records and accountability in federally funded programs.

Nature of Violations

1. **FOIA Non-Compliance:**
    - Agencies failed to meet acknowledgment and response deadlines under **5 U.S.C. § 552(a)(6)(A)** and **Conn. Gen. Stat. § 1-210**.
2. **ADA Violations:**
    - Ignored requests for accommodations, excluding me from participation and access, violating **42 U.S.C. § 12131** and **28 C.F.R. § 35.130 and § 35.160**.
3. **Constitutional Violations:**
    - These ongoing failures infringe on my:
        - **First Amendment right** to petition the government for redress of grievances.
        - **Fifth Amendment due process rights**, as agencies denied access to mandated processes and records.

- **Fourteenth Amendment equal protection rights**, as a person with disabilities.

4. **Medicaid Oversight Failures:**

    - Lack of transparency and accountability violates federal Medicaid regulations (**42 U.S.C. § 1396a**) and jeopardizes the integrity of taxpayer-funded programs.

Conclusion

The violations began on **October 25, 2024**, with my initial FOIA request and persist to this day. These ongoing failures represent a pattern of systemic neglect, deliberate non-compliance, and significant risks to public health, safety, and constitutional rights.

4. How Did You Discover This Action?

I discovered these violations through direct engagement with the Freedom of Information Act (FOIA) process, my role as a whistleblower advocating for transparency in the Medicaid Acquired Brain Injury (ABI) Waiver Program, and repeated attempts to secure reasonable ADA accommodations. Below is a detailed explanation of how I uncovered these systemic failures:

1. Submission of FOIA Requests

- **Date:** October 25, 2024
    - I submitted a FOIA request to the Connecticut Attorney General's Office, seeking records related to the Medicaid ABI Waiver Program to evaluate its oversight, compliance with federal Medicaid regulations, and effectiveness in serving vulnerable populations.
    - The lack of acknowledgment or response to this request, required under **Conn. Gen. Stat. § 1-210** and **5 U.S.C. § 552(a)(6)(A)**, indicated potential transparency failures and non-compliance with statutory obligations.

2. Follow-Up Communications

- **Dates:** October 31, November 2, and December 2, 2024
    - After receiving no acknowledgment, I sent multiple follow-up communications to both the Attorney General's Office and the Department of Social Services (DSS).

- The continued lack of response revealed systemic procedural failures and deliberate suppression of transparency, as required under state and federal FOIA laws.

3. Denial of ADA Accommodations

- Along with my FOIA request, I submitted **explicit ADA accommodation requests** due to my traumatic brain injury (TBI). These accommodations included:
  - Simplified communication formats.
  - Accessible records compatible with assistive technologies.
- The agencies' failure to fulfill these reasonable accommodation requests demonstrated non-compliance with **Title II of the ADA (42 U.S.C. § 12131)** and its implementing regulations (**28 C.F.R. § 35.130 and § 35.160**).
- This exclusion from participating in critical oversight processes further revealed systemic discrimination and procedural barriers.

4. Exclusion from Public Processes

- Despite being a direct stakeholder in the Medicaid ABI Waiver Program, I was excluded from public forums, discussions, and decision-making processes critical to Medicaid program oversight.

- This exclusion revealed violations of my:
    - **First Amendment right** to petition the government for redress of grievances.
    - **Fifth Amendment due process rights**, as I was denied access to legally mandated processes.
    - **Fourteenth Amendment right to equal protection**, as a person with disabilities.

5. Broader Investigation and Findings

- Through my advocacy efforts, I uncovered broader systemic issues, including:
    - **Lack of Transparency:** No publicly available records, audits, or enforcement actions exist detailing the Medicaid ABI Waiver Program's operations or accountability mechanisms.
    - **Potential Mismanagement:** Absence of records about complaints, violations, or corrective actions raises concerns about fraud, waste, and abuse of taxpayer-funded Medicaid resources.
    - **Barriers to Accountability:** Systemic delays and exclusionary practices obstruct meaningful oversight and advocacy efforts.

6. Corroborating Evidence

- **FOIA Submission Records:**

    - Copies of my FOIA request (October 25, 2024) and follow-ups (October 31, November 2, and December 2, 2024) provide evidence of agency non-compliance.

- **ADA Accommodation Requests:**
    - Documented requests for accommodations highlight the agencies' failure to comply with ADA mandates and ensure equitable participation.

- **Communication Logs:**
    - Correspondence with DSS and the Attorney General's Office confirms procedural barriers, delays, and systemic non-responsiveness.

- **Lack of Accountability Measures:**
    - The absence of publicly disclosed records on Medicaid program oversight supports allegations of systemic neglect and potential mismanagement.

Conclusion

I discovered these systemic failures through my direct involvement with the FOIA process, repeated denials of ADA accommodations, and exclusion from critical Medicaid oversight processes. These experiences revealed widespread violations of transparency laws, ADA requirements, and constitutional protections, necessitating immediate federal intervention.

What Action Would I Like OSC to Take?

1. Launch a Comprehensive Investigation

- **Systemic FOIA Non-Compliance:**
    - Investigate failures by the Connecticut Department of Social Services (DSS), the Connecticut Attorney General's Office, and related state agencies to comply with **FOIA (5 U.S.C. § 552)** and **Conn. Gen. Stat. § 1-210**.
    - Review delays and refusals to provide records related to Medicaid ABI Waiver Program operations, including:
        - Provider complaints.
        - Financial audits and fund usage.
        - Accountability measures, including investigations of fraud or misconduct.
- **ADA Non-Compliance:**
    - Investigate systemic refusal to provide reasonable accommodations under the **Americans with Disabilities Act (ADA)**, including:
        - Simplified communication formats.
        - Accessible public records.
        - Inclusion in public forums related to Medicaid program oversight.

- **Constitutional Violations:**
    - Examine infringements of:
        - **First Amendment:** Suppressing my right to petition the government for redress of grievances through FOIA obstruction.
        - **Fifth Amendment:** Denying access to due process by excluding me from government processes and failing to provide legally mandated public records.
        - **Fourteenth Amendment:** Discriminating against me as a person with disabilities, violating my equal protection rights.
- **Whistleblower Retaliation:**
    - Investigate procedural barriers, public exclusion, and systemic retaliation aimed at suppressing my advocacy for transparency and accountability.
    - Examine whether Connecticut state officials or agencies retaliated against me for exposing systemic Medicaid mismanagement.
- **Gross Mismanagement of Medicaid Funds:**
    - Investigate DSS and related entities for potential violations of **42 U.S.C. § 1396a**, including failure to:
        - Ensure efficient administration of federally funded Medicaid programs.
        - Prevent fraud, waste, and abuse of taxpayer dollars.

- Provide effective oversight of the ABI Waiver Program.

2. Enforce Immediate Corrective Actions

- **Transparency and FOIA Compliance:**
  - Compel DSS, the Attorney General's Office, and all implicated agencies to:
    - Immediately release all records requested under FOIA, including Medicaid provider complaints, financial audits, and enforcement actions.
    - Comply with statutory deadlines for FOIA requests and provide justifications for any redactions or exemptions under **5 U.S.C. § 552(b)**.
- **ADA Compliance:**
  - Mandate immediate implementation of ADA accommodations for individuals with disabilities, including:
    - Simplified communication formats and accessible public records.
    - Equal access to public forums and decision-making processes.
  - Enforce compliance with **28 C.F.R. § 35.130 and § 35.160**, which require effective communication and prohibit discriminatory practices.
- **Whistleblower Protections:**
  - Enforce protections under the **Whistleblower Protection Act** to prevent further retaliation against me for exposing systemic failures.

- Ensure that agencies involved are prohibited from imposing procedural barriers or other retaliatory actions.

3. Hold Individuals Accountable

- **Identify Responsible Parties:**
  - Investigate the roles of key individuals, including:
    - Andrea Barton Reeves (Commissioner, DSS).
    - Attorney General William Tong.
    - Barbara Manning (CMS Regional Administrator).
    - Chiquita Brooks-LaSure (CMS Administrator).
    - Governor Ned Lamont and his Chief of Staff, Matthew Brokman.
  - Determine whether their actions or inactions contributed to systemic non-compliance, retaliation, and gross mismanagement.
- **Disciplinary Measures:**
  - Recommend disciplinary action for officials found to have violated federal laws, suppressed whistleblower advocacy, or enabled discrimination and non-transparency.

4. Recommend Systemic Reforms

- **Structural Changes:**
    - Recommend the establishment of independent oversight mechanisms to ensure ADA compliance, whistleblower protections, and transparency within Medicaid programs.
    - Mandate annual independent audits of Medicaid programs to prevent fraud, waste, and abuse.
- **Whistleblower Protections:**
    - Recommend stronger federal oversight of whistleblower complaints related to federally funded programs.
    - Propose policies requiring immediate and comprehensive responses to whistleblower allegations.
- **Transparency Initiatives:**
    - Require DSS and related agencies to:
        - Publish annual reports on Medicaid program operations, including complaints, audits, and corrective actions.
        - Maintain a publicly accessible database of provider violations and enforcement outcomes.

5. Ensure Restorative Justice

- **Compensation for Harm:**
    - Seek restitution for damages caused by systemic retaliation, ADA violations, and procedural barriers that obstructed my advocacy and access to information.
    - Provide compensation for lost time, resources, and advocacy opportunities resulting from agency non-compliance.
- **Public Acknowledgment:**
    - Require public acknowledgment of systemic failures by DSS, CHRO, and the Attorney General's Office, including an apology for violating whistleblower protections and ADA compliance.

6. Promote Public Accountability

- **Public Reporting:**
    - Ensure that findings from OSC investigations are publicly disclosed, including corrective actions and enforcement measures.
    - Require regular updates to demonstrate progress in addressing systemic issues and ensuring compliance with federal laws.
- **Stakeholder Inclusion:**

- Mandate the inclusion of whistleblowers, disability advocates, and affected stakeholders in oversight and decision-making processes related to Medicaid programs.

7. Address Broader Public Safety Risks

- **Immediate Risk Mitigation:**
  - Address ongoing risks to public safety posed by systemic failures in Medicaid oversight, including:
    - Lack of provider accountability.
    - Potential neglect or mistreatment of Medicaid beneficiaries.
  - Strengthen enforcement of **42 U.S.C. § 1396a** to ensure Medicaid programs operate effectively and safely.
- **Policy Changes:**
  - Recommend federal policy changes to prevent similar systemic failures in other states, focusing on transparency, accountability, and whistleblower protections.

Conclusion

These actions are necessary to uphold **whistleblower protections**, ensure compliance with **FOIA**, **ADA**, and **constitutional rights**, and protect public safety. Immediate federal

intervention and systemic reform are critical to restoring transparency, accountability, and trust in Medicaid programs.

Request for Federal Representation

The Office of Special Counsel (OSC) and other relevant federal agencies, including the Department of Justice (DOJ), the Department of Health and Human Services (HHS), and the Centers for Medicare & Medicaid Services (CMS), must represent **both myself as a whistleblower and the broader public** in addressing these systemic violations. These actions should include:

1. Representing Whistleblower Rights

- **Protect My Advocacy Efforts:**
    - Enforce whistleblower protections under the **Whistleblower Protection Act** to safeguard my rights and ensure that my efforts to expose systemic failures are not met with retaliation.
    - Act as a federal intermediary to hold state agencies accountable for obstructing transparency and ADA compliance.
- **Provide Legal and Procedural Representation:**
    - Advocate for my access to records, ADA accommodations, and participation in oversight processes as required under **FOIA**, **ADA**, and **constitutional rights** provisions.
    - Assist in ensuring that state agencies, including DSS and the Connecticut Attorney General's Office, comply with federal laws and policies.

2. Representing the Broader Public Interest

- **Ensure Accountability for Medicaid Mismanagement:**
    - Represent the interests of taxpayers and Medicaid beneficiaries by investigating systemic mismanagement and potential misuse of federal funds under **42 U.S.C. § 1396a**.
    - Address gross waste of federal and state resources allocated to the Medicaid ABI Waiver Program, ensuring that these funds serve their intended purpose of supporting vulnerable populations.
- **Protect Public Safety:**
    - Act on behalf of individuals who rely on Medicaid services, ensuring program integrity and preventing harm to public health and safety caused by lack of oversight, transparency, or accountability.
    - Address the exclusion of stakeholders with disabilities from decision-making processes, which creates inequitable systems that endanger lives and erode public trust.

3. Federal Oversight of State Agencies

- **Hold State Agencies Accountable:**

- Represent federal authority in addressing Connecticut's systemic failures, ensuring that state agencies comply with federal laws, including **FOIA**, **ADA**, and Medicaid oversight regulations.
- Require the Connecticut Department of Social Services (DSS), the Connecticut Attorney General's Office, and CHRO to implement federal-mandated corrective actions.

- **Demand Systemic Reforms:**
  - Advocate for the establishment of independent oversight bodies to monitor ADA compliance, Medicaid program transparency, and whistleblower protections in Connecticut.

4. Advocating for Constitutional Protections

- **First Amendment:**
  - Ensure my right to petition the government for redress of grievances is fully protected by holding state agencies accountable for suppressing FOIA requests and obstructing advocacy efforts.
- **Fifth Amendment:**
  - Guarantee procedural due process in accessing public records, participating in Medicaid oversight, and ensuring equitable treatment under the law.
- **Fourteenth Amendment:**

- Demand equal protection for individuals with disabilities who are excluded from public forums, decision-making processes, and oversight roles due to systemic ADA violations.

5. Supporting Restorative Justice

- **Advocate for Compensation and Acknowledgment:**
  - Request compensation for the harm caused to myself and others affected by these systemic violations, including delays, barriers to advocacy, and exclusion from public processes.
  - Seek a public acknowledgment of failures by Connecticut state agencies to ensure accountability and transparency for the public.
- **Mandate Public Reforms:**
  - Represent the public interest by ensuring systemic reforms that guarantee transparency, accountability, and compliance with federal laws in all future Medicaid operations.

Conclusion

This request explicitly asks the federal government, through OSC and related agencies, to act on behalf of **both myself as a whistleblower** and the **broader public interest**, ensuring transparency, equity, and accountability in federally funded programs. The federal government's

role is essential to restoring trust in public institutions and protecting the rights of whistleblowers and vulnerable populations.

"Federal Representation for Justice: Addressing Systemic Violations of Constitutional Rights, ADA Protections, and Whistleblower Safeguards to Ensure Transparency and Accountability"

Complaint and Demand for Justice: Systemic Violations of Constitutional Rights, ADA Compliance, Whistleblower Protections, and State Transparency Obligations

What's Specifically Happening

1. **State Agencies Are Failing in Their Duties**

- **CHRO (Commission on Human Rights and Opportunities):**
  CHRO is responsible for investigating discrimination complaints, including ADA violations. David submitted a notarized complaint detailing ADA violation by DSS, yet CHRO refuses to assign a case number or take meaningful action. This failure obstructs justice, denies David's right to due process, and allows systemic discrimination to persist unchecked.

- **Connecticut DSS (Department of Social Services):**
  DSS officials have publicly ridiculed David, excluded him from discussions, and obstructed his access to information critical for accountability. DSS has also failed

to provide the ADA accommodations David needs to engage meaningfully in its processes.

- **Attorney General's Office:**

  Despite receiving evidence of systemic failures and misconduct, the Attorney General's Office has ignored David's calls for intervention, effectively enabling DSS and CHRO's inaction.

2. **Federal Agencies Are Neglecting Oversight Responsibilities**

   - **DOJ (Department of Justice):**

     David escalated his complaints to the DOJ, highlighting ADA violations, FOIA non-compliance, and whistleblower retaliation. Despite unmistakable evidence, DOJ has taken no substantive action to protect David's rights or hold Connecticut accountable.

   - **HHS OCR (Office for Civil Rights):**

     As the federal agency responsible for enforcing ADA compliance in healthcare settings, HHS OCR has failed to address the systemic failures within Connecticut's Medicaid program, leaving vulnerable populations without recourse.

3. **Exploitation of Disability**

   - Agencies are exploiting David's brain injury and related cognitive challenges, such as memory difficulties, by creating procedural barriers and refusing to

provide accommodations. This deliberate exclusion compounds his inability to navigate the system and enforce his rights effectively.

4. **Retaliation for Whistleblowing**

    - David's efforts to expose Medicaid mismanagement and corruption have made him a target of systemic retaliation. Rather than address the issues he has raised, state and federal entities are obstructing his advocacy, denying him access to justice, and suppressing his whistleblower protections.

The Broader Implications

1. **Erosion of Public Trust**

    - Connecticut's refusal to investigate or address its own systemic failures undermines public confidence in state agencies and their commitment to justice and transparency.

2. **Mismanagement of Taxpayer Funds**

    - The misuse or mismanagement of Medicaid funds harms taxpayers and jeopardizes the financial stability of federal healthcare programs.

3. **Endangerment of Vulnerable Populations**

    - By neglecting ADA compliance and suppressing whistleblowers, these agencies fail to protect individuals who depend on Medicaid and disability rights protections, perpetuating harm to vulnerable communities.

The violations of **ADA**, **civil**, and **constitutional rights** against David Medeiros stem from systemic corruption, deliberate inaction, and institutional self-preservation. Connecticut's state agencies and federal oversight bodies are fully aware of David's **brain injury**, which adds an egregious dimension to their failure to act. Below is a detailed analysis of the root causes and their implications.

1. Shielding Mismanagement

A Culture of Secrecy to Avoid Accountability

Connecticut's agencies operate within an environment of financial strain and heavy dependence on **Medicaid funding**. The exposure of systemic mismanagement would not only jeopardize federal funding but also trigger public scrutiny, damaging political stability and institutional reputations. These motivations drive a deliberate effort to suppress transparency and accountability.

Key Points:

- **Avoiding Scrutiny:** Connecticut officials prioritize obscuring inefficiencies and potential financial mismanagement rather than addressing whistleblower concerns.
- **Fiscal Vulnerability:** The state's precarious financial position fuels an incentive to suppress whistleblowers and deny transparency to prevent federal audits or public fallout.
- **Retaliatory Measures:** Agencies such as DSS retaliate against whistleblowers like David Medeiros to deter future accountability efforts, reinforcing a culture of impunity.

2. Lack of Federal Enforcement

Deferred Oversight Creates a Vacuum of Accountability

Federal agencies like the **Department of Justice (DOJ)** and **Office for Civil Rights (OCR)** within the **Department of Health and Human Services (HHS)** are tasked with enforcing ADA compliance and whistleblower protections. However, these agencies frequently defer to state jurisdictions, allowing violations to persist unchecked.

Key Points:

- **Vacuum of Accountability:** Federal inaction emboldens state agencies like DSS and CHRO, which exploit procedural loopholes to evade oversight.
- **Under prioritization of Disability Complaints:** ADA violations and whistleblower complaints, especially from individuals with disabilities, are often deprioritized due to bureaucratic inefficiency or limited resources.
- **Implicit Endorsement of State Inaction:** The lack of federal enforcement signals that state agencies can act with impunity, undermining the very purpose of federal protections.

3. Systemic Corruption

Institutional Self-Preservation Over Justice

The refusal to act on credible complaints and the systemic obstruction faced by David Medeiros are indicative of deeper corruption. Agencies prioritize shielding themselves and their leadership over upholding public trust or addressing misconduct.

Key Points:

- **Corruption-Fueled Retaliation:** DSS and CHRO are complicit in protecting officials engaged in discriminatory or retaliatory practices by refusing to investigate or acknowledge complaints.
- **Erosion of Public Trust:** The failure to address David's complaints undermines confidence in government accountability, fostering public disenfranchisement.
- **Misaligned Priorities:** Agencies prioritize maintaining their power structures over ensuring justice, enabling discrimination and retaliatory practices to persist.

Exploitation of David Medeiros' Brain Injury

The deliberate disregard for David's documented **cognitive challenges** is not just an act of negligence; it represents a **weaponization of his disability** to suppress his advocacy and deny him justice.

4. Deliberate Procedural Barriers

Agencies such as DSS and CHRO have systematically refused to provide ADA-mandated accommodations, including simplified processes, email-only correspondence, and accessible

formats. These failures exacerbate David's difficulties as a **traumatic brain injury (TBI)** survivor.

Specific Examples:

- **Procedural Delays:** Refusal to simplify communication has created insurmountable delays and confusion, making it nearly impossible for David to pursue justice effectively.
- **Weaponized Complexity:** Agencies have used procedural obstacles to exhaust David's resources, undermine his advocacy, and delay action indefinitely.
- **Institutional Knowledge of Disability:** Officials are aware of David's cognitive challenges yet exploit them to silence his voice and obstruct his efforts to hold the system accountable.

5. Retaliation and Exclusion

David Medeiros' whistleblowing activities have made him a target for systemic retaliation. DSS officials and other state actors have exploited his disability to undermine his credibility and suppress his advocacy.

Key Retaliatory Actions:

- **Public Ridicule:** DSS officials publicly ridiculed David during ABI Waiver forums, excluding him from critical discussions and decision-making processes.

- **Whistleblower Retaliation:** David's whistleblowing on Medicaid mismanagement has been met with systematic obstruction, inaction, and exclusion, violating federal whistleblower protections.
- **Suppression of Advocacy:** By denying David a platform, these agencies have silenced his advocacy, depriving vulnerable populations of a powerful voice.

The Broader Implications

The systemic failures and deliberate exploitation of David Medeiros' disability have far-reaching consequences that extend beyond his individual case.

1. Erosion of Public Trust

- Connecticut's refusal to investigate or address its own systemic failures undermines public confidence in government accountability.
- Federal inaction further erodes trust, signaling that the government is unwilling to protect constitutional rights or enforce transparency.

2. Endangerment of Vulnerable Populations

- By disregarding ADA compliance and whistleblower protections, these agencies fail to uphold the rights of individuals who depend on Medicaid and disability accommodations.

- This systemic neglect perpetuates harm to already marginalized communities, leaving them without recourse or protection.

3. Mismanagement of Public Funds

- The misuse or mismanagement of Medicaid funds, coupled with a lack of transparency, raises significant concerns about financial accountability.
- Taxpayer dollars intended to support vulnerable populations are instead diverted or wasted, further exacerbating systemic inequality.

Conclusion: A Call for Justice

David Medeiros is not only a victim of systemic retaliation but also a symbol of the broader failures within Connecticut's state agencies and federal oversight bodies. The deliberate exploitation of his disability and suppression of his advocacy represents a fundamental violation of **constitutional rights**, **ADA protections**, and **public trust**.

These coordinated failures demand immediate and decisive federal intervention to restore justice, enforce accountability, and ensure systemic reform.

The Crux of the Matter

David Medeiros is trapped in a system designed to suppress whistleblowers, marginalize individuals with disabilities, and shield governmental misconduct. Each agency involved is either actively retaliating against him or passively allowing injustices to continue, leaving him without meaningful recourse.

This pattern of neglect and retaliation is not just a personal injustice—it represents a systemic failure that threatens the rights of all vulnerable populations.

Would you like this clarified further, or should we strengthen specific aspects of the complaint?

Complaint and Demand for Justice: Systemic Violations of Constitutional Rights, ADA Compliance, Whistleblower Protections, and State Transparency Obligations

Complainant:

David Medeiros

Founder, ABI Resources

Willimantic, Connecticut

Filed Against:

- **Connecticut Commission on Human Rights and Opportunities (CHRO)**

- **Connecticut Attorney General's Office**
- **Connecticut Department of Social Services (DSS)**
- **Unidentified State and Federal Officials**
- **U.S. Department of Justice (DOJ), Civil Rights Division**
- **U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)**

Preface and Executive Summary

This complaint seeks to expose a systemic and coordinated failure by Connecticut state agencies, compounded by federal inaction, to uphold constitutional rights, enforce ADA compliance, protect whistleblowers, and maintain transparency through FOIA and related laws. As a whistleblower and a person with a brain injury, David Medeiros has been systematically retaliated against, discriminated against, and excluded from public processes vital to his rights, his advocacy, and his ability to serve the community of individuals with disabilities.

This primary complaint is submitted to demand:

1. Immediate enforcement of legal protections and accommodations.
2. A comprehensive investigation into systemic misconduct.
3. Transparent accountability and systemic reform to prevent recurrence of these injustices.

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1. Introduction and Purpose of the Complaint

David Medeiros files this primary complaint to document, expose, and demand immediate redress for systemic violations of his rights as a whistleblower, advocate, taxpayer, and person with a disability. Connecticut state agencies, including CHRO and DSS, have engaged in

deliberate and coordinated actions to suppress transparency, deny lawful accommodations, and retaliate against his efforts to expose Medicaid mismanagement and advocate for individuals with disabilities.

Despite notifying federal agencies, including the DOJ and HHS OCR, of these violations, no meaningful action has been taken. This complaint seeks enforcement of all applicable federal and state laws, systemic reform, and relief for the harms caused to David Medeiros and the broader population affected by these failures.

2. Legal Background and Framework

This complaint is rooted in foundational legal principles, federal statutes, and state laws designed to protect constitutional rights, ensure equity, and uphold accountability in public services.

A. Constitutional Provisions

1. **First Amendment**: Protects the right to petition the government for redress of grievances. CHRO's refusal to assign a case number and the Connecticut Attorney General's inaction constitute suppression of this fundamental right.
2. **Fifth Amendment**: Guarantees due process protections, violated by the state's failure to provide substantive responses or avenues for redress.
3. **Fourteenth Amendment**: Ensures equal protection under the law, which has been denied to David Medeiros as a person with a disability and whistleblower.

B. Federal Statutes

1. **Americans with Disabilities Act (ADA) Title II (42 U.S.C. § 12132)**: Prohibits discrimination in public services, requiring accessibility and accommodations.
2. **Rehabilitation Act (29 U.S.C. § 794)**: Mandates accessibility and prohibits discrimination in federally funded programs.
3. **Whistleblower Protection Act (5 U.S.C. § 2302)**: Protects individuals reporting government misconduct, ensuring they are shielded from retaliation.
4. **Freedom of Information Act (FOIA, 5 U.S.C. § 552)**: Mandates timely access to public records to ensure accountability and transparency.

C. Connecticut Statutory Obligations

1. **Connecticut FOIA (C.G.S. § 1-200 et seq.)**: Ensures public access to government records and transparency in state agency operations.
2. **Anti-Discrimination Laws under CHRO's Jurisdiction**: Mandate investigation of complaints alleging discrimination or retaliation.

D. Case Law Supporting the Complaint

1. **Tennessee v. Lane (2004)**: Reaffirmed the ADA's applicability to public services and institutions.
2. **NARA v. Favish (2004)**: Established FOIA's role in ensuring transparency in matters of public interest.
3. **Chevron U.S.A., Inc. v. NRDC (1984)**: Limited agency discretion to ensure compliance with statutory mandates.

3. Factual Background and Timeline of Events

October 24, 2024 – Filing of CHRO Complaint

- David Medeiros submitted a notarized complaint to CHRO detailing ADA violations and systemic retaliation by DSS.
- Request: Assignment of a case number and initiation of an investigation.
- CHRO Response: No acknowledgment, no case number, and no investigation, violating statutory obligations.

October 30, 2024 – Follow-Up with CHRO

- David requested an update on the status of his complaint and reiterated the need for a case number.
- CHRO Response: Continued silence and inaction, creating procedural barriers.

November 1, 2024 – Appeal to Connecticut Attorney General

- Evidence of misconduct by DSS and CHRO submitted to the Attorney General, requesting oversight and intervention.
- AG Response: No acknowledgment or action, constituting abdication of statutory duties.

November 10, 2024 – Escalation to DOJ

- David submitted a detailed complaint to the DOJ, citing constitutional violations, ADA non-compliance, and whistleblower retaliation.

- DOJ Response: No substantive action, perpetuating systemic inaction and allowing violations to persist.

November 28, 2024 – Current Status

- CHRO: Refuses to act on the complaint or provide a case number.
- Attorney General: Has ignored all submissions, shielding state agencies from accountability.
- DOJ: Failed to enforce federal protections under the ADA and whistleblower statutes.

4. Systemic Violations of Law

A. Constitutional Violations

1. **First Amendment**
    - **Violation**: The Connecticut Commission on Human Rights and Opportunities (CHRO), the Connecticut Attorney General's Office, and DSS have systematically suppressed David Medeiros' right to petition for redress of grievances. CHRO's refusal to assign a case number to his notarized complaint constitutes an outright denial of access to due process mechanisms.
    - **Supporting Precedent**:

- *Borough of Duryea v. Guarnieri (2011)*: Affirmed the right of individuals to petition the government for redress, reinforcing that denial of this right constitutes a constitutional violation.

- **Actions Involved**:
  - Delays and procedural barriers to processing the complaint.
  - Obstructive silence from CHRO, DSS, and the Attorney General's office.

2. **Fifth Amendment**

- **Violation**: Connecticut agencies' refusal to engage with David's complaints, issue case numbers, or provide updates denies him the procedural due process guaranteed under the Fifth Amendment.
- **Supporting Precedent**:
  - *Mathews v. Eldridge (1976)*: Established procedural due process requirements for fair and meaningful engagement with citizens.
- **Actions Involved**:
  - Arbitrary and capricious denial of access to legal and investigative procedures by CHRO.
  - DSS's retaliation and lack of transparency regarding Medicaid programs.

3. **Fourteenth Amendment**

- **Violation**: Connecticut agencies have disproportionately harmed David Medeiros, a person with disabilities and a whistleblower, through discriminatory practices and the denial of equal protection under the law.
- **Supporting Precedent**:
  - *Obergefell v. Hodges (2015)*: Reinforced the Fourteenth Amendment's equal protection guarantees, particularly for marginalized groups.
  - *Tennessee v. Lane (2004)*: Established the right of individuals with disabilities to access public services without discrimination.

B. Americans with Disabilities Act (ADA) Violations

1. **Denial of Reasonable Accommodations**
   - **Violation**: Connecticut agencies failed to provide ADA-compliant accommodations, such as accessible communication formats (e.g., email-only correspondence) and assistance with navigating complex procedural barriers.
   - **Supporting Precedent**:
     - *Tennessee v. Lane (2004)*: Highlighted the obligation of public entities to accommodate individuals with disabilities in their access to government services.
     - *Alexander v. Choate (1985)*: Prohibited discriminatory practices that deny individuals meaningful access to public services.
2. **Retaliation Against Disability Advocacy**

- **Violation**: DSS and CHRO retaliated against David Medeiros by excluding him from forums, ridiculing him publicly, and ignoring his requests for case numbers, all while knowing his disability-related challenges.

- **Supporting Precedent**:

  - *Olmstead v. L.C. (1999)*: Confirmed the ADA's mandate against unnecessary exclusion and segregation of individuals with disabilities.

C. Rehabilitation Act (Section 504) Violations

- **Violation**: DSS and CHRO, as recipients of federal funding, failed to meet Section 504's requirements to provide accessible services and accommodations to individuals with disabilities.

- **Supporting Precedent**:

  - *Barnes v. Gorman (2002)*: Enforced financial accountability for entities violating Section 504.

D. Whistleblower Protection Violations

1. **Retaliation for Reporting Medicaid Mismanagement**

   - **Violation**: David Medeiros faced retaliation for exposing systemic Medicaid mismanagement and corruption within DSS. This included exclusion from critical forums and the withholding of vital information.

- **Supporting Statutes**:
    - *Whistleblower Protection Act (5 U.S.C. § 2302)*: Prohibits retaliation against individuals reporting government misconduct.
- **Actions Involved**:
    - DSS's refusal to provide records, information, or updates related to whistleblower reports.
    - CHRO and the Attorney General's office enabling retaliatory practices by refusing oversight.

2. **Lack of Federal Enforcement**
    - **Violation**: Despite being notified, the DOJ failed to enforce whistleblower protections or investigate reported retaliation, allowing Connecticut agencies to perpetuate systemic misconduct.

E. FOIA and Transparency Violations

1. **Failure to Respond to FOIA Requests**
    - **Violation**: DSS and related agencies failed to respond to FOIA requests for Medicaid records, ABI Waiver program details, and whistleblower case information within statutory timelines.
    - **Supporting Statutes**:

- FOIA (5 U.S.C. § 552): Mandates timely and comprehensive responses to public records requests.

2. **Non-Referral of Misdirected FOIA Requests**

   - **Violation**: Agencies did not forward improperly file FOIA requests to the appropriate offices, violating statutory requirements under FOIA.

F. Connecticut State Law Violations

1. **Anti-Discrimination Statutes**

   - **Violation**: CHRO failed to investigate DSS's discriminatory practices, violating its statutory mandate under Connecticut anti-discrimination laws.

2. **Connecticut FOIA (C.G.S. § 1-200 et seq.)**

   - **Violation**: DSS obstructed transparency by withholding requested records related to Medicaid policies and whistleblower reports, violating state FOIA laws.

5. Impact on Vulnerable Populations

The systemic failures outlined in this complaint have far-reaching consequences:

- **Individuals with Disabilities**: Excluded from vital public services and decision-making processes due to ADA violations.

- **Whistleblowers**: Silenced and retaliated against, eroding public trust in accountability mechanisms.
- **Taxpayers**: Denied transparency into the use of federal and state funds, raising concerns about financial mismanagement and corruption.

6. Demands for Immediate Relief and Systemic Accountability

Immediate Relief

1. Assignment of a CHRO case number and initiation of a full investigation into DSS's discriminatory practices.
2. Enforcement of ADA accommodations for all communications and procedures involving David Medeiros.

Federal Oversight

1. DOJ: Launch a formal investigation into systemic ADA violations and whistleblower retaliation.
2. HHS OCR: Enforce federal oversight to ensure DSS complies with ADA and Medicaid standards.

Accountability Measures

1. Full disclosure of DSS's Medicaid fund usage, specifically related to the ABI Waiver Program.

2. Disciplinary action against officials responsible for retaliation and non-compliance.

Systemic Reform

1. Enact policies ensuring timely responses to whistleblower complaints and ADA accommodation requests.
2. Strengthen oversight mechanisms to prevent retaliation, corruption, and systemic discrimination.

7. Conclusion and Final Demands

David Medeiros' rights as a whistleblower, advocate, and individual with a disability have been systematically violated at every level of government. This master complaint demands immediate enforcement of federal and state laws, systemic reform, and full accountability for the harms caused.

By upholding these demands, the federal government can restore public trust, protect vulnerable populations, and affirm its commitment to justice and transparency.

Complaint and Demand for Justice

Complainant:

David Medeiros

Founder, ABI Resources

Willimantic, Connecticut

Filed Against:

- **Connecticut Commission on Human Rights and Opportunities (CHRO)**
- **Connecticut Attorney General's Office**
- **Connecticut Department of Social Services (DSS)**
- **Unidentified State and Federal Officials**
- **U.S. Department of Justice (DOJ), Civil Rights Division**
- **U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)**

Preface and Executive Summary

This complaint exposes systemic failures and coordinates inaction by Connecticut state agencies and federal oversight bodies, leading to the violation of constitutional rights, non-compliance with ADA standards, retaliation against whistleblowers, and denial of transparency through FOIA. As a whistleblower and person with a disability, David Medeiros has faced retaliation, discrimination, and exclusion, leaving him unable to address systemic Medicaid mismanagement and protect the rights of vulnerable populations.

This document calls for:

1. **Immediate enforcement of legal protections** for whistleblowers and individuals with disabilities.
2. **Thorough investigation** into systemic misconduct by state agencies and federal inaction.
3. **Transparent accountability and reform** to ensure no recurrence of these injustices.

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7. Conclusion and Final Demands

1. Introduction and Purpose of the Complaint

David Medeiros submits this complaint to document and demand redress for systemic violations of his rights as a whistleblower, disability advocate, taxpayer, and citizen. Connecticut state agencies have suppressed transparency, retaliated against whistleblowers, and denied ADA accommodations, creating a dangerous precedent for the treatment of individuals seeking accountability.

Despite repeated submissions to federal oversight bodies, including the DOJ and HHS OCR, no meaningful action has been taken. This complaint seeks the enforcement of federal and state laws, the protection of constitutional rights, and systemic reform.

2. Legal Background and Framework

This complaint invokes federal statutes, constitutional principles, and state laws designed to safeguard equity, accountability, and accessibility in public services.

A. Constitutional Provisions

1. **First Amendment:** Protects the right to petition for redress of grievances.
    - CHRO and the Connecticut Attorney General's Office have suppressed this right by refusing to act on valid complaints.
2. **Fifth Amendment:** Guarantees due process protections, which were denied when agencies failed to provide substantive responses or case numbers.

3. **Fourteenth Amendment:** Protects against discrimination, which has been evident in the systemic exclusion and retaliation against David Medeiros as a person with a disability and whistleblower.

B. Federal Statutes

1. **Americans with Disabilities Act (ADA):**
    - Title II (42 U.S.C. § 12132): Mandates accessibility and prohibits discrimination in public services.
2. **Rehabilitation Act:**
    - Section 504 (29 U.S.C. § 794): Requires accessibility in federally funded programs.
3. **Whistleblower Protection Act (5 U.S.C. § 2302):**
    - Shields individuals exposing government misconduct from retaliation.
4. **Freedom of Information Act (FOIA, 5 U.S.C. § 552):**
    - Mandates timely access to public records for transparency.

C. Connecticut Statutory Obligations

1. **Connecticut FOIA (C.G.S. § 1-200 et seq.):**
    - Ensures public access to government records.
2. **Anti-Discrimination Laws under CHRO Jurisdiction:**

- Mandates investigation of complaints regarding discrimination and retaliation.

D. Supporting Case Law

1. **Tennessee v. Lane (2004):** Enforced ADA compliance for public institutions.
2. **NARA v. Favish (2004):** Reaffirmed FOIA's role in ensuring public accountability.
3. **Chevron U.S.A., Inc. v. NRDC (1984):** Limited agency discretion to ensure compliance with statutory mandates.

3. Factual Background and Timeline of Events

October 24, 2024 – Filing of CHRO Complaint

- David Medeiros submitted a notarized complaint to CHRO alleging ADA violations and systemic retaliation by DSS.
- **CHRO Response:** No acknowledgment, no case number, and no investigation initiated, in clear violation of its statutory obligations.

October 30, 2024 – Follow-Up with CHRO

- David reiterated his request for a case number and investigation status.
- **CHRO Response:** Continued silence, creating procedural barriers and denying justice.

November 1, 2024 – Appeal to Connecticut Attorney General

- Submitted evidence of DSS's misconduct and CHRO's inaction to the Attorney General.

- **AG Response:** No acknowledgment or action, allowing systemic violations to persist.

November 10, 2024 – Escalation to DOJ

- Detailed complaint submitted to the DOJ, outlining ADA violations, whistleblower retaliation, and suppression of constitutional rights.
- **DOJ Response:** No substantive action taken, perpetuating systemic inaction.

November 28, 2024 – Current Status

- **CHRO:** Still refuses to assign a case number or act.
- **Attorney General:** Continues to ignore the complaint.
- **DOJ:** Failed to enforce federal protections under ADA and whistleblower statutes.

4. Systemic Violations of Law

A. Constitutional Violations

1. **First Amendment:** Suppression of the right to petition for redress.
2. **Fifth Amendment:** Denial of due process by failing to provide substantive responses.
3. **Fourteenth Amendment:** Systemic discrimination against individuals with disabilities.

B. ADA Violations

1. Denial of reasonable accommodations, including accessible communication formats.
2. Retaliation against advocacy and whistleblowing efforts.

C. Rehabilitation Act Violations

Failure to meet federally funded programs' accessibility requirements.

D. Whistleblower Protection Violations

Retaliation for exposing Medicaid mismanagement and corruption.

E. FOIA and Transparency Violations

1. Failure to respond to FOIA requests.
2. Non-referral of misdirected FOIA requests.

F. Connecticut State Law Violations

1. Violation of CHRO's anti-discrimination mandate.
2. Failure to ensure public transparency under Connecticut FOIA.

5. Comprehensive Impact on Vulnerable Populations

The systemic failures outlined in this complaint have far-reaching and devastating effects on vulnerable populations, violating fundamental constitutional principles, statutory mandates, and ethical obligations. Below is a detailed analysis of how these violations impact three critical groups.

A. Individuals with Disabilities

1. **Exclusion from Public Services**

- **ADA Violations:** The refusal of Connecticut agencies, including DSS and CHRO, to provide reasonable accommodations as mandated by the Americans with Disabilities Act (ADA) systematically excludes individuals with disabilities from accessing public services. This violates their constitutional right to equal protection under the Fourteenth Amendment and statutory protections under the ADA and Section 504 of the Rehabilitation Act.
- **Specific Harm to David Medeiros:** As a person with a brain injury, David Medeiros has faced procedural and logistical barriers, including:
    - Failure to provide accessible communication formats, such as email-only correspondence and screen-reader-compatible documents.
    - The deliberate use of complex, inaccessible processes to impede his ability to advocate effectively.
- **Broader Implications:** These actions signal to other individuals with disabilities that their needs will be ignored or obstructed, discouraging engagement with public institutions and perpetuating systemic discrimination.

2. **Segregation and Stigmatization**

- **Constitutional Violation:** Exclusion from decision-making processes and public forums creates a de facto segregation of individuals with disabilities, reinforcing stigmas and systemic barriers. This directly contravenes the Supreme Court's mandate in *Tennessee v. Lane (2004)*, which established the necessity of public institutions providing equitable access.

B. Whistleblowers

1. **Silencing Advocacy**

    - **Suppression of Free Speech:** Retaliation against David Medeiros for exposing Medicaid mismanagement violates his First Amendment right to free speech. By silencing whistleblowers, Connecticut agencies erode a cornerstone of democratic accountability and transparency.

    - **Chilling Effect:** DSS's public ridicule and exclusion of David Medeiros, combined with CHRO's refusal to investigate, create a hostile environment for other potential whistleblowers, deterring them from reporting misconduct or advocating for systemic change.

2. **Erosion of Public Accountability**

    - **Violation of Whistleblower Protection Laws:** By failing to act on David Medeiros' reports of Medicaid mismanagement, DSS and CHRO undermine federal and state whistleblower protections, including those enshrined in the Whistleblower Protection Act (5 U.S.C. § 2302). This enables corruption and malpractice to persist unchecked.

    - **Impact on Democratic Oversight:** Whistleblowers are critical to uncovering government mismanagement and corruption. Suppressing their voices undermines public trust and weakens institutional accountability.

C. Taxpayers

1. **Denial of Transparency in Public Fund Usage**

    - **FOIA Violations:** The refusal to provide timely responses to FOIA requests and transparency regarding Medicaid fund allocations deprives taxpayers of their right to scrutinize how public funds are managed. This violates federal FOIA laws (5 U.S.C. § 552) and Connecticut FOIA statutes (C.G.S. § 1-200 et seq.).

    - **Specific Allegations:** DSS's obstruction of records related to Medicaid, including the ABI Waiver Program, raises concerns about the potential misuse or mismanagement of federal and state funds.

2. **Financial Harm**

    - **Mismanagement of Medicaid Funds:** Inefficient or corrupt use of Medicaid resources directly impacts taxpayers, who bear the financial burden of supporting these programs. The lack of oversight and transparency perpetuates waste and undermines public confidence in government stewardship.

3. **Broader Consequences:** Taxpayer dollars intended to support vulnerable populations are diverted or wasted due to systemic failures, eroding public trust and the integrity of federally funded programs.

6. Demands for Immediate Relief and Systemic Accountability

To address the systemic violations outlined above, the following measures are demanded to restore justice, enforce legal protections, and uphold transparency:

Immediate Relief

1. **Assignment of a CHRO Case Number:**
    - CHRO must immediately assign a case number to David Medeiros' complaint and provide a timeline for investigating DSS's discriminatory practices.
    - A full and transparent investigation must be conducted, with findings publicly reported to ensure accountability.
2. **Enforcement of ADA Accommodations:**
    - All communications with David Medeiros must adhere to ADA standards, including email-only correspondence, accessible formats, and simplified processes.
    - Federal and state agencies must review their ADA compliance protocols to prevent further violations.

Federal Oversight

1. **DOJ Investigation:**
    - The Department of Justice must launch a formal investigation into systemic ADA violations, whistleblower retaliation, and constitutional rights infringements by Connecticut agencies.

2. **HHS OCR Enforcement:**

    - The Office for Civil Rights at HHS must enforce oversight of Connecticut's Medicaid program to ensure compliance with ADA and Rehabilitation Act requirements.

Accountability Measures

1. **Full Disclosure of DSS Medicaid Fund Usage:**

    - DSS must release detailed records of Medicaid fund usage, particularly those related to the ABI Waiver Program, to determine whether federal funds have been mismanaged.

2. **Disciplinary Actions Against Officials:**

    - State officials responsible for retaliation, non-compliance, or discriminatory practices must face disciplinary measures, including removal from positions of authority where appropriate.

Systemic Reform

1. **Timely Responses to Whistleblower Complaints:**

    - Policies must be enacted to ensure that all whistleblower complaints are addressed promptly and transparently, with legal protections strictly enforced.

2. **Strengthened Oversight Mechanisms:**

- Oversight bodies must implement safeguards to prevent retaliation, corruption, and systemic discrimination within federally funded programs.

7. Conclusion and Final Demands

David Medeiros' constitutional rights, statutory protections, and dignity as a whistleblower and individual with a disability have been systematically violated at every level of government. These coordinated failures demand immediate federal intervention, systemic reform, and full accountability.

Final Demands:

1. Immediate enforcement of federal and state laws to protect whistleblowers and individuals with disabilities.
2. Comprehensive investigations by the DOJ and HHS OCR into systemic failures and non-compliance.
3. Structural reforms to ensure transparency, accountability, and equitable access to public services for all individuals.

By addressing these demands, the federal government can restore public trust, safeguard vulnerable communities, and reaffirm its commitment to justice, equality, and transparency.

Demands for Immediate Relief

1. **Formal Acknowledgment and Redress**

- **CHRO Case Number and Investigation Timeline:** CHRO must immediately assign a case number to David's complaint, ensuring transparency in its investigation of DSS's discriminatory practices.
- **Public Apology:** A formal apology from Connecticut DSS, CHRO, and the Attorney General for retaliatory actions, discrimination, and neglect of their constitutional and statutory obligations.

2. **Immediate Enforcement of ADA Accommodations**
   - **Accessibility Protocols:** All communication with David must adhere to ADA standards, including:
     - Email-only correspondence.
     - Screen-reader-compatible documents.
     - Summarized and simplified information to accommodate his TBI-related cognitive challenges.
   - **Dedicated Accessibility Advocate:** Appoint a state and federal-level liaison to oversee all accommodations provided to David in the complaint process.
3. **Cease Retaliatory Practices**
   - **Immediate Suspension of Retaliatory Officials:** DSS and CHRO officials identified in discriminatory or retaliatory actions must be removed from any involvement with David's case until investigations are complete.

- **Protection from Future Retaliation:** A legally binding agreement must be enacted to prevent further acts of retaliation or discrimination against David, his business (ABI Resources), or any associated individuals.

Federal Oversight and Systemic Accountability

1. **DOJ Investigation**
    - The Department of Justice must launch a formal investigation into Connecticut's systemic violations of:
        - David's constitutional rights (First, Fifth, and Fourteenth Amendments).
        - ADA compliance failures.
        - Whistleblower retaliation under federal statutes.
2. **HHS OCR Enforcement**
    - The Office for Civil Rights must audit DSS and CHRO to assess ADA compliance and Medicaid program management, particularly in the context of the ABI Waiver Program.
3. **Federal Protection of Whistleblowers**
    - DOJ must enforce whistleblower protections under the Whistleblower Protection Act, ensuring David is shielded from retaliation and any whistleblowing actions are fully investigated.

4. **Transparency in Medicaid Fund Usage**

    - Connecticut DSS must provide a detailed, audited report on its use of Medicaid funds, specifically those allocated to the ABI Waiver Program, to determine potential misuse or mismanagement.

5. **Immediate Federal Oversight**

    - Appoint a federal oversight committee to review Connecticut's handling of ADA compliance, Medicaid administration, and whistleblower protection.

Demands for Systemic Reform

1. **Strengthened ADA Compliance Mechanisms**

    - **Independent Audits:** Regular, independent audits of Connecticut's compliance with ADA and Rehabilitation Act standards in all state agencies.

    - **Training Programs:** Mandate comprehensive training for state employees on ADA requirements, disability rights, and whistleblower protections.

2. **Enhanced Whistleblower Protections**

    - **Expedited Whistleblower Claims:** Implement clear timelines and federal oversight for whistleblower complaints, ensuring prompt investigations and resolutions.

- **Whistleblower Advocacy Office:** Establish an independent advocacy office to assist whistleblowers in navigating complaints, ensuring protection from retaliation.

3. **FOIA and Transparency Reform**

- **Timely FOIA Responses:** Enforce strict compliance with FOIA and Connecticut FOIA statutes, including penalties for non-compliance.
- **Mandatory Record Forwarding:** Require all improperly submitted FOIA requests to be forwarded to the appropriate agency within five business days.

4. **Structural Reform in Connecticut Agencies**

- **Oversight Committees:** Create independent oversight committees to monitor DSS and CHRO operations, ensuring transparency, accountability, and adherence to legal standards.
- **Public Reporting:** Mandate public reporting on the outcomes of ADA and whistleblower-related complaints to restore public trust.

Restorative Justice for David Medeiros

1. **Compensatory Damages**

- Financial compensation for the pain, suffering, and professional harm caused by the systemic violations of David's constitutional rights, ADA protections, and whistleblower status.

2. **Legal and Advocacy Support**

- Demand: Appoint federally funded legal counsel to provide David Medeiros with specialized, comprehensive legal representation to ensure the full enforcement of his rights under constitutional, federal, and state law.
- Purpose:
- To Level the Playing Field: Ensure David has access to expert legal resources to counter the institutional advantages of state and federal agencies, which have repeatedly failed to address his grievances and protect his rights.
- To Enforce Compliance: Guarantee the enforcement of ADA mandates, whistleblower protections, and constitutional safeguards that have been systematically ignored.
- To Ensure Accessibility: Provide legal counsel trained in ADA compliance to meet David's unique needs as a brain injury survivor, ensuring equitable participation and effective advocacy throughout the legal process.
- Rationale:
- Systemic Complexity: The violations span multiple legal frameworks, including the Americans with Disabilities Act (ADA), the Rehabilitation Act, whistleblower statutes, constitutional law, and FOIA requirements. Legal expertise is essential to navigate these intersecting areas effectively.

- Power Imbalance: David faces well-resourced government entities that have demonstrated a coordinated effort to suppress his advocacy and obstruct justice. Federally funded legal counsel is necessary to balance this disparity.
- ADA Obligations: David's brain injury imposes cognitive challenges, such as memory deficits and processing difficulties. Denying legal support would effectively exclude him from the justice system, compounding the ADA violations he has already endured.
- Institutional Accountability: Legal representation is critical for compelling compliance from state and federal agencies that have failed to act on their statutory and constitutional obligations.
- Precedents Supporting the Demand:
- Powell v. Alabama (1932): Recognized the right to legal counsel as essential to due process under the Fourteenth Amendment.
- Tennessee v. Lane (2004): Affirmed the right of individuals with disabilities to access public services, including justice systems, without discrimination.
- Olmstead v. L.C. (1999): Established the principle that unnecessary exclusion of individuals with disabilities constitutes discrimination under the ADA.
- Expected Outcomes:
- Effective Advocacy: Legal counsel will ensure that David's complaints are pursued vigorously, with no room for procedural dismissals or oversight failures.

- Enforcement of Rights: Legal expertise will hold agencies accountable for their statutory violations and secure compliance with ADA, whistleblower, and transparency laws.
- Prevention of Further Retaliation: Federally funded legal representation will function as a safeguard against continued retaliation and systemic neglect by state and federal agencies.
- Restoration of Justice: Legal support will not only protect David's rights but also serve as a precedent for enforcing similar rights for other whistleblowers and individuals with disabilities.
- Conclusion:
- Appointing federally funded legal counsel is not optional—it is a necessary and immediate measure to rectify the systemic injustices David has faced, ensure the enforcement of his legal rights, and restore public confidence in the accountability of government institutions.
- Appoint federally funded legal counsel to assist David in navigating ongoing complaints and ensuring enforcement of all relevant laws.

3. **Restoration of Professional Standing**

- Public acknowledgment of David's contributions as a whistleblower and advocate for individuals with disabilities, highlighting his role in exposing systemic failures.

4. **Public Investigation of Retaliatory Practices**

    - A federal investigation into the retaliatory culture within Connecticut agencies, with a specific focus on DSS and CHRO.

Final Demands for Justice and Systemic Change

1. **Restoration of Constitutional Rights**

    - Immediate enforcement of David's First, Fifth, and Fourteenth Amendment protections, ensuring he is no longer subject to segregation, discrimination, or retaliation.

2. **Comprehensive Federal and State Investigations**

    - DOJ and HHS OCR must collaborate to investigate systemic failures, ensuring federal laws are enforced and future violations are prevented.

3. **Permanent Policy Changes**

    - Enact structural reforms to ensure ADA compliance, protect whistleblowers, and enforce transparency laws at all levels of government.

Why These Demands Are Necessary

David Medeiros has suffered profound personal and professional harm due to systemic failures, discriminatory practices, and retaliatory actions by Connecticut agencies. These injustices not

only violate his constitutional and statutory rights but also undermine public trust in the institutions responsible for protecting vulnerable populations.

Addressing these demands will:

- Restore David's dignity and rights as a U.S. citizen, whistleblower, and disability advocate.
- Send a clear message that federal and state governments are committed to upholding justice, transparency, and accountability.
- Protect future whistleblowers and individuals with disabilities from similar injustices.

By taking decisive action, the federal government can reaffirm its commitment to justice, equity, and the rule of law while honoring the courage and integrity of those, like David Medeiros, who fight to protect it.

Sincerely,

David Medeiros

David Medeiros

Founder, ABI Resources

TBI and Stroke Survivor

Constitutional rights, First Amendment, Fifth Amendment, Fourteenth Amendment, Americans with Disabilities Act (ADA), Rehabilitation Act Section 504, Whistleblower Protection Act, Freedom of Information Act (FOIA), disability rights, systemic corruption, Medicaid mismanagement, public accountability, state transparency, ADA compliance, whistleblower retaliation, civil rights violations, equal protection under the law, due process rights, reasonable accommodations, procedural justice, TBI advocacy, structural reform, federal oversight, systemic discrimination, government accountability, taxpayer protections, misuse of public funds, retaliation prevention, transparency enforcement, restorative justice, federal investigations, independent audits, anti-discrimination statutes, equitable access, whistleblower protections, legal redress, systemic reform policies, and federal-state compliance. Transparency: Enforce FOIA and ADA compliance to reveal systemic failures and establish trust in government institutions. Accountability: Demand disciplinary actions and investigations to address misconduct in state agencies.

Justice: Restore constitutional and statutory rights for whistleblowers and individuals with disabilities.

Equity: Advocate for fair access to public services, as mandated by ADA and constitutional protections.

Oversight: Ensure federal agencies actively monitor state adherence to federal laws.

David Medeiros, Founder of ABI Resources, continues to advocate for systemic reform and transparency to protect vulnerable populations, uphold constitutional principles, and safeguard the integrity of federal programs. DB.42.131.Inf. DOGE

1. What action did they take?

Actions Taken by the Involved Parties

1. **Connecticut Department of Social Services (DSS)**:
    - Publicly ridiculed and excluded David Medeiros during ABI Waiver forums, violating ADA and First Amendment protections.
    - Refused to provide ADA-mandated accommodations, including accessible communication formats and simplified processes.
    - Obstructed access to critical information about Medicaid programs, including ABI Waiver policies, in violation of FOIA.
    - Retaliated against David Medeiros for whistleblowing on systemic Medicaid mismanagement.
2. **Connecticut Commission on Human Rights and Opportunities (CHRO)**:
    - Refused to assign a case number or investigate David's notarized complaint alleging ADA violations and discrimination by DSS.
    - Ignored follow-up inquiries regarding the status of the complaint, denying due process and perpetuating discrimination.
3. **Connecticut Attorney General's Office**:
    - Failed to act on evidence submitted by David Medeiros regarding DSS misconduct and CHRO's inaction.

- Neglected its statutory duty to uphold constitutional and civil rights protections in Connecticut, effectively enabling systemic violations.

4. **U.S. Department of Justice (DOJ), Civil Rights Division**:
    - Ignored David's formal complaints regarding ADA violations, whistleblower retaliation, and systemic corruption within Connecticut's Medicaid program.
    - Failed to investigate or enforce federal protections, allowing violations to persist unchecked.
5. **U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)**:
    - Did not investigate systemic ADA violations in Connecticut's Medicaid program, despite clear evidence of non-compliance and harm to individuals with disabilities.
6. **Connecticut Governor's Office**:
    - Failed to intervene or provide oversight of DSS and CHRO despite being alerted to systemic violations and retaliation against David Medeiros.
7. **Centers for Medicare & Medicaid Services (CMS)**:
    - Did not enforce federal Medicaid oversight to ensure that Connecticut DSS complies with federal regulations and ADA mandates.

Summary of Actions:

- **Exclusion**: Agencies excluded David from forums and processes critical to his advocacy and whistleblower activities.
- **Retaliation**: State and federal actors retaliated against David for exposing Medicaid mismanagement, violating whistleblower protections.
- **Non-Compliance**: Agencies failed to uphold ADA requirements and constitutional rights, creating systemic barriers and procedural delays.
- **Neglect**: Federal oversight bodies deferred action, enabling Connecticut agencies to act with impunity.

Constitutional Violations and Crimes Committed

12. **First Amendment Violations**
    - **Suppression of Petition Rights**: By ignoring David Medeiros' complaints and failing to investigate or act on his claims, Connecticut state agencies and federal oversight bodies have suppressed his constitutional right to petition the government for redress of grievances.
    - **Retaliation Against Free Speech**: Retaliatory actions, such as public ridicule and exclusion from public forums, violate David's right to free speech, as protected by the First Amendment.
13. **Fifth Amendment Violations**
    - **Denial of Procedural Due Process**: Connecticut DSS, CHRO, and the Attorney General's Office failed to provide timely and meaningful responses to David's complaints. The refusal to issue case numbers,

investigate complaints, or enforce ADA compliance constitutes a denial of due process rights under the Fifth Amendment.

- **Arbitrary Actions**: The lack of transparency and accountability in denying David access to procedural protections constitutes arbitrary and capricious state actions, violating the principles of fundamental fairness guaranteed by the Fifth Amendment.

14. **Fourteenth Amendment Violations**

- **Denial of Equal Protection**: David, as an individual with a disability, has been subjected to systemic discrimination and segregation. Connecticut agencies' failure to provide reasonable accommodations and their active exclusion of David from critical processes violate the Equal Protection Clause.
- **State-Sanctioned Discrimination**: The coordinated inaction and refusal to investigate complaints by CHRO, DSS, and the Attorney General's Office amount to state-sanctioned discrimination against an individual with disabilities.

15. **Americans with Disabilities Act (ADA) and Rehabilitation Act Violations**

- **Failure to Accommodate**: DSS and CHRO failed to provide ADA-mandated accommodations, such as email-only correspondence, accessible documents, and simplified processes. This denies David equal access to public services as required under federal law.

- **Segregation and Exclusion**: David was excluded from forums and decision-making processes, creating a de facto segregation, which is prohibited under the ADA and Section 504 of the Rehabilitation Act.

16. **Whistleblower Protection Act Violations**

- **Retaliation for Protected Activity**: DSS retaliated against David for exposing Medicaid mismanagement and systemic corruption, violating his protections under the Whistleblower Protection Act. The refusal to investigate his complaints further compounds this retaliation.
- **Chilling Effect on Advocacy**: The systemic retaliation discourages other whistleblowers from coming forward, undermining the principles of transparency and accountability protected under federal law.

17. **FOIA Violations**

- **Denial of Access to Public Records**: DSS's refusal to respond to FOIA requests regarding Medicaid fund usage and ABI Waiver details denies David his right to access public information, a key component of government transparency.
- **Failure to Forward Requests**: Improper handling and failure to forward FOIA requests to appropriate agencies further obstruct David's right to information, violating federal and state FOIA statutes.

Cumulative Impact

The above violations collectively represent a systemic disregard for constitutional principles and federal protections. The acts of retaliation, exclusion, and failure to act demonstrate a pattern of willful neglect and abuse, undermining David Medeiros' rights as a whistleblower, individual with a disability, and U.S. citizen. These violations demand immediate federal oversight and corrective action to restore justice and ensure accountability.

2. When did this occur?

Timeline of Events

1. **October 24, 2024 – Filing of CHRO Complaint**
    - David Medeiros submitted a notarized complaint to the Connecticut Commission on Human Rights and Opportunities (CHRO), detailing ADA violations, systemic discrimination, and retaliation by the Connecticut Department of Social Services (DSS).
2. **October 30, 2024 – Follow-Up with CHRO**
    - David requested a status update and assignment of a case number for his complaint. CHRO failed to respond, creating procedural barriers to justice.
3. **November 1, 2024 – Appeal to Connecticut Attorney General**
    - David escalated his complaints to the Connecticut Attorney General's Office, providing evidence of systemic violations and requesting oversight of DSS and CHRO. The Attorney General's Office did not respond or take any action.

4. **November 10, 2024 – Submission to DOJ**

    - David submitted a comprehensive complaint to the U.S. Department of Justice (DOJ), detailing ADA violations, constitutional breaches, whistleblower retaliation, and systemic mismanagement by Connecticut agencies. Despite the urgency, the DOJ failed to initiate an investigation or enforce compliance.

5. **November 28, 2024 – Current Status**

    - **CHRO**: Refuses to assign a case number or act on David's complaint, obstructing due process.
    - **Connecticut Attorney General**: Has ignored all communications, abdicating responsibility for overseeing state agency compliance.
    - **DOJ**: Has not taken substantive action to investigate federal violations or ensure ADA compliance.
    - **HHS OCR**: Remains unresponsive despite its mandate to enforce ADA compliance and Medicaid program integrity.

These violations and inactions have created a continuous pattern of systemic neglect and retaliation against David Medeiros, with no resolution or accountability to date.

4. How did you discover this action?

How the Action Was Discovered

David Medeiros, as a whistleblower and disability advocate, discovered the actions through direct personal experience and documentation, which include:

6. **Personal Experience with Discrimination and Retaliation**
    - David experienced firsthand acts of exclusion, public ridicule, and procedural barriers during interactions with Connecticut Department of Social Services (DSS) officials. For example:
        - He was excluded from critical discussions related to the ABI Waiver Program.
        - He was subjected to public ridicule during forums, despite being a known advocate for individuals with disabilities and a whistleblower exposing Medicaid mismanagement.
7. **Documented Failures of State Agencies**
    - David submitted a notarized complaint to the Connecticut Commission on Human Rights and Opportunities (CHRO) detailing ADA violations and retaliation. However, CHRO failed to acknowledge the complaint, assign a case number, or investigate the allegations, creating procedural obstacles.
8. **Evidence of Inaction by the Connecticut Attorney General**
    - Despite escalating the matter and providing comprehensive evidence of systemic failures, the Connecticut Attorney General's Office did not respond to or investigate the allegations, effectively enabling discriminatory practices.

9. **Federal Agency Inaction**

    - After submitting a detailed complaint to the U.S. Department of Justice (DOJ) and the Department of Health and Human Services Office for Civil Rights (HHS OCR), David received no meaningful response or enforcement action, revealing a vacuum of oversight and accountability.

10. **Pattern of Retaliation and Non-Compliance**

    - Through repeated attempts to obtain ADA accommodations, transparency in Medicaid fund usage, and responses to whistleblower complaints, David identified a systemic pattern of evasion, retaliation, and disregard for constitutional and statutory obligations by Connecticut state agencies and federal oversight bodies.

These actions were uncovered as part of David's ongoing efforts to advocate for the rights of individuals with disabilities, ensure transparency in public programs, and expose systemic failures in government accountability.

Additional Facts Supporting the Allegation

1. **Documented Failures by State Agencies**

    - **Connecticut Commission on Human Rights and Opportunities (CHRO):**

- David Medeiros submitted a notarized complaint to CHRO on October 24, 2024, detailing ADA violations and systemic retaliation by DSS. CHRO failed to:
    - Assign a case number.
    - Investigate the allegations.
    - Provide any substantive acknowledgment or response, violating its statutory mandate to investigate discrimination complaints.
- This procedural inaction obstructs justice and denies David's right to due process.

2. **Connecticut Department of Social Services (DSS) Retaliation:**
    - DSS officials publicly ridiculed David during ABI Waiver forums and excluded him from critical discussions, despite his role as a whistleblower and disability advocate.
    - DSS has refused to provide reasonable ADA accommodations, including accessible communication formats (e.g., email-only correspondence), in direct violation of the ADA and Section 504 of the Rehabilitation Act.
3. **Inaction by the Connecticut Attorney General's Office:**
    - Despite receiving evidence of systemic ADA violations, whistleblower retaliation, and Medicaid mismanagement, the Attorney General's Office failed to investigate or respond, abdicating its responsibility to enforce state and federal laws.
4. **Federal Oversight Failures:**

- The U.S. Department of Justice (DOJ) and the Department of Health and Human Services Office for Civil Rights (HHS OCR) were notified of systemic ADA violations, whistleblower retaliation, and constitutional breaches in November 2024. Despite this, no federal investigations or enforcement actions have been initiated, perpetuating state agency misconduct.

5. **Evidence of ADA Non-Compliance:**
    - DSS repeatedly refused David's requests for ADA-compliant communication, such as screen-reader-compatible documents and simplified processes, exacerbating the challenges he faces as a traumatic brain injury (TBI) survivor.
6. **Mismanagement of Public Funds:**
    - DSS has obstructed transparency regarding Medicaid fund usage, particularly funds allocated to the ABI Waiver Program. This raises significant concerns about potential misuse or mismanagement of taxpayer dollars.
7. **Exploitation of Disability:**
    - State and federal officials are aware of David's brain injury and cognitive challenges, yet they have exploited his disability by creating procedural barriers and denying accommodations, effectively excluding him from advocacy and justice processes.
8. **Pattern of Systemic Corruption and Retaliation:**

- Agencies at both the state and federal levels have demonstrated a clear pattern of protecting their leadership and shielding systemic inefficiencies, corruption, and discrimination, rather than addressing legitimate complaints.
- By refusing to act on whistleblower disclosures, these agencies have enabled misconduct, eroded public trust, and fostered an environment where accountability is absent.

9. **Violation of Transparency Laws:**
    - DSS and CHRO have failed to comply with Freedom of Information Act (FOIA) requests and Connecticut FOIA statutes, denying access to public records necessary for oversight and accountability.
10. **Legal Precedents Supporting the Allegation:**
    - **Tennessee v. Lane (2004):** Establishes the obligation of public entities to provide equitable access for individuals with disabilities.
    - **Whistleblower Protection Act (5 U.S.C. § 2302):** Prohibits retaliation against individuals reporting government misconduct.
    - **Mathews v. Eldridge (1976):** Guarantees procedural due process protections under the Fifth Amendment.

These additional facts provide clear evidence of systemic failures, retaliatory practices, and non-compliance with federal and state laws, underscoring the urgency for federal intervention.

1. **Gross Mismanagement:**

    1. **Mismanagement of Medicaid Funds:**

        - The Connecticut Department of Social Services (DSS) has obstructed transparency regarding the allocation and use of Medicaid funds, particularly those allocated to the Acquired Brain Injury (ABI) Waiver Program. This raises significant concerns about:

            - Potential misuse or diversion of federal and state funds.

            - Failure to ensure Medicaid resources reach vulnerable populations who rely on these programs for essential services.

    2. **Failure to Enforce ADA Compliance:**

        - DSS and the Connecticut Commission on Human Rights and Opportunities (CHRO) have failed to implement federally mandated ADA accommodations. This mismanagement denies equitable access to government programs and services for individuals with disabilities, violating their civil rights and federal law.

    3. **Lack of Oversight and Accountability:**

        - Despite numerous complaints and evidence of systemic issues, neither state nor federal agencies, including the DOJ and HHS OCR, have taken

appropriate enforcement action. This absence of oversight enables further mismanagement and neglect of statutory responsibilities.

4. **Inadequate Response to Whistleblower Disclosures:**
    - State agencies and federal oversight bodies have disregarded whistleblower allegations of systemic corruption and Medicaid mismanagement. By failing to investigate these claims, they allow financial inefficiencies and unethical practices to persist unchecked.
5. **Procedural Failures:**
    - CHRO's refusal to assign a case number or investigate complaints demonstrates a lack of procedural rigor, leading to delays, inaction, and denial of justice for complainants like David Medeiros.
    - DSS's refusal to provide ADA-compliant communication formats further exemplifies mismanagement of its internal processes, directly impacting the ability of individuals with disabilities to access critical services.
6. **Exploitation of Vulnerable Populations:**
    - The ongoing failures disproportionately harm individuals with disabilities, Medicaid recipients, and whistleblowers, undermining public trust and violating fundamental principles of equity and justice.
7. **Failure to Address Retaliation:**

- The retaliatory actions taken against whistleblowers, including exclusion, ridicule, and denial of accommodations, are evidence of a system designed to suppress accountability rather than address mismanagement.

8. **Erosion of Public Trust:**

    - The systemic failures of DSS, CHRO, and federal oversight bodies have created a culture of impunity, eroding public confidence in the integrity of government institutions and their ability to serve the public effectively.

These actions and inactions constitute gross mismanagement, endangering the integrity of federally funded programs, compromising public accountability, and perpetuating harm to vulnerable populations. Immediate federal intervention is required to address these systemic issues.

The listed individuals and entities engaged in or facilitated actions that collectively constitute systemic violations of constitutional rights, ADA non-compliance, whistleblower retaliation, and mismanagement of public funds. These actions include:

1. Suppression of Whistleblower Rights and Retaliation

- **DSS (Connecticut Department of Social Services):**
    - Publicly ridiculed and excluded David Medeiros from critical forums related to Medicaid and the ABI Waiver Program.
    - Obstructed David's advocacy efforts by withholding ADA-mandated accommodations, such as accessible communication formats and email-only correspondence.
    - Refused to provide requested records or updates, effectively silencing his whistleblowing efforts and suppressing public accountability.
- **CHRO (Commission on Human Rights and Opportunities):**
    - Refused to assign a case number to David's notarized complaint, delaying and obstructing justice.
    - Failed to investigate claims of systemic discrimination and retaliation, despite statutory mandates.
- **Connecticut Attorney General's Office:**
    - Ignored multiple submissions of evidence regarding DSS misconduct and CHRO's failure to act.

- Failed to intervene or provide oversight to enforce transparency, ADA compliance, and whistleblower protections.

2. Violations of ADA Protections and Disability Rights

- **DSS:**
  - Denied reasonable accommodations to David Medeiros, a traumatic brain injury (TBI) survivor, making it impossible for him to meaningfully participate in public processes.
  - Weaponized David's disability by exploiting his cognitive challenges to create procedural delays, obstruct communication, and undermine his advocacy.
- **CHRO:**
  - Failed to enforce ADA and anti-discrimination statutes by not investigating documented violations or taking any corrective actions.
- **Federal Agencies (DOJ, HHS OCR, CMS):**
  - Neglected oversight responsibilities to ensure ADA compliance and accessibility in Connecticut's Medicaid program, enabling DSS to continue discriminatory practices unchecked.

3. Mismanagement of Public Funds and Lack of Transparency

- **DSS:**

- Withheld public records related to Medicaid fund allocations, including the ABI Waiver Program, violating FOIA and state transparency laws.
- Mismanaged Medicaid resources by failing to meet federal ADA standards while continuing to receive federal funding.

- **Federal Agencies (CMS, HHS OCR):**
  - Failed to audit or investigate the misuse of Medicaid funds in Connecticut, despite whistleblower complaints highlighting systemic issues.

4. Abuse of Authority and Gross Mismanagement

- **Connecticut Leadership (OPM, Governor's Office):**
  - Allowed systemic failures in oversight and enforcement by not addressing persistent complaints of corruption, discrimination, and retaliation.
  - Enabled DSS and CHRO's non-compliance with state and federal laws by failing to enact structural reforms.
- **Federal Agencies (DOJ, OSC):**
  - Ignored whistleblower reports and failed to initiate investigations into Connecticut's systemic mismanagement of Medicaid and ADA violations.

By engaging in these actions, state and federal officials created an environment that suppresses transparency, perpetuates discrimination, and denies whistleblowers like David Medeiros the protections guaranteed under federal and state law.

Timeline of Events

1. **October 24, 2024 – Filing of CHRO Complaint**
    - David Medeiros submitted a notarized complaint to the Connecticut Commission on Human Rights and Opportunities (CHRO), detailing ADA violations, systemic discrimination, and retaliation by the Connecticut Department of Social Services (DSS).
2. **October 30, 2024 – Follow-Up with CHRO**
    - David requested a case number and an update on the status of his complaint.
    - CHRO failed to respond or assign a case number, effectively obstructing the complaint process.
3. **November 1, 2024 – Appeal to Connecticut Attorney General**
    - David submitted evidence and documentation to the Connecticut Attorney General's Office, requesting oversight and intervention to address systemic misconduct by DSS and CHRO.
    - The Attorney General's Office ignored the submission and failed to act.
4. **November 10, 2024 – Escalation to DOJ**
    - David submitted a detailed whistleblower complaint to the U.S. Department of Justice (DOJ), highlighting ADA violations, FOIA non-compliance, whistleblower retaliation, and systemic mismanagement of Medicaid funds.

- DOJ failed to take substantive action or provide updates, perpetuating systemic inaction.

5. **November 28, 2024 – Current Status**

   - **CHRO:** Continues to refuse to assign a case number or act on the complaint, obstructing the investigation process.
   - **Attorney General's Office:** Remains unresponsive, abdicating its role in enforcing state laws and oversight.
   - **DOJ:** Has not enforced federal protections under the ADA, FOIA, or whistleblower statutes, enabling ongoing violations.
   - **HHS OCR (Office for Civil Rights):** Failed to investigate or ensure ADA compliance in Connecticut's Medicaid program.

These actions, delays, and failures demonstrate a coordinated and systemic effort to suppress transparency, deny justice, and perpetuate discrimination against David Medeiros.

Discovery of Actions

David Medeiros discovered these actions through firsthand experience and documented interactions with the involved parties. The following key events and observations provided evidence of the actions taken against him:

1. **Refusal to Assign a Case Number by CHRO**
    - After submitting a notarized complaint to CHRO on October 24, 2024, David received no acknowledgment or case number, despite following up multiple times.
    - The lack of response signaled procedural obstruction and a failure to fulfill CHRO's statutory obligations.
2. **Exclusion and Ridicule by DSS**
    - During public forums related to the ABI Waiver Program, DSS officials publicly ridiculed and excluded David, creating a hostile environment for his advocacy.
    - Witnesses corroborated these incidents, providing evidence of discriminatory practices.
3. **Ignored Submissions to the Attorney General's Office**
    - Despite submitting detailed evidence of DSS and CHRO misconduct to the Attorney General on November 1, 2024, no acknowledgment or action was taken.
    - This inaction became apparent when repeated attempts to follow up were ignored.
4. **Federal Oversight Failures**

- Complaints to the DOJ and HHS OCR, submitted on November 10, 2024, included comprehensive documentation of ADA violations, whistleblower retaliation, and systemic mismanagement.
- The absence of substantive action or follow-up from these federal agencies revealed a broader pattern of neglect and inaction.

5. **FOIA and ADA Compliance Failures**

- Requests for ADA-compliant communication and public records related to Medicaid funds and the ABI Waiver Program were either ignored or obstructed.
- These failures were documented through email exchanges, unanswered requests, and a lack of transparent processes.

Each discovery is supported by correspondence records, witness testimony, and David's detailed documentation of the systemic barriers and retaliatory practices he encountered. These actions collectively indicate deliberate neglect and systemic discrimination.

Additional Facts Supporting the Allegations

1. **Documented Retaliation and Exclusion by DSS:**
    - DSS officials publicly ridiculed David Medeiros during ABI Waiver forums, as corroborated by witnesses and documented in communications. These actions created a hostile environment, directly impeding his ability to advocate for Medicaid beneficiaries and individuals with disabilities.
    - DSS failed to provide reasonable accommodations under the ADA, including email-only correspondence and simplified processes, despite David's documented cognitive challenges as a brain injury survivor.
2. **CHRO's Failure to Investigate:**
    - Despite submitting a notarized complaint on October 24, 2024, and multiple follow-up communications, CHRO refused to assign a case number or initiate an investigation, violating its statutory obligation to investigate discrimination complaints.
    - CHRO's inaction effectively denied David due process and equal protection under the law, prolonging systemic discrimination and retaliation.
3. **Attorney General's Office Inaction:**
    - Submissions to the Connecticut Attorney General included detailed evidence of DSS's ADA violations and whistleblower retaliation. Despite the compelling nature of the evidence, the office failed to respond, investigate, or intervene.

- This neglect demonstrates a disregard for its duty to ensure state agency compliance with federal and state laws.

4. **Federal Oversight Failures (DOJ and HHS OCR):**
    - The Department of Justice and the Office for Civil Rights at HHS were notified of systemic ADA violations, misuse of Medicaid funds, and whistleblower retaliation. Despite comprehensive documentation, neither agency initiated a substantive investigation or provided updates.
    - Federal inaction perpetuates the culture of impunity within Connecticut's state agencies.
5. **FOIA and Transparency Failures:**
    - DSS obstructed transparency by refusing to provide records related to Medicaid fund usage and ABI Waiver operations, despite FOIA and state FOIA laws mandating timely responses.
    - Requests for ADA-compliant documents and communication were ignored, compounding David's inability to access critical information.
6. **Pattern of Systemic Neglect and Corruption:**
    - Connecticut's financial reliance on Medicaid creates an incentive to suppress transparency and accountability. The refusal to investigate whistleblower complaints, accommodate disabilities, or ensure compliance highlights a coordinated effort to shield systemic mismanagement.
7. **David Medeiros' Vulnerability as a Brain Injury Survivor:**

- Agencies weaponized David's cognitive challenges to create procedural barriers, delay responses, and obstruct justice, further exacerbating the discrimination and retaliation he faced.
- The refusal to accommodate his needs constitutes a violation of the ADA and Rehabilitation Act, underscoring the systemic failure to protect vulnerable individuals.

Summary of Supporting Evidence:

- Witness testimony from public forums and interactions with DSS officials.
- Documentation of correspondence with CHRO, DSS, the Attorney General's Office, DOJ, and HHS OCR.
- Records of FOIA requests, ADA accommodation requests, and their subsequent denials or lack of response.
- Evidence of retaliatory exclusion and ridicule during advocacy efforts.
- Clear patterns of systemic neglect and procedural obstruction across all involved agencies.

These facts demonstrate a coordinated effort to suppress whistleblower protections, violate ADA standards, and obstruct transparency, requiring immediate federal intervention and oversight.

Abuse of Authority: Retaliatory Actions and Discriminatory Practices

1. **Connecticut Department of Social Services (DSS):**
    - **Retaliatory Exclusion:** DSS officials deliberately excluded David Medeiros from critical public forums related to the ABI Waiver Program, denying him a platform

to advocate for Medicaid beneficiaries and individuals with disabilities. These actions targeted him specifically as a whistleblower, suppressing his ability to expose systemic Medicaid mismanagement.

- **Public Ridicule:** During public meetings, DSS officials publicly ridiculed David, leveraging his disability as a brain injury survivor to discredit his advocacy efforts and silence his concerns. This abuse of authority undermines the principles of public accountability and transparency.
- **ADA Violations:** DSS knowingly failed to provide reasonable accommodations for David's disability, such as email-only correspondence and simplified processes, obstructing his ability to navigate complex procedural systems and defend his rights.

2. **Connecticut Commission on Human Rights and Opportunities (CHRO):**
    - **Failure to Investigate:** Despite being mandated to investigate discrimination complaints, CHRO refused to assign a case number or take action on David's notarized complaint. This inaction denied him due process and equal protection, effectively protecting DSS and perpetuating systemic discrimination.
    - **Neglect of Statutory Duty:** CHRO's refusal to fulfill its investigative role demonstrates an abuse of authority by prioritizing institutional preservation over its mission to protect civil rights.
3. **Connecticut Attorney General's Office:**

- **Inaction on Documented Evidence:** Despite receiving comprehensive evidence of DSS's retaliatory practices, ADA violations, and systemic discrimination, the Attorney General's Office failed to act. This neglect reflects an abdication of its responsibility to ensure state agencies comply with federal and state laws, effectively enabling retaliatory practices.

4. **Federal Oversight Bodies (DOJ and HHS OCR):**
    - **Failure to Intervene:** Despite being notified of systemic ADA violations, whistleblower retaliation, and misuse of Medicaid funds, both the Department of Justice and the Office for Civil Rights within HHS failed to enforce federal protections. Their inaction perpetuated the abuse of authority by state agencies, signaling tolerance for these violations.

Retaliatory Actions Against Whistleblowing Efforts:

- **Suppression of Advocacy:** By excluding David from forums and ridiculing his efforts, DSS and other agencies sought to suppress his whistleblowing on Medicaid mismanagement.
- **Weaponized Disability:** Agencies exploited David's cognitive challenges as a brain injury survivor to create procedural barriers, delay responses, and obstruct justice, effectively silencing his advocacy.
- **FOIA Obstruction:** DSS obstructed transparency by refusing to fulfill FOIA requests, denying David access to information crucial for holding the agency accountable.

Discriminatory Practices Against a Whistleblower with a Disability:

- **Exclusion from Public Decision-Making:** By barring David from participating in public discussions, DSS violated his First Amendment rights to petition the government and participate in public forums.
- **Denial of Accommodations:** Refusing to honor ADA accommodation requests, including simplified communication and accessible formats, demonstrates systemic discrimination against individuals with disabilities.

Key Evidence of Abuse of Authority:

- Documented public ridicule and exclusion by DSS officials during ABI Waiver forums.
- Refusal of CHRO to investigate notarized complaints, ignoring statutory obligations.
- Lack of action from the Connecticut Attorney General's Office despite clear evidence of violations.
- Procedural barriers and delays created to undermine David's advocacy.
- Denials of FOIA requests and ADA accommodations, obstructing access to justice and accountability.

Summary:

The retaliatory and discriminatory practices by state and federal entities demonstrate a gross abuse of authority, targeting David Medeiros for his whistleblowing efforts. These actions violate constitutional protections, ADA mandates, and whistleblower laws, necessitating immediate federal oversight to address systemic failures and ensure accountability.

1. **Who Took the Action?**

    1. **Connecticut Department of Social Services (DSS):**

        - DSS officials actively retaliated against David Medeiros by excluding him from ABI Waiver Program forums, publicly ridiculing him, and denying ADA-mandated accommodations.

    2. **Connecticut Commission on Human Rights and Opportunities (CHRO):**

        - CHRO failed to investigate David's notarized complaint regarding ADA violations and discrimination, refusing to assign a case number or fulfill its statutory duty.

    3. **Connecticut Attorney General's Office:**

        - The Attorney General's Office ignored evidence of systemic violations, failing to intervene or provide oversight for DSS and CHRO's actions.

    4. **Federal Oversight Bodies:**

        - **Department of Justice (DOJ):** Failed to act on David's complaints regarding ADA violations, whistleblower retaliation, and systemic misuse of Medicaid funds.

        - **Office for Civil Rights (OCR), Department of Health and Human Services (HHS):** Neglected its responsibility to enforce ADA compliance within federally funded programs, allowing systemic violations to persist.

    5. **Unnamed State and Federal Officials:**

- Participated in obstructing transparency, denying due process, and creating procedural barriers to silence David's advocacy and whistleblowing efforts.

Individuals and Entities Involved in Abuse of Authority

State-Level Actors

6. **Deidre S. Gifford**
    - Commissioner, Connecticut Department of Social Services (DSS)
    - Role: Oversaw the agency's discriminatory practices, denial of ADA accommodations, and retaliatory actions against David Medeiros.
7. **Tanya Hughes**
    - Executive Director, Connecticut Commission on Human Rights and Opportunities (CHRO)
    - Role: Failed to ensure the investigation of complaints, neglected to assign case numbers, and ignored statutory responsibilities to address systemic discrimination.
8. **William Tong**
    - Connecticut Attorney General
    - Role: Ignored evidence of systemic failures and violations, failing to intervene or hold DSS and CHRO accountable.

Federal-Level Actors

4. **Merrick B. Garland**

- U.S. Attorney General, Department of Justice (DOJ)
- Role: Failed to act on complaints regarding ADA violations, whistleblower retaliation, and constitutional breaches.

5. **Xavier Becerra**
    - Secretary, U.S. Department of Health and Human Services (HHS)
    - Role: Neglected oversight responsibilities related to ADA compliance within Medicaid-funded programs.
6. **Chiquita Brooks-LaSure**
    - Administrator, Centers for Medicare & Medicaid Services (CMS)
    - Role: Allowed systemic Medicaid mismanagement and misuse of federal funds without intervention.
7. **Lisa J. Pino**
    - Director, Office for Civil Rights (OCR), HHS
    - Role: Failed to enforce ADA compliance and investigate systemic discrimination and retaliatory practices within Medicaid-funded programs.

Other Potentially Involved Officials

8. **Regional and Program Managers within DSS, CHRO, and CMS**
    - Roles: Conducted, enabled, or failed to prevent retaliatory practices and procedural barriers aimed at silencing David Medeiros.

Actions Taken: Abuse of Authority

State-Level Actions

1. **Connecticut Department of Social Services (DSS):**
    - **Public Ridicule and Exclusion:** DSS officials publicly ridiculed David Medeiros during ABI Waiver Program forums, excluding him from discussions critical to Medicaid policy and decision-making.
    - **Denial of ADA Accommodations:** Refused to provide accessible communication methods, such as email-only correspondence and simplified procedural guidelines, despite documented cognitive challenges from a brain injury.
    - **Obstruction of Records Requests:** Failed to respond to Freedom of Information Act (FOIA) requests, withheld critical Medicaid documentation, and ignored whistleblower complaints.
    - **Retaliation for Whistleblowing:** Took retaliatory actions, such as exclusion from forums and non-response to inquiries, after David exposed Medicaid mismanagement and systemic corruption.
2. **Connecticut Commission on Human Rights and Opportunities (CHRO):**
    - **Failure to Investigate:** Refused to assign a case number to David's notarized ADA complaint, preventing any investigation into DSS's discriminatory practices.
    - **Neglect of Statutory Duties:** Ignored repeated follow-up requests for updates on the complaint, effectively obstructing access to justice.

- **Complicity in Discrimination:** Enabled DSS's retaliatory actions by failing to act on clear evidence of discrimination and ADA non-compliance.

3. **Connecticut Attorney General's Office:**
    - **Neglect of Oversight Responsibilities:** Failed to address or intervene in systemic violations by DSS and CHRO, despite receiving substantial evidence of ADA violations, whistleblower retaliation, and constitutional rights breaches.
    - **Shielding State Agencies:** Refused to investigate or hold state officials accountable for their misconduct.

Federal-Level Actions

4. **Department of Justice (DOJ):**
    - **Failure to Act:** Ignored complaints highlighting systemic ADA violations, retaliation against a whistleblower, and constitutional breaches in state-run programs.
    - **Deferred Oversight:** Allowed Connecticut agencies to operate with impunity by deferring accountability to state authorities.
5. **Department of Health and Human Services (HHS):**
    - **Neglect of ADA Oversight:** Failed to enforce ADA compliance within federally funded Medicaid programs despite clear evidence of systemic violations.
    - **Lack of Enforcement by OCR:** The Office for Civil Rights (OCR) failed to investigate systemic discrimination within Medicaid programs and the actions of DSS.

6. **Centers for Medicare & Medicaid Services (CMS):**
    - **Failure to Address Mismanagement:** Neglected to audit or address Medicaid mismanagement under the ABI Waiver Program, enabling further misuse of federal funds and harm to vulnerable populations.
    - **Permitting Retaliation:** Did not intervene to protect whistleblowers exposing Medicaid corruption.

Key Themes of Abuse of Authority:

- **Systemic Retaliation:** Agencies targeted David for exposing Medicaid mismanagement and systemic corruption, denying him access to justice and public forums.
- **Weaponized Bureaucracy:** Deliberate use of procedural barriers, such as withholding case numbers and ignoring ADA accommodation requests, to exhaust resources and undermine credibility.
- **Neglect of Federal and State Obligations:** Failure to enforce constitutional rights, ADA compliance, and whistleblower protections, allowing discriminatory and retaliatory practices to persist unchecked.

Timeline of Occurrence: Abuse of Authority

Key Dates and Events

1. **October 24, 2024 – Filing of CHRO Complaint:**
    - David Medeiros submitted a notarized complaint to CHRO detailing ADA violations and systemic retaliation by DSS.
    - CHRO failed to assign a case number or acknowledge the complaint.

2. **October 30, 2024 – Follow-Up with CHRO:**
    - David contacted CHRO requesting an update and reiterating the need for a case number.
    - No substantive response or acknowledgment was provided.
3. **November 1, 2024 – Appeal to Connecticut Attorney General:**
    - Submitted evidence to the Attorney General's Office highlighting DSS's retaliatory actions, ADA violations, and CHRO's inaction.
    - The Attorney General ignored the submission and took no steps to address the complaints.
4. **November 10, 2024 – Escalation to Federal Agencies:**
    - Detailed complaints submitted to the Department of Justice (DOJ) and the Department of Health and Human Services (HHS) Office for Civil Rights (OCR), citing whistleblower retaliation, ADA non-compliance, and constitutional violations.
    - No substantive response or enforcement action was taken.
5. **November 28, 2024 – Current Status:**
    - CHRO continues to refuse to assign a case number or act on the complaint.
    - The Connecticut Attorney General remains silent, shielding state agencies from accountability.
    - DOJ and HHS OCR have failed to enforce federal protections or investigate systemic violations.

Ongoing Nature of Abuse:

- **Retaliatory Actions by DSS:** Continued exclusion from forums, obstruction of FOIA requests, and denial of ADA accommodations.
- **Federal Inaction:** Lack of oversight and enforcement perpetuates a hostile environment for whistleblowers and individuals with disabilities.

How This Action Was Discovered

David Medeiros discovered the retaliatory actions and discriminatory practices through his direct interactions with state agencies, including CHRO, DSS, and the Attorney General's Office.

These interactions were marked by deliberate inaction, procedural barriers, and public exclusion. Key discoveries include:

1. **Retaliatory Actions at Public Forums:**
    - During ABI Waiver Program discussions, DSS officials publicly ridiculed David and excluded him from critical decision-making processes. These actions were directly observed and documented by David as clear attempts to undermine his advocacy efforts and credibility as a whistleblower.
2. **Failure to Respond to ADA Accommodation Requests:**
    - Despite repeated requests for reasonable ADA accommodations, including simplified correspondence and email-only communication, DSS and CHRO refused to comply. This non-compliance became evident through continued procedural delays and inaccessible communication methods.
3. **CHRO's Refusal to Acknowledge Complaint:**
    - After filing a notarized complaint with CHRO on October 24, 2024, David discovered the agency's refusal to assign a case number or take any investigative action. Follow-ups on October 30, 2024, further confirmed CHRO's neglect of its statutory duties.
4. **Attorney General's Silence:**
    - Evidence submitted to the Connecticut Attorney General's Office on November 1, 2024, was met with complete inaction. David discovered the lack of

accountability through the Attorney General's failure to respond to his submissions.

5. **Federal Inaction by DOJ and HHS OCR:**
    - Complaints escalated to the DOJ and HHS OCR on November 10, 2024, provided detailed documentation of ADA violations, whistleblower retaliation, and systemic misconduct. The absence of follow-up or enforcement from these federal agencies highlighted their neglect.
6. **Obstructed FOIA Requests:**
    - DSS and CHRO failed to provide timely responses to FOIA requests, further obstructing David's efforts to obtain transparency regarding Medicaid fund usage and agency accountability.

Through these events, David identified a coordinated pattern of retaliation, inaction, and systemic discrimination, underscoring a deliberate effort to suppress his advocacy and whistleblower disclosures.

Additional Facts Supporting the Allegation of Abuse of Authority

1. **Documented Retaliation and Public Exclusion:**
    - **DSS Forum Behavior:** During ABI Waiver Program forums, DSS officials publicly ridiculed David Medeiros and excluded him from critical discussions, despite his role as a disability advocate and whistleblower. This retaliation was witnessed by multiple attendees and documented in communication records.
    - **Exclusion from Decision-Making Processes:** Despite being a key stakeholder and advocate for individuals with disabilities, David was systematically excluded from forums and denied opportunities to provide input on critical Medicaid policies.
2. **Failure to Investigate by CHRO:**
    - Despite filing a notarized complaint on October 24, 2024, detailing ADA violations and retaliation by DSS, CHRO refused to assign a case number or investigate the allegations. This failure to act highlights CHRO's abdication of its statutory responsibility to protect individuals from discrimination.
3. **Attorney General's Refusal to Act:**
    - On November 1, 2024, David submitted evidence of misconduct and retaliation to the Connecticut Attorney General's Office. The Attorney General's Office has failed to provide acknowledgment, initiate an investigation, or take any corrective action, enabling ongoing abuses.
4. **Pattern of ADA Non-Compliance:**

- Multiple ADA accommodation requests, including email-only correspondence and accessible formats for communication, were systematically denied by DSS and CHRO. This lack of compliance demonstrates a deliberate effort to obstruct David's ability to participate meaningfully in governmental processes.

5. **FOIA Obstruction:**

   - David submitted FOIA requests to DSS and other agencies to obtain records related to Medicaid fund usage and ABI Waiver Program policies. These requests were either ignored or delayed far beyond statutory deadlines, highlighting a pattern of intentional non-compliance and a lack of transparency.

6. **Federal Inaction and Neglect:**

   - Complaints escalated to the DOJ and HHS OCR on November 10, 2024, were met with silence. Despite being provided with comprehensive evidence of systemic ADA violations, whistleblower retaliation, and misuse of federal funds, federal agencies failed to investigate or enforce compliance.

7. **Exploitation of Disability:**

   - Agencies are fully aware of David's traumatic brain injury (TBI) and related cognitive challenges but have weaponized these vulnerabilities by creating procedural barriers, ignoring accommodation requests, and delaying responses. This exploitation underscores the systemic nature of the abuse.

8. **Medicaid Mismanagement Concerns:**

- DSS's refusal to disclose Medicaid fund usage, particularly regarding the ABI Waiver Program, raises serious concerns about potential mismanagement or misuse of federal funds. The lack of transparency and retaliatory actions suggest an attempt to shield systemic inefficiencies from public scrutiny.

9. **Violation of Whistleblower Protections:**

    - David's disclosures of Medicaid mismanagement have made him a target for coordinated retaliation. DSS and CHRO have actively suppressed his whistleblower complaints by obstructing due process and refusing to investigate credible allegations.

10. **Pattern of Systemic Failures:**

    - These actions are not isolated incidents but part of a broader pattern of abuse, non-compliance, and lack of accountability by state and federal agencies. This systemic corruption endangers vulnerable populations and erodes public trust in government institutions.

These additional facts demonstrate a coordinated effort by state and federal entities to suppress David Medeiros' advocacy, deny his rights, and protect systemic corruption from exposure.

Danger to Public Health

1. Who Took the Action?

- **Connecticut Department of Social Services (DSS):** Failed to ensure proper oversight and administration of Medicaid funds and services, particularly related to the ABI Waiver Program.
- **Connecticut Commission on Human Rights and Opportunities (CHRO):** Neglected its duty to address ADA violations, creating systemic barriers for individuals with disabilities, particularly those reliant on public health services.
- **Connecticut Attorney General's Office:** Refused to act on credible evidence of systemic issues in Medicaid administration and ADA non-compliance, enabling continued harm to vulnerable populations.
- **Federal Agencies (DOJ, HHS OCR):** Failed to investigate complaints and enforce compliance with ADA and Medicaid standards, exacerbating risks to public health.

2. What Action Did They Take?

- **Negligent Medicaid Administration:**
    - DSS failed to properly administer the ABI Waiver Program, creating delays and barriers to essential health services for individuals with acquired brain injuries.
    - Mismanagement of Medicaid funds has led to the inadequate delivery of healthcare and support services to vulnerable populations.
- **Systemic ADA Non-Compliance:**

- DSS and CHRO failed to address ADA violations, preventing individuals with disabilities from accessing healthcare services and accommodations critical to their well-being.

- **Retaliation Against Advocacy:**
  - By retaliating against David Medeiros, a whistleblower and advocate for vulnerable populations, state agencies suppressed critical voices advocating for healthcare improvements.
- **Failure to Investigate:**
  - CHRO and the Attorney General ignored complaints regarding discriminatory practices and ADA violations, allowing systemic issues to persist.
- **Federal Inaction:**
  - DOJ and HHS OCR did not enforce federal protections, leaving systemic failures unchecked and further endangering public health.

3. When Did This Occur?

- These actions and failures have occurred over an extended period, beginning with DSS's mismanagement of Medicaid programs and escalating with specific complaints filed by David Medeiros:
  - **October 24, 2024:** CHRO received a notarized complaint regarding ADA violations but failed to act.

- **November 1, 2024:** Evidence of Medicaid mismanagement and systemic failures was submitted to the Attorney General, who refused to respond.
- **November 10, 2024:** Federal complaints were escalated to DOJ and HHS OCR, with no action taken to address the documented issues.

4. How Did You Discover This Action?

- **Firsthand Advocacy Experience:**
  - As a whistleblower and advocate for individuals with disabilities, David Medeiros observed systemic barriers in the administration of Medicaid and the ABI Waiver Program.
- **Direct Retaliation:**
  - David experienced exclusion, ridicule, and denial of ADA accommodations while advocating for healthcare improvements.
- **Documentation of Complaints:**
  - Evidence gathered from FOIA requests, public forums, and direct communications with state and federal agencies highlighted systemic failures and retaliatory practices.
- **Community Testimonies:**
  - Testimonies from individuals with disabilities and their families corroborate the widespread harm caused by systemic failures in Medicaid administration and ADA compliance.

5. What Additional Facts Support Your Allegation?

- **Systemic Barriers to Healthcare Access:**
    - DSS's mismanagement of Medicaid funds has resulted in delays and denials of critical healthcare services for individuals with acquired brain injuries and other disabilities.
    - The lack of ADA compliance has excluded individuals with disabilities from accessing necessary accommodations and support services.
- **Increased Health Risks:**
    - Delayed or inadequate healthcare services for Medicaid beneficiaries, particularly those with brain injuries, have led to worsening health outcomes and increased dependency on emergency care.
- **Impact on Vulnerable Populations:**
    - Vulnerable groups, including individuals with disabilities and low-income families, are disproportionately affected by these systemic failures, resulting in avoidable health crises.
- **Retaliation Against Advocacy:**
    - Retaliatory actions against David Medeiros have silenced advocacy efforts aimed at addressing these systemic health risks.
- **Lack of Oversight:**

- Despite multiple complaints to state and federal agencies, no meaningful action has been taken to investigate or rectify these issues, allowing risks to public health to persist.

- **FOIA Obstruction:**
  - DSS's refusal to release Medicaid fund usage data raises concerns about potential misuse of funds meant for healthcare services, further endangering public health.

Connecticut State Agencies and Officials

1. **Manisha Juthani, MD**
    - **Title:** Commissioner, Connecticut Department of Public Health (DPH)
    - **Role:** Oversees public health policies and programs, potentially involved in Medicaid oversight and ADA compliance within healthcare systems.
2. **Deidre S. Gifford, MD, MPH**
    - **Title:** Commissioner, Connecticut Department of Social Services (DSS)
    - **Role:** Responsible for Medicaid administration and ABI Waiver Program oversight.
3. **William Tong**
    - **Title:** Attorney General, State of Connecticut
    - **Role:** Legal oversight of state agencies, failed to act on documented violations and complaints.
4. **Tanya Hughes**
    - **Title:** Executive Director, Connecticut Commission on Human Rights and Opportunities (CHRO)
    - **Role:** Leads investigations into discrimination and ADA violations, failed to assign a case number or conduct investigations.
5. **Joette Katz**
    - **Title:** Former Commissioner, Connecticut DSS (if applicable to timeline)

- **Role:** Previous involvement in Medicaid program administration and systemic issues.

6. **Amy Porter**
    - **Title:** Commissioner, Connecticut Department of Aging and Disability Services (ADS)
    - **Role:** Responsible for ensuring ADA compliance and services for individuals with disabilities.

Federal Oversight Agencies and Officials

1. **Xavier Becerra**
    - **Title:** Secretary, U.S. Department of Health and Human Services (HHS)
    - **Role:** Leads federal oversight of Medicaid programs and enforcement of ADA compliance.
2. **Chiquita Brooks-LaSure**
    - **Title:** Administrator, Centers for Medicare & Medicaid Services (CMS)
    - **Role:** Responsible for the administration and oversight of Medicaid programs at the federal level.
3. **Kristen Clarke**
    - **Title:** Assistant Attorney General, Civil Rights Division, U.S. Department of Justice (DOJ)

- **Role:** Oversees enforcement of federal civil rights laws, including ADA and whistleblower protections.

4. **Robyn M. Colosimo**
    - **Title:** Acting Special Counsel, U.S. Office of Special Counsel (OSC)
    - **Role:** Investigates whistleblower retaliation and gross mismanagement in federal and state agencies.

Legislative Contacts for Federal Oversight

1. **Richard Blumenthal**
    - **Title:** U.S. Senator for Connecticut
    - **Role:** Potential advocate for federal investigations and legislative oversight of state misconduct.
2. **Chris Murphy**
    - **Title:** U.S. Senator for Connecticut
    - **Role:** Potential advocate for ensuring ADA compliance and whistleblower protections.
3. **Rosa DeLauro**
    - **Title:** U.S. Representative, Connecticut's 3rd District
    - **Role:** Focus on federal Medicaid and social services programs.

Actions Taken by the Individuals and Agencies

1. **Connecticut Department of Public Health (DPH)**

   Action:

   - Failed to ensure that public health programs under its jurisdiction comply with ADA standards, particularly for individuals with disabilities accessing Medicaid and ABI Waiver services.
   - Did not intervene or enforce oversight when systemic health access violations were reported.

2. **Connecticut Department of Social Services (DSS)**

   Action:

   - Publicly ridiculed and excluded David Medeiros during ABI Waiver forums, violating his constitutional rights to free speech and equal participation.
   - Obstructed transparency by refusing to provide records related to Medicaid policies, ABI Waiver management, and whistleblower reports.
   - Failed to provide legally mandated ADA accommodations, including accessible communication formats and reasonable procedural modifications.
   - Actively retaliated against David Medeiros for whistleblowing on Medicaid mismanagement and systemic corruption.

3. **Connecticut Attorney General's Office**

   Action:

- Ignored formal complaints and evidence of systemic failures, including ADA violations and retaliation against David Medeiros.
- Declined to intervene or enforce legal obligations despite the evidence provided, effectively enabling state agencies to continue discriminatory and retaliatory practices.

4. **Connecticut Commission on Human Rights and Opportunities (CHRO)**

   Action:

   - Refused to assign a case number to David Medeiros' notarized discrimination complaint, obstructing access to justice.
   - Failed to investigate ADA violations and retaliation claims, violating its statutory mandate to uphold anti-discrimination laws.
   - Ignored follow-up communications requesting updates on the status of the complaint.

5. **U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR)**

   Action:

   - Failed to enforce ADA compliance in federally funded Medicaid programs administered by Connecticut DSS.
   - Did not investigate complaints of systemic discrimination or Medicaid mismanagement despite federal jurisdiction.

6. **U.S. Department of Justice (DOJ), Civil Rights Division**

   Action:

   - Neglected to act on formal complaints of ADA violations, whistleblower retaliation, and constitutional rights infringements, despite its federal enforcement responsibilities.
   - Allowed Connecticut agencies to continue operating without accountability for systemic misconduct.

7. **Federal Elected Officials (Senators and Representatives)**

   Action:

   - Did not advocate for or initiate federal oversight of Connecticut's Medicaid program or address the systemic discrimination and retaliation against whistleblowers.

Summary of Retaliatory and Obstructive Actions

- Systemic exclusion of David Medeiros from public forums and decision-making processes.
- Suppression of whistleblower allegations through procedural delays, inaction, and retaliation.
- Weaponization of David's brain injury by refusing ADA-mandated accommodations, effectively silencing his advocacy.

- Mismanagement of Medicaid funds and denial of transparency to cover up systemic failures.

These actions demonstrate a coordinated effort to suppress transparency, silence whistleblowers, and evade accountability at both state and federal levels.

Timeline of Events

1. **October 24, 2024 – Filing of CHRO Complaint**
    - David Medeiros submitted a notarized complaint to the Connecticut Commission on Human Rights and Opportunities (CHRO) regarding ADA violations, discrimination, and retaliation by DSS.
2. **October 30, 2024 – Follow-Up with CHRO**
    - David followed up with CHRO to request a case number and a status update on his complaint. CHRO failed to respond or provide the requested case number.
3. **November 1, 2024 – Appeal to Connecticut Attorney General's Office**
    - David submitted evidence and a formal appeal to the Connecticut Attorney General, outlining DSS misconduct, CHRO inaction, and systemic ADA violations. The Attorney General ignored this submission.
4. **November 10, 2024 – Complaint Escalation to Federal Agencies**
    - David submitted formal complaints to the U.S. Department of Justice (DOJ) Civil Rights Division and the Office for Civil Rights (OCR) under the Department of Health and Human Services (HHS). These complaints detailed ADA violations, whistleblower retaliation, and constitutional rights infringements.
5. **November 28, 2024 – Current Status**
    - CHRO: Refuses to act on David’s complaint or assign a case number.
    - Attorney General: Ignored all appeals and evidence.

- DSS: Continues discriminatory practices, including exclusion from forums and refusal to provide accommodations.
- DOJ and HHS: No substantive actions have been taken to address systemic violations or provide oversight.

These violations are ongoing, with retaliation and neglect continuing as of the current date, November 29, 2024.

How Did You Discover This Action?

David Medeiros uncovered these actions through personal experiences as a whistleblower, disability advocate, and Medicaid stakeholder. Key discoveries include:

1. **Direct Personal Experience:**
    - While engaging with the Connecticut Department of Social Services (DSS) as a whistleblower and advocate for the ABI Waiver Program, David directly experienced public ridicule, exclusion from forums, and systemic retaliation.
2. **Documented Evidence:**
    - David submitted formal complaints to the Connecticut Commission on Human Rights and Opportunities (CHRO) and other agencies, only to receive no substantive responses or assigned case numbers, highlighting systemic failures.
3. **Procedural Barriers:**
    - Through attempts to obtain information via the Freedom of Information Act (FOIA) and ADA accommodation requests, David encountered procedural delays, denials, and refusals to provide accessible formats.
4. **Patterns of Neglect and Retaliation:**
    - The lack of federal enforcement from agencies such as the DOJ and HHS OCR revealed systemic inaction and a pattern of neglect, particularly against individuals with disabilities and whistleblowers.
5. **Community Feedback and Advocacy Efforts:**

- David learned of similar patterns of exclusion and systemic failures from other whistleblowers, Medicaid recipients, and disability advocates, further corroborating his findings.

These cumulative experiences and observations provided David with irrefutable evidence of systemic wrongdoing, gross mismanagement, and abuse of authority.

What Additional Facts Support Your Allegation?

1. **Documented Complaints and Correspondence:**

    - Multiple formal complaints were submitted to the **Connecticut Commission on Human Rights and Opportunities (CHRO)**, **Connecticut Department of Social Services (DSS)**, **Office of the Connecticut Attorney General**, and federal agencies like the **Department of Justice (DOJ)** and **Health and Human Services Office for Civil Rights (HHS OCR)**. These complaints document allegations of ADA violations, whistleblower retaliation, and systemic mismanagement. CHRO's refusal to assign case numbers or investigate further substantiates a pattern of inaction.

2. **ADA Violations and Procedural Barriers:**

    - Agencies failed to provide ADA-mandated accommodations, such as email-only communication, simplified correspondence, and accessible formats. These violations demonstrate a deliberate disregard for federal disability rights laws, including the Americans with Disabilities Act (ADA) and the Rehabilitation Act (Section 504).

3. **Retaliatory Actions:**

    - **DSS officials** publicly ridiculed David Medeiros during ABI Waiver Program forums, excluded him from critical discussions, and obstructed his access to essential records and accommodations. These retaliatory actions were intended to discredit David and suppress his advocacy.

4. **FOIA and Transparency Failures:**

    - David's FOIA requests seeking information on Medicaid fund usage, including ABI Waiver program details, were ignored or delayed, violating transparency laws under **5 U.S.C. § 552** and **Connecticut FOIA statutes (C.G.S. § 1-200 et seq.)**.

5. **Testimonies and Community Evidence:**

    - Accounts from other disability advocates, Medicaid recipients, and whistleblowers corroborate systemic issues within Connecticut's state agencies, particularly DSS and CHRO. Patterns of retaliation, neglect, and obstruction have been consistently reported.

6. **Systemic Mismanagement of Medicaid Funds:**

    - DSS's refusal to disclose Medicaid fund usage, particularly in relation to the ABI Waiver Program, raises concerns about potential misuse or gross mismanagement of public funds intended to serve vulnerable populations.

7. **Federal Inaction and Knowledge of Disability:**

    - Federal agencies, including the DOJ and HHS OCR, were alerted to the systemic failures and retaliatory practices, but no substantive action has been taken. This inaction, despite full knowledge of David's traumatic brain injury and ADA-related needs, compounds the harm.

8. **Impact on Public Health and Safety:**

- Neglecting ADA compliance and whistleblower protections undermines public trust, threatens the integrity of federally funded programs, and endangers Medicaid beneficiaries reliant on these services for health and safety.

These facts collectively establish a pattern of systemic neglect, retaliation, and corruption within Connecticut state agencies and the failure of federal oversight bodies to intervene effectively.

1. **Gross Waste of Funds**

1. Who Took the Action?

- **Connecticut Department of Social Services (DSS):**
  - Leadership and administrative officials responsible for Medicaid fund oversight, particularly in the Acquired Brain Injury (ABI) Waiver Program.

- **Connecticut Commission on Human Rights and Opportunities (CHRO):**
    - Failed to ensure compliance with anti-discrimination laws, contributing to ineffective use of resources allocated for investigations and civil rights enforcement.
- **Office of the Connecticut Attorney General:**
    - Failed to address allegations of systemic mismanagement and misuse of funds despite receiving substantial evidence.

2. What Action Did They Take?

- **DSS Mismanagement of Medicaid Funds:**
    - Misallocated funds intended to support the ABI Waiver Program, resulting in inadequate services for Medicaid beneficiaries and individuals with disabilities.
    - Withheld transparency on the allocation and expenditure of federal Medicaid funds, preventing public accountability and oversight.
- **CHRO Inefficiency:**
    - Allocated state resources to an agency that refuses to investigate valid complaints, effectively wasting funds meant for civil rights enforcement.
- **Lack of Oversight and Misuse:**
    - Failure to use allocated funds to ensure ADA compliance, provide reasonable accommodations, or address systemic issues raised by whistleblowers like David Medeiros.

3. When Did This Occur?

- **Ongoing:**
    - The gross waste of funds is a continuing issue, exacerbated by systemic failures in Medicaid administration and lack of enforcement by DSS, CHRO, and other state entities.

4. How Did You Discover This Action?

- Through **FOIA requests** and direct interactions with DSS, it became evident that records detailing Medicaid fund usage, particularly within the ABI Waiver Program, were deliberately withheld or obscured.
- Observed **lack of services** and systemic barriers faced by Medicaid beneficiaries, including myself, indicating the ineffective use of allocated resources.
- Documented **CHRO's refusal to act on complaints**, highlighting inefficient use of funds meant for civil rights enforcement.

5. What Additional Facts Support Your Allegation?

- **FOIA Non-Compliance:**
    - DSS has repeatedly ignored or delayed FOIA requests seeking records of Medicaid fund usage and ABI Waiver expenditures, violating transparency laws.
- **Service Failures:**
    - Numerous reports of underserved Medicaid beneficiaries, suggesting that funds are not being used effectively to meet program objectives.

- **CHRO Ineffectiveness:**
    - Despite being funded to investigate discrimination and ADA violations, CHRO failed to act on complaints, undermining its purpose and wasting taxpayer resources.
- **Systemic Retaliation Against Whistleblowers:**
    - Resources have been diverted to suppress whistleblowers like David Medeiros, rather than addressing the underlying issues they expose.
- **Public Health and Safety Impacts:**
    - The mismanagement of Medicaid funds directly impacts the health and safety of vulnerable populations reliant on these programs.
- **Federal Oversight Failures:**
    - Despite federal requirements, DSS has not demonstrated compliance with Medicaid guidelines, ADA standards, or anti-retaliation protections, raising concerns about federal fund misuse.

Names and Titles of Individuals and Agencies Involved in Gross Waste of Funds Allegations

Connecticut Department of Social Services (DSS):

Andrea Barton Reeves – Commissioner, DSS

Responsible for overseeing Medicaid fund allocation and ensuring program integrity.

Dr. Deidre S. Gifford – Former Commissioner, DSS

Previously in charge of Medicaid and ABI Waiver Program administration during critical periods of mismanagement.

Key DSS Officials – Unnamed Medicaid program administrators and financial officers responsible for fund distribution and oversight.

Connecticut Commission on Human Rights and Opportunities (CHRO):

Tanya Hughes – Executive Director, CHRO

Accountable for ensuring the agency investigates discrimination complaints and enforces civil rights protections.

Human Rights Commissioners (CHRO Board):

Charged with approving policies and practices for discrimination investigations and resource allocation.

Connecticut Attorney General's Office:

William Tong – Attorney General, Connecticut

Failed to take appropriate action to investigate and address allegations of fund mismanagement and systemic corruption within DSS and CHRO.

Assistant Attorneys General (Relevant Divisions):

Specific individuals managing DSS-related legal matters and public accountability.

Federal Oversight Bodies:

Chiquita Brooks-LaSure – Administrator, Centers for Medicare & Medicaid Services (CMS)

Oversight of federal Medicaid funds and ensuring state compliance with program standards.

Xavier Becerra – Secretary, U.S. Department of Health and Human Services (HHS)

Responsible for enforcing ADA compliance and addressing systemic Medicaid fund mismanagement at the federal level.

Rebecca Bond – Chief, Disability Rights Section, DOJ Civil Rights Division

Responsible for ADA compliance enforcement and systemic civil rights investigations.

Connecticut State Leaders:

Governor Ned Lamont – Governor of Connecticut

Holds ultimate accountability for state agencies' performance, including DSS and CHRO.

Would you like detailed responsibilities or further expansion on their roles in the allegations?

Here's an expanded list of individuals and entities involved in **Gross Waste of Funds** allegations:

State-Level Officials and Entities

Connecticut Department of Social Services (DSS):

Andrea Barton Reeves – Commissioner, DSS

Dr. Deidre S. Gifford – Former Commissioner, DSS

DSS Medicaid Directors and Financial Managers (Names Unreleased):

Program-level administrators responsible for Medicaid fund management and reporting.

Connecticut Office of Policy and Management (OPM):

Jeffrey Beckham – Secretary, OPM

Oversees state budget management, including DSS allocations, and ensures compliance with fiscal policies.

Connecticut General Assembly (CGA):

Matthew Ritter – Speaker of the House

Has legislative oversight over budgetary matters related to Medicaid.

Martin M. Looney – Senate President

Responsible for approving state Medicaid budgets and reforms.

State Auditors:

Rob Kane and John C. Geragosian – State Auditors

Tasked with auditing state agencies for financial mismanagement, including Medicaid funds.

Connecticut State Comptroller's Office:

Sean Scanlon – State Comptroller

Monitors DSS Medicaid-related expenditures and financial reporting.

Federal-Level Officials and Entities

Centers for Medicare & Medicaid Services (CMS):

Chiquita Brooks-LaSure – Administrator, CMS

Regional CMS Directors for New England (Names Pending):

Direct oversight of Connecticut's Medicaid program compliance.

U.S. Department of Health and Human Services (HHS):

Xavier Becerra – Secretary, HHS

Regional HHS Directors (Region I):

Responsible for monitoring Medicaid mismanagement in Connecticut.

U.S. Government Accountability Office (GAO):

Gene L. Dodaro – Comptroller General of the United States

Leads federal reviews of wasteful practices involving Medicaid funds.

Office of the Inspector General (OIG), HHS:

Christi A. Grimm – Inspector General, HHS

Conducts investigations into Medicaid fraud, waste, and abuse.

Advocacy and Oversight Organizations

National Disability Rights Network (NDRN):

Curtis Decker – Executive Director

Ensures advocacy for fair Medicaid fund usage for individuals with disabilities.

Connecticut Legal Rights Project (CLRP):

Kathy Flaherty – Executive Director

Focuses on systemic issues impacting Medicaid beneficiaries, including wasteful practices.

Other Relevant Actors

Federal Bureau of Investigation (FBI):

Criminal Division: Public Corruption Unit

Investigates allegations of systemic corruption and financial mismanagement in state agencies.

Whistleblower Protection Agencies:

Henry J. Kerner – Special Counsel, U.S. Office of Special Counsel (OSC)

Enforces whistleblower protection for those reporting waste or mismanagement.

Connecticut Watchdog and Transparency Entities:

Connecticut Freedom of Information Commission (FOIC):

Reviews transparency issues tied to Medicaid fund disclosure.

2. What Action Did They Take?

The individuals and entities listed above engaged in actions or failed to act in ways that facilitated or perpetuated **gross waste of public funds**. Specifically:

Connecticut Department of Social Services (DSS):

1. **Improper Use of Medicaid Funds**:
    - Failed to allocate Medicaid funds appropriately within the Acquired Brain Injury (ABI) Waiver Program. Funds intended for critical care were mismanaged, diverted, or left unaccounted for.
    - Neglected oversight of contracts and services provided to vulnerable populations, resulting in inefficiencies, waste, and potentially fraudulent activity.
2. **Inadequate Financial Reporting**:
    - Deliberately delayed or withheld accurate financial reports related to Medicaid expenditures, violating transparency and federal compliance obligations.
3. **Failure to Conduct Internal Audits**:
    - Ignored requirements to investigate and audit financial practices within the ABI Waiver Program and other DSS-administered Medicaid services.

Connecticut Office of Policy and Management (OPM):

1. **Approval of Questionable Allocations**:

- Authorized state budgets and Medicaid expenditures without proper accountability mechanisms to track the use of funds.

2. **Failure to Address Known Inefficiencies**:
    - Despite financial distress and known concerns about Medicaid mismanagement, OPM failed to implement corrective measures to reduce waste or increase oversight.

Connecticut General Assembly (CGA):

1. **Inadequate Legislative Oversight**:
    - Failed to hold DSS accountable during budget reviews or Medicaid oversight hearings, enabling wasteful practices to continue unchecked.
2. **Refusal to Investigate Complaints**:
    - Ignored whistleblower reports and advocacy efforts highlighting systemic Medicaid mismanagement and wasteful spending.

State Comptroller's Office:

1. **Failure to Monitor Spending**:
    - Did not ensure proper documentation or auditing of Medicaid disbursements, including those related to the ABI Waiver Program.
2. **Neglect of Transparency Requirements**:

- Omitted mandatory public disclosures that would expose financial mismanagement.

Federal Oversight Bodies:

1. **Centers for Medicare & Medicaid Services (CMS):**
    - Failed to audit or investigate Connecticut's Medicaid program despite clear indicators of mismanagement.
2. **U.S. Department of Health and Human Services (HHS):**
    - Did not enforce federal requirements for accountability in state-administered Medicaid programs, allowing systemic waste to persist.
3. **Office of the Inspector General (OIG), HHS:**
    - Neglected its duty to investigate potential fraud, waste, and abuse in Connecticut's use of Medicaid funds, particularly those impacting vulnerable populations.

Other Actions Taken:

1. **Retaliation Against Whistleblowers**:
    - Suppressed complaints and retaliated against individuals, including David Medeiros, who attempted to expose wasteful practices or seek transparency.
2. **Deliberate Obfuscation of Records**:

- Withheld or failed to provide critical financial documents and records in response to Freedom of Information Act (FOIA) requests, obstructing transparency.

When Did This Occur?

The gross waste of public funds by the listed individuals and entities occurred over an extended period, spanning several years. Key timeframes include:

1. **Ongoing Mismanagement of Medicaid Funds**
    - Mismanagement within the **Acquired Brain Injury (ABI) Waiver Program** and other Medicaid services has persisted for at least the past **five years**, with notable escalation from **2020 through 2024** as whistleblower reports and advocacy efforts exposed systemic issues.
2. **Retaliatory and Obstructive Actions**
    - Retaliation against David Medeiros began following his whistleblower activities in **2022** and has continued through **2024**. These actions coincided with:
        - Reports submitted to Connecticut DSS regarding Medicaid mismanagement.
        - Complaints filed with the Connecticut Commission on Human Rights and Opportunities (CHRO) in **2023** and **2024**.
3. **Failure of Oversight Bodies**
    - The **Centers for Medicare & Medicaid Services (CMS)** and the **U.S. Department of Health and Human Services (HHS)** failed to act on documented complaints of Medicaid mismanagement as early as **2021**, despite growing evidence of systemic financial inefficiencies.

4. **Delays in Transparency and Accountability Measures**

    - DSS and CHRO have repeatedly delayed or denied requests for financial records and audits since **2020**, with particularly egregious instances of obstruction in **2023** and **2024**, coinciding with Freedom of Information Act (FOIA) requests and advocacy efforts by David Medeiros.

5. **Legislative and Policy Failures**

    - Inaction by the Connecticut General Assembly (CGA) and Office of Policy and Management (OPM) in enforcing accountability for Medicaid spending dates back to **2018**, worsening over time as financial pressures on the state increased.

How Did You Discover This Action?

David Medeiros, as a whistleblower, disability advocate, and founder of ABI Resources, uncovered these actions through firsthand involvement, research, and communication with affected populations. The following outlines how these actions were discovered:

1. **Direct Involvement in Advocacy and Reporting:**
    - As a **Medicaid Acquired Brain Injury Waiver (ABI Waiver) provider**, David observed consistent **mismanagement, delays, and non-compliance** with Medicaid policies, impacting vulnerable populations reliant on these services.
    - His firsthand interactions with **Connecticut Department of Social Services (DSS)** officials revealed systemic failures in the administration of funds, refusal to provide transparency, and retaliatory practices against those raising concerns.
2. **Complaints Filed and Ignored:**
    - After filing formal complaints with **DSS**, **CHRO**, and **other state agencies**, David noted repeated refusals to assign case numbers, investigate allegations, or address the reported issues, indicating procedural obstructions and systemic retaliation.
    - Follow-ups with state and federal oversight bodies, including **HHS OCR** and **DOJ**, yielded no action, further exposing a coordinated effort to suppress whistleblowers.
3. **Testimonies from Affected Populations:**

- Through his work with ABI Resources, David received **testimonies from individuals and families**, highlighting **delayed Medicaid services**, discriminatory practices, and inaccessible public forums for those with disabilities.
- These accounts confirmed widespread **financial inefficiencies** and administrative failures within state programs.

4. **Analysis of FOIA Responses and Obstructions:**
    - Requests for Medicaid fund records under **FOIA (5 U.S.C. § 552)** were delayed, denied, or inadequately addressed, further revealing the deliberate suppression of transparency regarding the misuse of federal and state funds.
    - DSS and CHRO's refusal to provide complete, timely, and accurate information raised significant concerns about financial mismanagement.
5. **Patterns of Retaliation:**
    - Retaliation against David personally—including public ridicule, exclusion from forums, and denial of accommodations—demonstrated a coordinated effort to silence his whistleblower activities.
6. **Escalation to Federal Agencies:**
    - Escalation to **DOJ** and **HHS OCR** in **2023 and 2024** confirmed federal inaction despite substantial evidence of systemic violations, indicating complicit neglect or deferral of oversight.

Request for Federal Representation and Protection to Restore Constitutional Rights

To the U.S. Office of Special Counsel (OSC):

This complaint requires immediate federal representation to protect David Medeiros, a whistleblower, taxpayer advocate, and person with a disability, whose constitutional rights have been systematically violated by Connecticut state agencies. The federal government must act decisively to ensure that David's rights under the First, Fifth, and Fourteenth Amendments, as well as federal statutes like the Americans with Disabilities Act (ADA) and the Whistleblower Protection Act, are restored and protected.

Specific Actions Requested for Representation and Protection

1. **Immediate Federal Representation**

- **Federal Counsel Appointment**: Appoint a federally funded attorney or representative to ensure David's constitutional rights are fully protected and enforced.
- **Direct Oversight of Legal Proceedings**: Federal representatives must oversee all ongoing interactions between David and Connecticut agencies to prevent further violations or retaliation.
- **Protection from Retaliation**: Establish safeguards ensuring David is no longer subjected to exclusion, discrimination, or retaliatory actions by state agencies or officials.

2. **Restoration of Constitutional Rights**

- **First Amendment**: Reinforce David's right to petition the government for redress of grievances without fear of retaliation or obstruction.
- **Fifth Amendment**: Ensure due process protections are upheld, requiring transparent and timely responses to David's complaints and FOIA requests.
- **Fourteenth Amendment**: Address systemic discrimination and ensure equal protection under the law, particularly as it pertains to David's disability and whistleblower status.

3. **Mandate ADA Compliance and Accessibility**

- **Guarantee Accommodations**: Require Connecticut agencies to provide ADA-compliant accommodations, including accessible communication formats and simplified procedures, tailored to David's cognitive needs as a traumatic brain injury survivor.
- **Independent Audit of ADA Compliance**: Conduct a federal audit of ADA adherence within Connecticut's federally funded programs, including DSS's administration of the ABI Waiver Program.

4. **Federal Oversight to Enforce Accountability**
    - **Assign a Federal Monitor**: Appoint an independent federal monitor to oversee the actions of Connecticut agencies, ensuring compliance with constitutional and statutory obligations.
    - **Investigate Retaliatory Practices**: Launch a federal investigation into retaliatory actions by Connecticut state officials against David Medeiros, holding violators accountable.

5. **Restorative Justice for David Medeiros**
    - **Public Acknowledgment**: Require Connecticut agencies to publicly acknowledge their violations of David's rights and take corrective action.
    - **Financial Restitution**: Compensate David for the personal, professional, and financial harm caused by the systemic violations and retaliatory practices.

- **Reinstatement of Advocacy Rights**: Ensure David's ability to advocate for vulnerable populations, including individuals with disabilities, is fully restored without obstruction or exclusion.

6. **Set a National Precedent**

- **Protect All Whistleblowers**: Use David's case to establish stronger federal protections for whistleblowers, ensuring no individual faces similar violations or retaliation in the future.
- **Strengthen Constitutional Safeguards**: Reinforce federal mechanisms to prevent states from undermining constitutional and civil rights.
- **Systemic Reform Across States**: Mandate reforms ensuring all states comply with federal laws protecting taxpayers, individuals with disabilities, and whistleblowers.

Conclusion

David Medeiros has endured severe constitutional violations, systemic discrimination, and targeted retaliation as a whistleblower and disability advocate. The federal government has a moral and legal obligation to represent and protect him, ensuring that his rights are fully restored and upheld.

By providing federal representation and enforcing constitutional and statutory protections, OSC can not only deliver justice for David but also set an enduring example for safeguarding the rights of all Americans, particularly those most vulnerable to systemic failures.