

*Fraud, Waste and Excess Profits: The Fate of Money Intended to Treat People With
Serious Mental Illness*

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Executive Summary:

- There has been a significant deterioration of public mental health services over the past three decades. It is widely believed that this deterioration is attributable to decreased funding. In fact, the funds available to state mental health agencies in constant dollars have increased modestly since 1982.
- There are suggestions that a significant amount of public mental health funds are being lost to fraud, waste, and excess profits to for-profit managed care companies. We estimate that this loss is between 10 and 20 percent of the approximately \$40 billion per year spent by state mental health agencies; *The loss therefore totals approximately \$4 to \$8 billion* and is one reason for the deterioration of public mental health services.
- This amount of money, if used for individuals with serious mental illness, could purchase:
 - 3 months of state hospitalization for 112,000 individuals
 - 1 year of Assertive Community Treatment for 267,000 individuals
 - 1 year of Assisted Outpatient Treatment for 800,000 individuals
 - 1 year of a clubhouse rehabilitation program for 364,000 individuals
 - 1 year of supported housing for 333,000 individuals
 - 1 year of standard antipsychotic medication for 6.7 million individuals
 - 1 year of clozapine treatment for 667,000 individuals

The public mental health funds currently being lost to fraud, waste and excess profits are sufficient to provide psychiatric services for most of the estimated

216,000 individuals with serious mental illness who are currently homeless as well as the 350,000 who are in jail and prison.

- **Fraud:** For 2014 our study identified 18 media stories about mental health Medicare and Medicaid fraud. One example involved \$258 million in false claims; together they totaled approximately \$1 billion. An additional 10 cases of possible mental health Medicare and Medicaid fraud were under investigation. Much of the Medicare and Medicaid fraud was blatant. For example, a social worker billed for 64 hours of therapy and a mental health therapist billed for 78 hours of therapy in a single day. A psychiatrist billed for psychotherapy sessions when he was not in the country. A nurse submitted over 6,000 false claims.
- **Waste:** In California in 2004 voters approved a special tax specifically to help individuals diagnosed with serious mental illness. The tax has produced over \$1 billion per year. However, some of the money was diverted to activities such as yoga, line-dancing, therapeutic drumming and community gardens. As the *San Francisco Examiner* noted: “Unfortunately, \$1 out of every \$5 may be funding mildly therapeutic programs for people who do not remotely suffer from serious illness—or may even be funding frivolous perks for government employees.”
- **Excess Profits:** In Florida in 2003 WellCare acquired a contract to provide mental health services to Florida’s Medicaid population, and was allowed to keep 20 percent of the Medicaid premiums for administrative expenses and profit. In a secretly recorded conversation a WellCare vice president claimed the company was keeping 50 percent of the premiums. In 2013 three Wellcare executives were convicted of fraud and sentenced to prison.

- ***Recommendations:*** To correct the current situation, we recommend that the federal Health Care Fraud Prevention and Enforcement Action Team (HEAT Task Force) should be significantly expanded since it has been shown to pay for itself. State mental health agencies should also exert active, assertive oversight over community programs. This should include vigorous examination of Medicaid and Medicare claims; unannounced audits of community mental health programs looking for theft and waste; and a prohibition on the use of for-profit managed care companies. Such corrective actions are unlikely to happen unless mental health advocacy groups and the public in general demand it.

I. Introduction

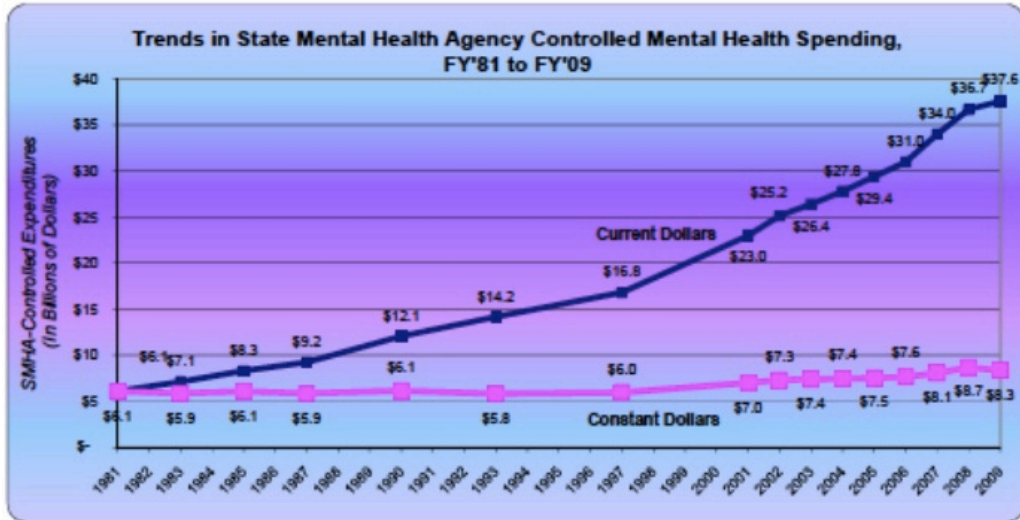
In June, 2015, the federal Department of Health and Human Services (DHHS), in partnership with the Department of Justice (DOJ), announced “the largest criminal health care fraud takedown in the history of the Department of Justice.” A total of 243 individuals were charged with falsely billing Medicare and Medicaid for approximately \$712 million in claims. This was the most recent action in the stepped-up federal efforts to combat health care fraud, an ongoing investigation that began in 2009 with the organization of the Health Care Fraud Prevention and Enforcement Action Team, referred to as the HEAT Task Force.¹

The 243 individuals against whom charges were brought in June were charged with a variety of types of fraud. Prominently featured were examples of home health care; physical and occupational therapy; pharmacy; medical equipment; and psychotherapy fraud. In 2014 Richard Kusserow, the former Inspector General of DHHS, claimed that “many healthcare fraud

investigators believe mental healthcare givers, such as psychiatrists and psychologists, have the worst fraud records of all disciplines.”²

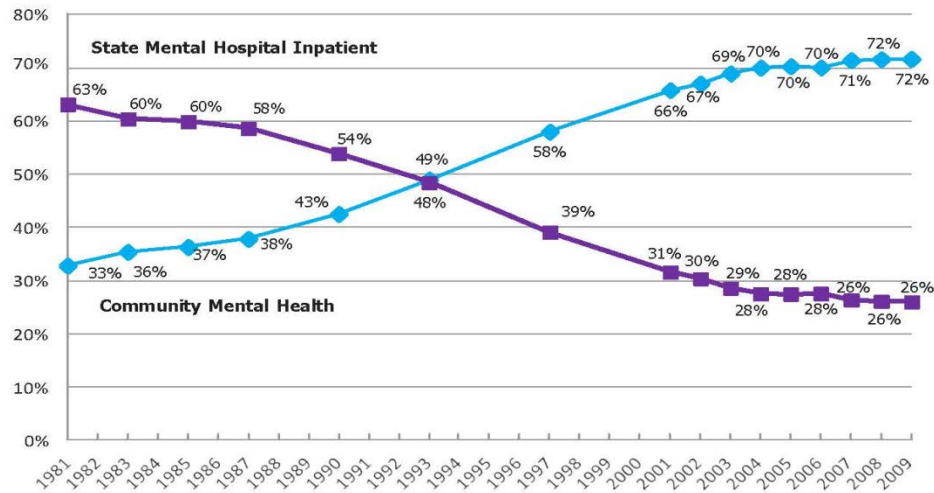
If Medicare and Medicaid fraud are as widespread as now appears to be the case, and if mental healthcare providers commit a disproportionate share of such fraud, as Kusserow alleges, this has important implications for the delivery of mental health services in the United States. State services for individuals with mental illnesses, especially those with serious mental illnesses such as schizophrenia and bipolar disorder, have deteriorated markedly in recent decades. The percentage of seriously mentally ill individuals in local jails and state prisons has increased from approximately 5% in the 1970s to 20% or more today. The number of mentally ill individuals among the homeless has also markedly increased—they have become homesteaders on urban sidewalks. Mentally ill individuals have increasingly overrun public parks and libraries, bus and train stations, and hospital emergency rooms. Law-enforcement officials have become *de facto* frontline mental health workers, causing major problems, including increasing officer related shootings. Of greatest concern has been an increase in violence by a subset of seriously mentally ill individuals who are not being treated; mass killings in places such as Tucson, Aurora and Newtown have become scars on our national consciousness.³

Many mental health advocates and providers have asserted that this deterioration of mental health services is primarily attributable to decreased funding allocated for such services. However, the facts do not support this assertion. In 2012, according to data collected annually by the National Association of State Mental Health Program Directors (NASMHPD), state mental health agencies spent a total of \$39.4 billion on mental health services. Compared to 1981, this amount of money in constant dollars has increased by 36 percent.⁴



The source of the \$39.4 billion spent by state mental health agencies was as follows: 42% from state general funds; 48% from Medicaid (federal and state match); 2% from Medicare; 1% from the federal Block Grant; 1% from other federal funds; 2% from local funds; and 4% from other sources. Note that Medicaid and Medicare together make up half of the state mental health spending, suggesting that fraud in these programs could have a significant effect on services. Thus, during the last three decades, during which time state services for seriously mentally ill persons have markedly deteriorated, the amount of state funds available for such services has actually increased in real terms, beyond the cost of inflation.

SMHA-Controlled Expenditures for State Psychiatric Hospital Inpatient and Community-Based Mental Health Services, FY 1981 to FY 2009



If the total amount of money available to fund state mental health services is not the main problem, what is? The answer is suggested by NASMHPD's analysis of long-term trends in state mental health agency expenditures. In 1981, 63 percent of the state expenditures went to state mental hospitals and 33 percent to community mental health programs. In 1981 state mental hospitals still held over 126,000 patients and some states, such as New Hampshire, also owned the community mental health centers in that state. The state mental health agency had direct responsibility for patient care and thus had knowledge and some control regarding how the state mental health funds were being spent. State mental health agencies at that time also employed a significant number of psychiatrists, psychologists and other mental health professionals to oversee the state programs.

By 2009 there had been a major shift in state mental health expenditures. As seen in the graph, the proportion of funds going to state mental hospitals had decreased from 63 to 26 percent, while the proportion going to community mental health programs had increased from 33 to 72 percent.⁴ This was the essence of deinstitutionalization. *State mental health agencies no*

longer had direct responsibility for patient care but rather contracted that responsibility to a variety of nonprofit and for-profit mental health providers. This was a fundamental change in the delivery of mental health services, reversing how things had been done for a century and a half. This shift was also reflected in the personnel of the state mental health agencies; most of the mental health professionals who had held leadership positions had been replaced by lawyers, accountants, and other contract-knowledgeable officials. The closing of the state hospitals and shift to contracted community mental health programs has often been publicly rationalized as being more humane and improving the quality of life for patients. In reality, the driving force behind the shift has been the states' wishes to shift the cost of care from themselves to the federal government.⁵

In 2012, 72 percent of the \$39.4 billion total state mental health expenditures, or approximately \$28 billion dollars, was contracted out by the states to private community mental health programs. What has happened to this money? The authors undertook the present study to try and answer four questions:

1. Is there any evidence to support the allegation that mental health providers are responsible for a disproportionate amount of Medicare and Medicaid Fraud?
2. In addition to such fraud, are there other activities which result in the loss of state mental health funds and their diversion from their intended purpose?
3. Is it possible to estimate the total amount of state mental health funds that are being lost?
4. Is there any evidence that the loss of state mental health funds is a new problem or getting worse?

II. Fraud

Medicaid and Medicare have been subject to varying degrees of fraud ever since Congress enacted the programs in 1965. Currently, Medicaid spends about \$415 billion and Medicare \$600 billion each year. In 2012, Donald Berwick, the former administrator of the Centers for Medicare and Medicaid Services, estimated that approximately 10 percent of the total Medicaid and Medicare money is lost to fraud.⁶

Mental health Medicaid and Medicare fraud takes many forms. These include:

- billing for phantom visits;
- billing for services not provided;
- double billing; billing for unnecessary services;
- billing for services provided by an unqualified person;
- inflating the services provided.

Many of the examples are egregious. A mental health therapist is alleged to have billed Medicaid for 78 hours of therapy she claims to have provided in a single day.⁷ Similarly, Michael Reinstein, a Chicago psychiatrist, “submitted at least 140,000 false claims to Medicare and Medicaid for antipsychotics he had prescribed based on the kickbacks he received from pharmaceutical companies.” One company paid Reinstein almost \$600,000 to prescribe their drug and gave him paid trips to Florida “to go on a \$800 boat cruise, a golf outing and at least two dinners costing more than \$1,400 each.” In early 2015, he pleaded guilty to the charges and agreed to pay \$3.79 million to the state and federal governments.⁸

Mental health Medicaid and Medicare fraud have periodically surfaced in the past. In the late 1980s, for-profit psychiatric hospital chains were widely accused of such abuses. In 1998,

following a federal investigation, 80 community mental health centers were expelled from the federal Medicare program because of abusing partial hospitalization; centers were being reimbursed \$600 per day for individuals, some of whom had no history of mental illness, to watch movies.⁹ In 2002, *New York Times* reporter Clifford Levy wrote an astonishing account of mental health Medicare fraud. Seriously mentally ill patients living in group homes in New York were forced to have unnecessary eye operations or prostate surgery to generate Medicare reimbursements for the physicians and group home operators. In a single group home Levy identified 30 residents who had had laser or cataract surgery and 20 who had had prostate surgery; at least eight residents had been subjected to both. The ophthalmologist involved pled guilty to fraud and billing for more than 10,000 services that were either “improper, unnecessary or never conducted.”¹⁰

More recently, in 2010, the Office of the Inspector General in the federal Department of Health and Human Services examined Medicare partial hospitalization claims from 195 of the 206 existing Community Mental Health Centers (CMHCs). The office reported that 102 of the 195 CMHCs (52 percent) “met or exceeded the threshold that indicated unusually high billing for at least 1 of 9 questionable billing characteristics.” And this was only for their partial hospitalization claims. Most of these CMHCs were located in Florida, Texas and Louisiana.¹¹

How common is mental health Medicaid and Medicare fraud? There is little data on this. To obtain an approximate idea, we carried out an Internet search to identify stories on mental health Medicaid or Medicare fraud that appeared in the media during 2014. The stories included both new events that occurred in 2014 as well as follow-up stories from previous years. The results were as follows:

Alaska

- Shubhranjan Ghosh, M.D., pleaded guilty to Medicaid fraud totaling more than \$1 million and will spend at least one year in jail. He treated children with psychiatric problems.¹²

Florida

- Roger Bergman, M.D., working as a physician assistant, was sentenced to 15 years in prison for his role in a \$200 million Medicare fraud scheme. Seven CMHCs under the American Therapeutic Corporation in Miami, owned by Lawrence Duran, were involved in the scheme; Duran was sentenced to 15 years in prison.^{13,14}
- Christopher Gable, chief executive officer of a psychiatric hospital in Hollywood, pleaded guilty to submitting fraudulent claims for \$67 million to Medicare. Five other defendants were subsequently found guilty in this scheme.¹⁵
- Antonio Macli, his son Jorge Macli, and his daughter Sandra Huarte were sentenced to 30, 25 and 22 years in prison, respectively, for their roles in a \$55 million Medicare fraud scheme at the Biscayne Milieu CMHC in Miami. Gary Kushner, a psychiatrist, was sentenced to 12 years.^{13,16}
- Todd Farha, Paul Behrens and William Kale, three top executives of WellCare, were sentenced to prison terms for Medicaid fraud on state mental health managed care contracts.¹⁷

Georgia

- Gary Hankerson, Lisa Hankerson and Pierre Hixon, owners of First Step Counseling Services in Marietta, were sentenced to seven years, one year and 2.5 years in prison, respectively, for submitting more than 3,000 false Medicaid claims totaling \$622,125.¹⁸

Iowa

- Angela Ellison, R.N., owner of Cornerstone Counseling Center in Centerville, was sentenced to one year in prison for submitting more than 6,000 false claims, totaling \$724,359, to Medicaid and insurance companies.¹⁹

Michigan

- Glenn English, co-owner of two adult day care centers, was sentenced to prison for eight years for Medicare fraud. English and his co-defendant, Richard Hogan, promised individuals seeking narcotics they could see a doctor who would prescribe narcotics for them on the condition that they sign up for a psychotherapy program, for which they billed Medicare \$3.3 million.²⁰

Nebraska

- James Holt, owner of Umoja Counseling in Omaha, pleaded guilty to nine counts of theft of public money for submitting 231 false claims to the state's Medicaid program.²¹

Nevada

- Selange Phillips pleaded guilty and was sentenced to 20 days in jail for submitting false Medicaid claims for mental health services.²²

New Jersey

- Howard Lundy, owner of mental health facilities in Neptune and Lawrenceville, was fined \$2.7 million for submitting more than 2,859 false Medicaid claims, including claims for care on days when the clinics were closed.²³

North Carolina

- Aliya Boss, a social worker in Charlotte, pleaded guilty to conspiracy to defraud Medicaid of \$4.3 million by claiming reimbursement for mental health services she did not perform. Boss billed for 64 hours of therapy in one 24-hour period.²⁴
- Zaria Davis Humphries, a social worker in Charlotte, pleaded guilty to charges of attempting to steal \$850,000 from Medicaid by false billing.²⁴
- Ieshia Watkins, a social worker employed by Mecklenburg County, pleaded guilty to selling for \$10,000 the identities of social service clients to Ronnie Robinson, who used the information to file false Medicaid claims for mental health services.^{25,26}

Pennsylvania

- Andrew Newton, a psychiatrist in Harrisburg, pleaded guilty to six counts of theft or embezzlement. He billed Medicare for face-to-face psychotherapy sessions when he was in England and France.²⁷

Tennessee

- The AIM Center, a Chattanooga mental health center, agreed to pay \$800,000 to settle claims of false Medicaid billing.²⁸

Texas

- Mansour Sanjar M.D., and Cyrus Sajadi M.D., of Spectrum Care CMHC in Houston were convicted of submitting false claims to Medicare for \$97 million for partial hospitalization.¹⁴
- Ernest Gibson, president of Riverside Hospital in Houston, his son and two others were convicted by a federal jury in a \$158 million Medicare fraud scheme involving false claims for mental health treatment.²⁹

Thus, a simple Internet search for 2014 identified 18 stories about mental health Medicaid and Medicare fraud in 12 states that resulted in guilty pleas or convictions. Combined with the larger fraud in Louisiana described below, these cases of fraud total approximately \$1 billion. In addition to these cases of definite fraud, the Internet search identified an additional 10 other cases of possible fraud in which the individuals were being investigated or had been charged but had not yet been convicted. These cases of definite or possible Medicaid and Medicare mental health fraud include, of course, only those in which the person committing the fraud was caught, the case was reported by the media and the media report was discoverable with an Internet search (e.g., not behind a pay wall). Because not every fraud is detected or prosecuted, and not every prosecution or conviction is reported in a discoverable media report, the total diversion of mental health funds to fraudulent purposes can realistically be projected in the low billions of dollars.

In addition to simple Medicaid and Medicare fraud, there are many other ways in which money intended for the treatment of mentally ill individuals in the community can be diverted. For example, mentally ill individuals may be subjected to unnecessary diagnostic or surgical procedures, as illustrated by the *New York Times* series by Clifford Levy, cited above.¹⁰ Another scheme is to use home health aides to make home visits to mentally ill individuals, sometimes

twice a day, to observe them take their medication. In recent years this has increasingly been taken over by for-profit home health aide companies, which studies have shown deliver poorer quality services and are more expensive than non-profit companies.³⁰ Although such visits often last only 15 minutes, the company will sometimes bill Medicare for a 90-minute visit, for which it is reimbursed \$150 with the money usually being split between the company and the home health nurse. Reimbursement for such visits depends on a physician authorizing the services. One of the authors had been asked to do this on a routine basis and refused once he understood the discrepancy between the services authorized and those provided.

Other schemes involve outright theft, or the “misappropriation of public funds,” as theft is often called when it is a white-collar crime. Most state mental health authorities exert remarkably little oversight over their contracts with community agencies, which may incentivize theft of mental health funds. The type of fraud can range from embezzlement by a single individual to complicated schemes involving multiple individuals. An example of the former is Faye Clemmons, a 45-year-old business manager for the East Ridge Mental Health Center in Martinsburg, West Virginia. In 1995, Clemmons was convicted of felony theft of \$41,000 in mental health center funds that she used to pay for her son’s college expenses. She was required to repay the money and sentenced to two years of probation.³¹

The variety of fraud schemes that have been used over the years to divert mental illness treatment funds is impressive. The following examples illustrate some of the complex schemes that have been used. Examples were selected from both past and more recent years and suggest that such schemes are not new.

Los Angeles, California

In 2004, three for-profit hospitals in the Los Angeles area developed a plan to keep their hospital beds full. The City of Angels Medical Center, Tustin Hospital in Orange County and Metropolitan Medical Center hired Estill Mitts, a Vietnam veteran, to recruit homeless persons from the city's Skid Row who had Medicaid (called Medi-Cal in California) eligibility cards. The homeless people, the majority of whom had serious mental illness and/or substance abuse problems, were promised payments, usually \$20 or \$30, if they would agree to be hospitalized for a few days.

Mitts was a very effective recruiter. He set up shop in the Christian Day Center on Skid Row and hired associates to walk the streets, calling out "like street salesmen for anyone who had a multicolored Medi-Cal eligibility card. "Red, white and blue! Let it do what it do!"²⁷ Those recruited would then be driven in cars and vans to the hospitals. According to one observer, "Sometimes they were so full of people that they put people in the trucks of cars."³² Once admitted to the hospital, Medi-Cal would be billed for various tests and procedures, which may or may not have been done. One woman was "given a nitroglycerin patch for her non-existent cardiopulmonary condition," which induced a "dangerous drop in blood pressure."³² The plan was "to squeeze \$6500 per patient for Medicare and Medicaid."³³

Tustin Hospital was guaranteed 40 to 50 patients per month under this scheme; City of Angels got 25 to 30; and Metropolitan was given patients "whenever beds were available."³⁴ The hospitals in turn paid Mitts as much as \$24,000 per month, depending on his recruitment. Some of the payments were done using shell companies. For example, the owners of the City of Angels Medical Center, Rudra Sabaratnam, M.D., a psychiatrist, and Robert Bourseau, set up two single-employer corporations. At that time Sabaratnam was living in a \$5 million mansion in the exclusive Brentwood section of Los Angeles.³⁵

The rent-a-homeless person scheme began to unravel in 2006 when hospital vans were observed leaving homeless persons, some still wearing hospital gowns, at homeless shelters. An investigation by police revealed what was going on, and 11 persons were eventually indicted. Estill Mitts pleaded guilty to healthcare fraud, money laundering and tax evasion and was sentenced to 1.5 years in prison and fined \$9.8 million. Sabratnam received a sentence of two years and was fined \$4.1 million. Boursuea was sentenced to three years.³⁶ Kenneth Thaler, M.D., the physician in charge of admissions to Tustin Hospital, received a one-year sentence and fine of \$11 million.³⁷ The Pacific Health Corporation, which owned the Tustin and Metropolitan hospitals, was fined \$16.5 million.³⁸

Provo, Utah

In the 1980s, The Timpanogos Community Mental Health Center in Utah was responsible for delivering services to three counties and had an annual budget of approximately \$8 million. Its executive director was Glen Brown, a former state legislator. Brown, along with psychologist Carl Smith and business manager Craig Stephens, set up a series of contracts whereby, according to the Deseret News, “these employees were paying themselves repeatedly to perform their regular duties.” For example, Smith in one year alone earned \$728,503. In addition, five of the center employees “were given American Express credit cards for virtually unlimited use.” During this same period this CMHC reduced its psychiatric services because of a shortage of funds. In 1988, the Utah attorney general filed 117 felony counts against the three men. They each pleaded guilty to five felony counts and were sentenced to two years in prison.³⁹

Fort Worth, Texas

In the late 1980s, the Tarrant County Mental Health-Mental Retardation Services in Texas had a budget of approximately \$24 million. Its executive director was Lloyd Kilpatrick, a former high school football coach. Doug Hazelwood was head of purchasing. In 1990, a Tarrant County grand jury indicted Kilpatrick on four counts of felony theft and Hazelwood on a misdemeanor charge of tampering with government records. Kilpatrick and members of the board were accused of misusing “as much as \$500,000 in taxpayers’ money” for such things as bid-rigging on leased cars and other purchases by the agency.⁴⁰ At the same time the center’s money was being misused, its mental health services were regarded as among the worst in the state. During the investigation, Kilpatrick abruptly resigned and the entire board, except for one member, was replaced.⁴⁰

Houston, Texas

In 1990 the Harris County Mental Health-Mental Retardation Authority (MHMRA) had a budget of \$41.8 million and was housed, according to a newspaper account, in “the posh Wesleyan Tower.”⁴¹ At that time three men associated with MHMRA were indicted on felony charges of “engaging in organized crime.” They included Eugene Williams, the director of MHMRA; George L. Adams, M.D., a psychiatrist at Baylor University School of Medicine who was responsible for Baylor’s contract with MHMRA; and John Chambers, a psychotherapist whose company provided staff for MHMRA clinics through the Baylor contract.⁴¹ It was alleged that Chambers bought several properties and then sold them at inflated prices, with Adams’ and Williams’ support, to MHMRA. In one instance, according to a newspaper account, “a building with an appraised value of \$1.5 million was purchased by Chambers and his brother for \$2.1 million and sold four hours later to MHMRA for \$3.3 million.” Following such sales, “hundreds of thousands of dollars were signed over to Adams’ wife by Chambers’ wife.” Adams and

Williams were subsequently convicted and ordered to repay the funds. As a Harris County judge noted, “The county got ripped off . . . the people who need the services got ripped off.” The District Attorney observed that MHMRA “was operated in a way that apparently made it easy to steal.”⁴¹

Baton Rouge, Louisiana

In 2012, Hoor Naz Jafri and Roslyn Dogan were co-owners of the Shifa Community Mental Health Center and the Serenity Center in Baton Rouge. Medicare reimburses mental health centers for partial hospitalization services, a day program for seriously mentally ill individuals that is supposed to be an alternative to inpatient hospitalization. Dogan recruited Medicare beneficiaries living in nursing homes or assisted living facilities and paid them \$75 per week to attend the partial hospitalization program at her centers. She then “devised methods to keep the patients at the facilities for as long as possible without invoking scrutiny from Medicare, including by having patients involuntarily committed to local inpatient psychiatric hospitals and then discharged and re-admitted to one of the Shifa facilities.” She also directed therapists and administration “to falsify treatment records” and intercepted Medicare statements being sent to the patients “to prevent the patients from seeing the services that had been billed in their names.”⁴²

Dogan was also connected to the Shifa Community Health Center in Houston, where she paid James Hunter \$1,500 per week to similarly recruit patients for a partial hospitalization program there. To insure their admittance to the program, “Hunter coached beneficiaries on what to say to physicians about their supposed psychiatric symptoms.”⁴³ Jafri was also a part-owner of two residential facilities for mentally ill individuals, and she required all residents to attend the

partial hospitalization program “regardless of whether these patients actually needed or desired the services.”⁴⁴

The scheme was estimated to have resulted in \$258.5 million in fraudulent Medicare claims when indictments were handed down in 2012. Remarkably, while the investigations of the scheme were underway, Dogan accrued additional charges when, according to court records, “she personally even stole evidence from the U.S. Attorney’s Office in order to obstruct the investigation and conceal fraudulent activity.”⁴⁵ Ultimately, 17 people were indicted, including therapists, administrators and office managers at the three facilities. Zahid Imran, M.D., a psychiatrist who was the medical director and co-owner of two of the facilities, was sentenced to seven years in prison. Jafri was sentenced to almost nine years. Following their trial in 2014, Hunter was sentenced to six years in prison and fined \$3.2 million, while Dogan received a sentence of more than seven years and was fined \$43.5 million.

New York City, New York

In the 1980s Karl Easton, M.D., a psychiatrist, was the founder and medical director of the Brooklyn Psychosocial Rehabilitation Institute (BPRI). In addition to fraudulently overbilling Medicaid for more than \$1.4 million in one year alone, he set up a series of interlocking corporations controlled by his family and leased properties to BPRI. An investigation concluded “substantial sums of BPRI’s monies were being diverted from patient care and treatment to Dr. Easton’s family corporations.” New York State revoked Easton’s license to operate a mental health facility. The court called the evidence of Medicaid fraud “overwhelming” and awarded damages of \$7.5 million against DEaston.⁴⁶

A similar New York example from the 1980s was the New York Psychotherapy and Counseling Center (NYPCC), a nonprofit agency that provided outpatient psychiatric services at six clinics for mentally ill residents of group homes. NYPCC was run by Rabbi Isidore Klein, the executive director, and two psychiatrists, Jack Schnee, M.D. and Harold Finn, M.D. In 1989, the State Commission on Quality of Care for the Mentally Disabled issued a report accusing NYPCC of fraudulent Medicaid billing as well as having created a limited partnership, owned by Rabbi Klein, Drs. Schnee and Finn and their children, for purchasing real estate, which they then leased to NYPCC. This led to “profit-making of \$720,000 over a three-year period through less-than-arm’s length property transactions with a family owned business.” The Commission concluded that NYPCC was not really a nonprofit, but rather was “a profit-making corporation for its key officers.”⁴⁷

Such examples illustrate both the variety of fraud and theft schemes that have been utilized to divert funds intended for the treatment of mental illness, and also the fact that such fraud has been taking place for at least the past 40 years.

III. Waste

In addition to fraud, a significant amount of money under the control of state mental health agencies appears to be wasted. Funds intended for the treatment and rehabilitation of individuals with mental illness, especially serious mental illness, are not used for such individuals but rather are diverted to various social or educational causes. The causes may themselves be worthy, but their utilization for purposes other than the mental illness treatment for which they were intended diminishes the availability of needed mental illness services.

Although examples of the waste of public mental health funds can be found in every state, California has distinguished itself as a leader in such waste.

A current example of the misuse of funds comes from Proposition 63, a ballot measure approved by California voters in 2004. Under this measure, all taxpayers who report more than \$1 million dollars of income are charged a surtax of 1 percent, or \$10,000 for every million dollars in reportable income after the first million. The collected funds were to be used to fund programs for individuals with serious mental illness. The proposition was written by then-Assemblyman Darrell Steinberg and Sherman “Rusty” Selix, a lobbyist for many of the mental health organizations and departments, which hoped to – and later did – receive the funds . When the proposition was being publicly discussed in 2004 prior to the vote, its backers claimed that the funds would focus on individuals with serious mental illnesses and would fund “best practice” programs known to be effective for people with mental illness.⁴⁸ For example, they argued that “our prisons and jails are full of thousands of people with mental illnesses who would not be there if they had been offered treatment.” Proposition 63, they said, would help to “provide care before people end up on the streets, or behind bars.”⁴⁹ The *Los Angeles Times* predicted that passage of Proposition 63 would produce “hundreds more psychiatric beds . . . the building of more clinics and the training of more mental health workers to address continuing shortages.”⁵⁰ The proposition and ballot argument for the proposition promised strict financial accountability and oversight.⁵¹

When Proposition 63 passed in 2004, it officially became the Mental Health Services Act (MHSA). Oversight responsibility was handed to a 16-member Mental Health Services Oversight and Accountability Commission. At its first meeting, Steinberg was appointed chair. The state Department of Mental Health, which has since been abolished, was given responsibility

to establish guidelines for funding. Unfortunately, the Department of Mental Health had had weak leadership for two decades; under its guidelines, the intentions of the voters who passed Proposition 63 were set aside. In developing the regulations, the department listened to many individuals who were employed by agencies wishing to enrich their particular projects with MHSA grants and ignored the requirement that the funds be used for people with serious mental illness. The resulting regulations were more reflective of the ideology and dreams of the individuals who hoped to benefit from the MHSA money than the intent of the original Proposition. Money voters intended to be used for the needs of seriously mentally ill individuals were diverted from that purpose to frivolous recreational and “feel good” projects. At the same time, a cottage industry of consultants, some earning up to \$200 an hour, emerged, including, “an \$11 million public relations contract to generate good press for its bad results.”⁵²

In 2011, the San Jose Mercury News released a scathing report detailing the use of Proposition 63 funds. Among other things, the funds had been used for recreational programs, such as sweat lodges for Native Americans, massage chairs for students, yoga classes and community gardens.⁵³ Although the original regulations had specified that 20 percent of the funds should be used to prevent mental illnesses from becoming severe, the Associated Press reported that “... the Department of Mental Health developed guidelines for counties and dictated that the 20 percent would go to help people who had never been diagnosed with mental illness or even shown any evidence of mental illness. The idea was to promote mental wellness, not just treat mental disorders.”⁵⁴ The *San Francisco Examiner* wrote, “Unfortunately, \$1 out of every \$5 may be funding mildly therapeutic programs for people who do not remotely suffer from serious illness – or may even be funding frivolous perks for government employees.”⁵⁵

When those reports came out, the California Mental Health Services Oversight and Accountability Commission issued a report dismissing the criticism, instead justifying their funding of additional “wellness” programs, such as potlucks and powwows, cultural oral histories and arts programs, equine therapy for children reading below grade-level and a \$8.1 million San Bernardino holistic campus. The campus would include tai chi and Zumba classes for the general public and a prom for LGBT (lesbians, gays, bisexual and transgendered) individuals. As the Holistic Campus’ website enthusiastically described it, “We’re excited that we’ve been given permission to ‘play in the sandbox’ and be as innovative and creative as we like. . . .”⁵⁶ Some of the funds were used to provide California’s community college students who “struggle with psychological distress” with a free, online course that required them to interact with emotionally responsive avatars.⁵⁷ And CalMHSA, a joint county planning group for MHSA funds comprised of county mental health commissioners, passed a resolution that each of its members would be provided with an iPad so they could have convenience and speed and protect the environment.⁵⁸ Rose King, who also co-authored Proposition 63, said, “The state of California clearly did not comply with the law and they did not keep and honor the contract with the voters. It’s a corruption of purpose and it’s a boondoggle for consultants and entrepreneurs at the expense of core services.”⁵⁹

In establishing the regulation for use of MHSA funds, the Department of Mental Health issued confusing directives on whether the funds could be used for assisted outpatient treatment (AOT), an evidence-based practice recognized by multiple federal agencies and endorsed by a wide range of law enforcement, medical and other organizations. Counties feared being sued for using MHSA funds to establish outpatient commitment programs, resulting in almost universal rejection of the proven practice in the state (with only Nevada County fully implementing it

more than 10 years after state law authorized AOT). Compounding this, the state and federally funded California Disability Rights group, one of the ideological groups that had received MHSA grants, threatened to sue counties if they used MHSA funds for AOT.⁶⁰ A decade after its passage, the state legislature finally passed a separate bill clarifying that MHSA funds could be used to implement this program but, in the preceding years, hundreds – if not thousands – of severely mentally ill people were left on the streets or in jail without treatment. As summarized by the *San Francisco Examiner*, "Perhaps most troubling, no one in state government has bothered to account for all the money that has been spent. No one knows how much money has been directed to such frivolous enterprises."⁶¹

Three independent evaluations have been carried out to assess the effectiveness of the Proposition 63 program. In 2013, Mental Illness Policy Org. conducted an investigation of the 20% (\$200 million annually) in MHSA funds allocated to Prevention and Early Intervention (PEI) programs. It found a massive diversion of funds to programs outside the scope of the bill, and programs with zero evidence of effectiveness. It called the report, *California's Mental Health Service Act: A Ten Year, \$10 Billion Bait and Switch* and shared its findings with the State Auditor's Office.

In 2013, the California State Auditor's Office reported that it could find no evidence of the program's effectiveness and that the MHSA Oversight and Accountability Commission had provided little oversight.⁶² Then, in early 2015, the Little Hoover Commission – an independent state oversight agency – similarly reported that "the state can't quantify how well or effectively these [Proposition 63] funds are spent." The commission blamed "antiquated state technology and overlapping and sometimes unaccountable bureaucracies."⁶³ Reacting to the criticism, the California Association of Mental Health Directors and now-retired Senator Steinberg released

their own report through the newly established \$7.5 million MHSA-funded Behavioral Health Center of Excellence at the University of California at Davis, where Steinberg serves as director of policy and advocacy at its Steinberg Institute.⁶⁴ As reported in the *Sacramento Bee*, “The position is unpaid, which allows Steinberg to lobby the Legislature on behalf of the center without violating California’s revolving-door law. The law that forbids lawmakers from lobbying their former colleagues within a year of leaving office only applies when they are being paid to lobby.”⁶⁵ Steinberg is also now employed by the Greenberg Traurig law and lobbying firm. The report issued by the Steinberg institute claims that 40 percent of MHSA funding in 2011-12 went to programs for 35,110 mentally ill individuals in all age groups and has reduced incarceration or homelessness for some.⁶⁶ The report did not disclose the diagnosis of those served making it impossible to determine if the funds served the seriously mentally ill who are eligible or was spent on the less seriously ill. The report also did not make any claims about the \$1 billion allocated over the past ten years to Prevention and Early Intervention programs where waste has been extensively documented.

While it is encouraging to know some of the money is now being used for the Proposition 63’s original purpose, 11 years and \$13 billion dollars later, there is little evidence that MHSA programs have had any substantial effect on the number of mentally ill persons on California’s streets or in its jails or prisons, as promised. Most state residents are aware that both problems have grown worse, not better, over the past decade. And regarding the promised increase in psychiatric beds, 25 California counties no longer have any inpatient psychiatric units at all, although they may have Zumba classes and children’s pony rides.

Rarely have mental health funds been wasted so blatantly as have the Proposition 63 funds, and this waste is ongoing. Examples of such waste and misuse of mental health funds can

be found in every state but, like many things, California does things bigger. In 2011-13 the state responded to related criticism through a series of budget bills and ultimately abdicated most responsibility and oversight of the MHSA funds to the local counties. Now, instead of one governmental entity being responsible for outcomes and evaluations, there are 58 counties, with no or little oversight over what happens to the money.⁶⁷

Perhaps the ultimate comment on the waste of Proposition 63 funds was offered by Teresa Pasquini, a woman in Contra Costa County who has a child and a sibling with serious mental illness. Like many family members of people with serious mental illness, she welcomed the Proposition 63 initiative and “walked her neighborhood getting signatures” to place it on the ballot. She also serves on the Contra Costa County Mental Health Commission and has closely followed the allocation of Proposition 63 funds. She is, she says, “personally outraged by the spending priorities.” “If I were a millionaire,” she adds, “I’d be screaming from the rooftop.”⁶⁸

IV. *Excess Profits*

In addition to fraud and waste, another way in which significant amounts of state mental health agency funds are being lost is through excess profits taken by private, for-profit managed care companies with which the states are contracting. For-profit managed care companies initially became widespread in the United States in the 1980s, used by the states especially to control the costs of chronic illnesses such as diabetes, coronary heart disease and chronic obstructive pulmonary disease. By 1995, the *Wall Street Journal* was calling for-profit managed care companies “extremely profitable” with “plenty of potential for additional growth.”⁶⁹ By 2006 it was said that “more than one in three Medicaid beneficiaries now receive care through a private insurer” and “the companies are growing fast.”⁷⁰ Once it became clear that private

managed care could save money for the treatment of medical conditions, it was inevitable that it would also be tried for psychiatric conditions.

The history of for-profit care in psychiatry is a long and sordid one. In the early nineteenth century in England, mentally ill individuals were confined in for-profit asylums whose proprietors “realized very large fortunes by the confinement of their fellow creatures.”⁷¹ In 1845, in response to scandals involving the for-profit asylums, Lord Ashley, the director of the Commissioners in Lunacy, said, “Our present business . . . is to affirm that poor lunatics ought to be maintained at the public charge. I entertain . . . a very decided opinion that none of any class should be received for profit. . . . I feel strongly that the whole system of private asylums is utterly abominable and indefensible.”⁷¹

The recent rise of for-profit psychiatric care has proven yet again that Lord Ashley was correct. Studies have shown that the administrative costs of for-profit psychiatric hospitals are 32 percent higher than non-profit psychiatric hospitals and 83 percent higher than public psychiatric hospitals.⁷² In addition, compared to non-profit psychiatric hospitals, for-profit psychiatric hospitals have higher net revenues, higher profits, fewer fulltime employees and lower salary expenses.⁷³

Scandals involving for-profit psychiatric care have been common. For example, the Psychiatric Institutes of America and its parent corporation, National Medical Enterprises (NME), pleaded guilty to giving millions of dollars in bribes and kickbacks to get referrals, then falsely billing Medicare to recoup the money. This included practices such as charging patients \$40 per day for “relaxation therapy,” which consisted of playing taped music in the hall and charging a single patient for as many as 15 group therapy sessions, three dance therapy sessions,

two counseling sessions and one individual therapy sessions – in a single day.⁷⁴ In Rhode Island, United Behavioral Health Systems was fined \$100,000 for paying incentive bonuses to the company’s chief psychiatrist contingent on the company’s profits.⁷⁵ In Iowa, Merit Behavioral Care was paid a “commission” of \$880 for each adult who applied for, but was denied admission to, a psychiatric unit.⁷⁶

In fact, for-profit managed psychiatric care is an oxymoron; it is really only managed costs despite rhetoric to the contrary. For-profit medical companies, by their nature as investor-owned enterprises, usually place the interest of their shareholders above the interest of patients in order to maximize their profits and stock price. As one critic phrased it, “what’s good for the shareholders is bad for patients.”⁷⁰ Under most state contracts, for-profit companies receive a specified amount of money each month for each psychiatric patient assigned to them. This incentivizes them to provide treatment for the easiest and least expensive patients to treat and to provide as little treatment as possible for the most difficult and thus most expensive patients to treat. In practical terms, this means patients with depression, eating disorders and anxiety disorders may receive good treatment, but those diagnosed with paranoid schizophrenia with poor medication compliance, or recurrent mania with substance abuse, are ignored whenever possible. If such patients end up homeless or incarcerated, as is often the case, that is acceptable to the company since the company has been paid for the patients’ care and they then cost the company nothing. This is probably one reason why some individuals with serious mental illnesses become homeless and/or incarcerated.

According to data maintained by the Kaiser Family Foundation, there are currently approximately 20 major for-profit managed care companies that manage psychiatric (called “behavioral health”) patients, usually those on Medicaid, under state contracts in 39 states.⁷⁷

There are an even larger number of non-profit managed care companies doing the same thing and, in any given state, there may be a mix of both. For example, Hawaii has five Medicaid-managed care companies, three of which are non-profit (Kaiser, HMSA and AlohaCare) and two of which are for-profit (United Healthcare and WellCare, known there as Ohana).

In addition to for-profit managed care of psychiatric outpatients, Florida has carried privatization one step further by privatizing one of its five remaining state psychiatric hospitals. In 1998, the company gave a contract to the GEO Group Inc., a for-profit Florida company that runs many state prisons, to run the 335-bed South Florida State Hospital. In 2011, public attention focused on this arrangement when three hospital patients died within a two-month period. One was scalded to death in a bathtub and was on six psychiatric medications and five other medications at the time. The brother of one of the deceased individuals alleged that GEO was “hiring the cheapest people off the street who aren’t qualified for what they’re doing.”⁷⁸

The for-profit managed care of psychiatric patients can indeed be very profitable. The following are four examples: WellCare, UnitedHealth, Magellan and Centene. The authors have no reason to believe that these companies are any better or worse than the other major for-profit managed care companies.

WellCare

WellCare, based in Tampa, Florida, began in 1985 with a contract for the managed care of Florida’s Medicaid patients. It is a for-profit company listed on the New York Stock Exchange; on January 8, 2015, its stock was listed at \$78.80/share. WellCare’s total revenue increased from \$5.4 billion in 2010 to \$9.5 billion in 2013. The company’s net income was \$264.2 million in 2011; \$184.7 million in 2012; and \$175.3 million in 2013. Alec Cunningham,

who was chief executive officer (CEO) until he was ousted by the board in 2013, was paid \$4.4 million a year in salary and stock options. Ken Burdrick, hired as CEO in January 2015, is being paid \$1 million in salary plus a short-term incentive target of \$1.5 million and long-term incentive target of up to \$5 million.⁷⁹

WellCare operates exclusively with state Medicaid and Medicare programs. It has Medicaid contracts in nine states under a variety of names in addition to WellCare: Florida (Staywell, HealthEase), Georgia, South Carolina, Kentucky, Illinois (Harmony), Missouri, New Jersey, New York and Hawaii (Ohana). In 2013, the Medicaid contracts provided 59 percent of the company's revenues. WellCare is paid a fixed premium by the state per Medicaid member per month, and this amount is fixed for the duration of the state contract, usually three years. Thus, as described in WellCare's 2013 annual report, "Our profitability depends, to a significant degree, on our ability to predict and effectively manage our costs related to the provision of health care services."⁸⁰ Such cost management is necessary to deliver "competitive returns to our investors."

WellCare provides mental health services to a variable number of Medicaid recipients in the nine states. In Hawaii, for example, WellCare provides services for all Medicaid-eligible adults who have serious mental illnesses. The effectiveness of the program can be assessed by a 2011 study that compared the five managed care companies in Hawaii. On measures of overall quality of care, WellCare ranked fourth out of five. On measures of consumer satisfaction WellCare ranked last. WellCare also had the highest rate of emergency room use by its members, another measure of poor outpatient care.⁸¹ The quality of WellCare's program can also be assessed by the fact that, according to media reports, Hawaii has one of the most severe problems of homeless mentally ill individuals of any state. In addition, the state's two largest correctional

facilities apparently both hold more individuals with serious mental illness than does the state's lone mental hospital.

UnitedHealth Group

UnitedHealth Group, based in Minnetonka, Minnesota, ranked 14th among all U.S. corporations based on its 2013 revenues. In 2014, its revenues were \$97 billion, and its net earnings were \$4.1 billion. It is on the New York Stock Exchange and on January 12, 2015, its stock was listed at \$102.55/share. It typically pays dividends to its shareholders quarterly. Thirty percent of the earnings from operations for UnitedHealth Group come from Optum, which has contracts for managed healthcare in parts of 24 states and the District of Columbia. Some of these contracts include managed care for individuals with psychiatric disorders on Medicaid. Optum's operating earnings increased 61 percent between 2012 and 2013; according to their annual report the increased earnings were "primarily due to gains in operating efficiency and cost management as well as an increase in earnings from integrated care operations."⁸²

In 2013, Stephen J. Hemsely, CEO of UnitedHealth Group, was paid \$12.1 million in salary, bonuses, stock and other compensation. Larry C. Renfro, an executive vice president and CEO of Optum, was paid \$9.3 million in salary, bonuses, stock and other compensation.

Pierce County, Washington, which includes Tacoma, is one of the counties where Optum operates. Since 2009, Optum has had a state contract of \$54 million a year to manage the county mental health system. According to a published report, Optum in Pierce County "netted \$5.4 million in 2010."⁸³ What have been the psychiatric results? Psychiatric hospitalization has become the "absolute last resort"; for example, 90-day stays for Pierce County residents in the

state hospital fell from 58 in 2008 to 13 in 2010. As the director of neighboring King County's mental health services observed, "There's a profit incentive for Optum not to hospitalize people."⁸³ What happened to the people who were not hospitalized? In 2012, Judy Snow, the mental health manager at the Pierce County Jail, said she had seen "a marked increase" in the number of inmates with mental illness. She noted that, "since 2009, there's been a roughly 25 percent increase in the number of mental competency evaluations performed at the jail, indicating that many of the patients Optum claims are receiving treatment in the community are likely ending up behind bars instead."⁸³

Pierce County also witnessed a sharp increase in suicide attempts between 2008 and 2010, from 508 to 636 per year; in all but one other western Washington counties, the number of suicide attempts remained comparatively constant.⁸³ The Pierce County Rescue Squad also observed "a 30 percent increase in service calls involving mentally ill patients" between 2007 and 2012.⁸⁴ There have also been a series of individual tragedies. For example, Ronald Hillstrom, a 44-year-old mentally ill man, was beaten to death by four sheriff's deputies in 2014; Pierce County settled a lawsuit brought by his family for \$750,000.⁸⁵ Then there was Laura Sorenson, a 20-year-old Pierce County resident with paranoid schizophrenia, whose mother tried futilely to get treatment for her daughter and, in August, 2011, even wrote to the governor, "My daughter is back in the county jail for the second time this week. Jail is not the place for her! She will not get better there! If something doesn't change, there will be a tragedy in her future." One year later, Laura Sorensen walked into a store in Pierce County and shot three strangers.⁸⁶

New Mexico, where Optum manages \$338 million in mental health contracts, also has had problems with the company. Optum was reprimanded "for ignoring psychiatrist recommendations to hospitalize certain high-risk mental patients" and fined more than \$1 million

“for failing to reimburse local providers in a timely manner.” As the director of the Santa Fe County Sheriff’s Department forensic evaluation team noted, “All the decisions are made based on the profit motive. People are denied services until they end up in jail or prison, where it’s really expensive.”⁸³ Optum is, of course, not responsible for the jail and prison costs.

UnitedHealth Group, in its “corporate profile,” says it is “dedicated to delivering ‘more for less’ . . . more and better health care at lower costs to consumers on behalf of employers and governments.”⁸⁷ By 2013, Pierce County leaders were questioning the wisdom of the Optum contract. As the *Tacoma News Tribune* summarized it, “Suppose a deal that promised more for less turned out to be less for more.”⁸⁸

Magellan Health Services

Magellan Health Services, based in Avon, Connecticut, began operations in 1969. It is a for-profit company listed on the NASDAQ; on January 8, 2015, its stock was listed at \$60.76. Magellan’s total revenue increased from \$2.6 billion in 2009 to 3.6 billion in 2013. Its net income in 2013 was \$125.3 million. Barry M. Smith, Magellan’s CEO, was paid \$7.7 million in 2013 in salary, bonuses, stock and other compensation.

More than most managed care companies, Magellan has focused especially on the management of psychiatric (“behavioral health”) patients. It currently has contracts to manage Medicaid patients in parts of Pennsylvania and Florida. Between 2007 and 2013, Magellan had a large contract to manage Medicaid patients in Maricopa County, Arizona, covering Phoenix; this contract accounted for more than 10 percent of the company’s revenue. Magellan’s managed care revenue accounted for 77 percent of the company’s total revenue in 2013. The company has also diversified into pharmacy benefits and radiology services in other states.

The effectiveness of Magellan's management of seriously mentally ill individuals in Phoenix between 2007 and 2013 may be inferred by examining the revolving door in which they were homeless or incarcerated. A 2013 report on "Homelessness in Arizona" estimated that there were 17,280 homeless individuals in Maricopa County during that year. Among the chronically homeless, "35 percent identified themselves as having a mental illness."⁸⁹

Another subset of seriously mentally ill individuals in Phoenix have ended up in the Maricopa County Jail, run by Sheriff Joe Arpaio. He is nationally known for requiring prisoners to wear pink underwear and for housing over 2,000 prisoners in tents in which the temperature may reach 120 degrees in summer. It is estimated more than 25 percent of the Maricopa County jail inmates are mentally ill; those who are sickest are kept in the jail's 210 psychiatric beds.⁹⁰

The main reason why so many individuals with serious mental illness end up homeless or incarcerated is because they do not receive adequate treatment for their mental illness. As a psychiatrist who worked in Phoenix during the Magellan years described it, "Getting basic [psychiatric] services was very easy. The resistance from them [Magellan administration] came with the complicated and treatment non-adherent patients who required more involved services beyond basic case managers and biweekly [antipsychotic] injections."⁹¹ Those are the patients, of course, who are the most expensive to treat.

Centene

Centene began in the 1980s as Managed Health Services (MHS), a non-profit managed care company for Medicaid enrollees in Milwaukee. It subsequently became Centene, a for-profit company, and moved its headquarters to St. Louis. It is listed on the New York Stock Exchange; on January 15, 2015, its stock was selling for \$107.10. Between 2012 and 2013 Centene's

revenues increased from \$7.7 to \$10.5 billion, and its net earnings increased from \$88.5 million to \$161.2 million. In 2013, Centene ranked 303 among the Fortune 500 companies. Michael F. Neidorff, the CEO, earned \$14.5 million in salary, bonuses, stock and other compensation.

Centene manages medical care for Medicaid enrollees in 16 states under a variety of names, e.g., Sunshine Health in Florida, Magnolia Health in Mississippi, MHS Health in Wisconsin. The company's strategy, as outlined in its annual report, is to "enter a state under a single managed care contract, prove our value to our state customers, and expand our services to other populations within that state."⁹² In Wisconsin, MHS Health began managing medical and psychiatric services under the Medicaid program, called BadgerCare, in 1996 and now does so in 45 Wisconsin counties.

Although Wisconsin was rated among the states with the best public mental health services 25 years ago, it is now much worse. In 2000, it was estimated that "half of the 2,000 or so who live on Milwaukee's streets are chronically and persistently mentally ill."⁹³ A 2013 report on homelessness in Wisconsin reported 27,556 homeless individuals statewide, a 29 percent increase since 2008.⁹⁴

Wisconsin's county jails likewise have been inundated with mentally ill inmates. According to a 2012 report, "about a third of the men and two-thirds of the women in Wisconsin prisons have mental health conditions."⁹⁵ Such individuals create enormous problems; according to one report in one year there were "231 attacks on correctional officers caused by a mentally ill inmate."⁹⁶ Most of these mentally ill individuals would not have been homeless or incarcerated if they had received adequate treatment for their illness.

V. *Discussion*

The deterioration of state mental health services over the past three decades, even though the total funding to support these services has modestly increased, has many causes. One cause, as suggested by the foregoing data, is that an increasing amount of the funding allocated for the community mental health services is being lost to fraud, waste and excess profits.

As noted previously, the authors undertook the present study to try and answer four questions. The findings can be summarized as follows.

1. Is there any evidence to support the allegation that mental health providers are responsible for a disproportionate amount of Medicare and Medicaid fraud? The answer is a provisional yes. An Internet search for stories published during 2014 identified 18 stories about mental health Medicare and Medicaid fraud in 12 states. These cases totaled approximately \$1 billion. An additional 10 cases of possible fraud were identified as being under investigation. This does not include, of course, mental health fraud which was not detected or which was detected and prosecuted but not reported on the Internet. To definitively answer this question it will be necessary to do a comparative study assessing Medicare and Medicaid fraud against home health care, pharmacy, and other non-mental health types of fraud.

It is noteworthy that many of the cases of mental health related Medicare and Medicaid fraud were identified by the federal Health Care Fraud Prevention and Enforcement Action Team or by whistleblowers. State efforts in this regard are conspicuously underrepresented. One reason for this is that state mental health authorities' major goal is to close as many state mental hospital beds as possible, thereby effectively shifting the majority of costs of caring for such patients from the states to the federal government. State mental health authorities have little

incentive to see what happens to the patients who leave the state hospital or to find out what happens to the money being sent to the community programs.

For example, New York State in the 1980s and early 1990s had a Commission on Quality of Care for the Mentally Disabled which had the legal authority to make unannounced inspections of nursing homes and board-and-care homes and to publish their findings. The commission was effectively terminated in 1995 by then Gov. George Pataki.

A recent example of a state's lack of interest in exposing its own problems in the state mental health system was Virginia. For many years the state had been closing state mental health beds without making adequate provisions for the treatment of the released mentally ill individuals into the community. On November 18, 2013, the mentally ill son of State Senator Creigh Deeds was denied admission to a psychiatric hospital because of a shortage of beds. He was therefore taken home where he severely injured his father and then killed himself. An official investigation was undertaken in the Office of the State Inspector General by Douglas Bevelacqua, who had responsibility for investigating the Department of Behavioral Health and Developmental Services. Bevelacqua had previously noted the psychiatric bed problem and had made recommendations for correcting it which had been ignored by state authorities. In his investigation of the Deeds' tragedy Bevelacqua claimed that state officials interfered with his work and edited his report so as to put the state in a better light. On March 4, 2014, Bevelacqua publicly resigned from his position "citing interference by office leadership that weakened the still-unreleased report."⁹⁷

2. In addition to Medicare and Medicaid fraud, are there other activities which result in the loss of state mental health funds and their diversion from their intended purpose? This study identified two such activities in addition to Medicare and Medicaid fraud--waste, and excess profits by for-profit managed care companies. An example of the latter was WellCare's 2003 contract to provide mental health services for Florida's Medicaid population. Under what is known as Florida's 80/20 law, WellCare was required to spend 80 percent of the Medicaid premiums on mental health services but could keep the remaining 20 percent for administrative costs and profits. According to court documents, WellCare "allegedly set up a subsidiary to hide money from Florida regulators and falsified information on payments to doctors and mental health centers."⁹⁸ This criminal behavior came to light when a WellCare financial analyst became a whistleblower and began secretly recording conversations with WellCare executives. One company vice president was recorded claiming that WellCare was in fact keeping 50 percent of the Medicaid premiums. In 2007, the FBI raided WellCare's headquarters in Tampa and fraud charges were brought against the company's top executives. In a 2013 trial three were convicted. CEO Todd Farha was sentenced to 3 years in prison; chief financial officer Paul Behrens to 2 years; and vice-president William Kale to 1 year. WellCare has also paid over \$400 million in restitution and fines. The whistleblower was awarded over \$20 million under the federal False Claims Act. Despite WellCare's past criminal behavior, it has continued in business, as noted in the previous section, with Medicaid contracts in 9 states, including Florida.⁹⁸

How often for-profit managed care companies illegally take excess profits from the mental health contracts is not known. Most of WellCare's criminal behavior would not have become known if a whistleblower had not acted. And a 2004 review of Centene's Medicaid contract in

New Jersey reported that “hundreds of thousands of dollars that Centene counted as medical costs should have been considered administrative costs.”⁹⁹

Many other unrelated expenditures by for-profit managed-care companies are also ultimately generated by profits obtained by reducing psychiatric costs. Centene, for example, gave \$9.5 million to renovate the arts center in St. Louis; it is now called the Centene Center for Arts and Education. Similarly, Centene paid \$200,000 for the naming rights to the baseball stadium in Great Falls, Montana, the site of one of its regional offices.⁹⁹ Managed-care companies are also major political donors. WellCare, for example, contributed \$10,000 to the campaign of a Republican running to become the chief financial officer of Florida, WellCare’s biggest market. Some of these funds ultimately come from having denied psychiatric hospitalization to individuals with serious mental illness.

3. Is it possible to estimate the total amount of state mental health funds that are being lost?

As noted previously, state mental health agencies spent a total of \$39.4 billion in 2012.⁴ Of this amount, 72 percent, or approximately \$29 billion dollars went to community programs. The former administrator of the Centers for Medicare and Medicaid Services estimated that approximately 10 percent of Medicare and Medicaid funds are lost to fraud.⁶ And the former Inspector General of DHHS has suggested that “mental healthcare givers, such as psychiatrists and psychologists, have the worst fraud records of all disciplines.”² This would suggest that perhaps 15 percent of the state mental health Medicare and Medicaid funds are being lost to fraud. Since the mental health Medicare and Medicaid funds total approximately \$20 billion, the Medicare and Medicaid fraud loss alone would total approximately \$3.0 billion.

It is not possible to ascertain the amount of other state mental health funds that are being lost to waste and excess profits by for-profit managed care companies but the data that exists suggests that such losses are significant. *Considering everything that is known, it seems reasonable to estimate the total loss of mental health funds as being in the range of \$4 to \$8 billion.* The percentage lost almost certainly varies from state to state.

If these mental health funds were not being lost, what could they be used for? For individuals with serious mental illness, such as schizophrenia or bipolar disorder, \$4 billion could purchase one of the following or a combination thereof:

- 3 months of inpatient treatment in a state mental hospital for 112,000 individuals (assuming a bed cost of \$400/day)
- 1 year of outpatient care by an Assertive Community Treatment (ACT) team for 267,000 individuals (assuming an ACT team cost of \$15,000/person/year)
- 1 year of Assisted Outpatient Treatment (AOT) for 800,000 individuals (assuming an AOT cost of \$5,000/person/year)
- 1 year of a Fountain House clubhouse with psychiatric services and rehabilitation programs for 364,000 individuals (assuming a clubhouse cost of \$11,000/person/year)
- 1 year of supported housing for 333,000 individuals (assuming a cost of \$12,000/year)
- 1 year of standard antipsychotic medication (generic olanzapine or risperidone) for 6.7 million individuals (assuming a drug cost of \$600/person/year).

- 1 year of initial treatment with clozapine for 667,000 individuals (assuming start-up costs of \$6,000/person/year)

The loss of billions of dollars of public mental health funding to fraud, waste and excess profits thus has real world consequences. The funds being lost are sufficient to provide psychiatric services for most of the estimated 216,000 individuals with serious mental illness who are currently homeless as well as the 350,000 who are in jail and prison.

4. Is there any evidence that the loss of state mental health funds is a new problem or getting worse? The study identified numerous examples of fraud and theft of public mental health funds from the 1980s so this is clearly not a new problem. The authors are not aware of any comparative data from the past that could be used to assess the waste of mental health funds or the taking of excess profits by for-profit managed care companies.

Regarding the question of whether the problem is getting worse, the data is not sufficient to answer this definitively. The fact that there has been a progressive shift in the state funds from being under state control to being under the control of various nonprofit and for-profit community agencies as previously noted⁴, suggests that the problem may be getting worse. The recent stepped-up federal initiative to control Medicare and Medicaid fraud may also suggest that the problem is getting worse.

VI. Recommendations

What can be done to correct the loss of mental health funds by fraud, waste and excess profits? Several actions could produce improvements.

- State mental health authorities must become much more aggressive in overseeing the money being spent on community programs. They need to move beyond their current hear-no-evil/see-no-evil position to try and minimize these losses. Much more detailed reporting requirements must be built into the state mental health authority's contracts with its vendor agencies. The state should conduct unannounced inspections and audits of community mental health programs. New York State's Commission on Quality of Care for the Mentally Disabled, which existed in the 1980s and 1990s, is an excellent model.
- The federal Health Care Fraud Prevention and Enforcement Action Team (HEAT Task Force) should be significantly expanded since it has been shown that it pays for itself. All claims for "behavioral health" and psychiatric care should be carefully scrutinized; offenders should be vigorously prosecuted.
- Mental health advocacy organizations such as NAMI and MHA need to become much more active in publicly protesting the current sad state of state-funded mental health services. Since many of the state chapters of these groups receive funding from the state mental health agencies and, in some cases, also from for-profit or nonprofit managed-care companies operating in that state, these groups have been relatively ineffective in providing any impetus to oversight.
- Studies have reported that non-profit community mental health providers are superior to for-profit providers.¹⁰⁰ For this reason, and because it is extremely difficult to prevent for-profit providers from gaming the system by ignoring the difficult-to-treat patients, for-profit providers should be excluded from state contracts for mental health services.

- Innovative funding mechanisms should be tried and carefully evaluated to determine the most effective way of minimizing fraud, waste and excess profits. For example, rather than funding mental health services agencies on a per capita basis, perhaps they should be funded under pay-for-performance schemes in which the agency gets paid on the basis of the outcome of the illness, e.g., lack of rehospitalization, part time employment, better quality of life, etc.¹⁰¹
- State contracts with community health agencies should require that they prioritize services for individuals with serious mental illness. The community agencies should be evaluated on meaningful metrics such as decreased rates of hospitalization, incarceration, arrest, homelessness, and suicide.
- The National Association of State Mental Health Program Directors (NASMHPD) needs to make an annual, state-by-state report on fraud, waste and excess profits in public mental health, with specific recommendations of how to reduce each.

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