Planned Parenthood's Waste, Abuse, and Potential Fraud: Alliance Defending Freedom's 2013 Report on Federal and State Audits of Planned Parenthood Affiliates and State Family Planning Programs

April 10, 2013

Preface

On October 26, 2011, Alliance Defending Freedom[1] submitted its original report *Summary of State Audits of Planned Parenthood Affiliated Providers Showing Waste, Abuse, and Potential Fraud* to the Oversight and Investigations Subcommittee of the United States House of Representatives Energy and Commerce Committee. On February 7, 2012, the initial report was updated and supplemented for public release.

It is the purpose of this report to document and supplement our experiences in identifying waste, abuse, and potential fraud by Planned Parenthood Federation of America (PPFA) affiliates and other abortion providers, particularly with respect to federal and state Title XIX-Medicaid reimbursements. It has been our experience that Planned Parenthood's primary motivation is to maximize its revenues from complex, well-funded federal and state programs that are understaffed and rely on the integrity of the provider for program compliance.

It has likewise been our experience, particularly as more evidence of allegations of fraud by affiliates of PPFA are reported and as more evidence of negligent care and treatment of women by Planned Parenthood and other "family planning" facilities – in some cases leading to the deaths of women treated by these facilities, both regulated and unregulated – that Planned Parenthood is far less concerned with providing competent healthcare to women than it is with padding its bottom line with taxpayer dollars, which in fiscal year (FY) 2012 totaled $542 million.

The report concludes that improper practices by Planned Parenthood affiliates and state "family planning" programs have already resulted in more than $108 million, as a minimum, documented in waste, abuse, and potential fraud in Title XIX-Medicaid programs. Yet it is troublesome that all the audits conducted to date have been relatively superficial; none has yet examined more than a small subsection of an organization's billings. Thus, the total amount of waste, abuse, and potential fraud is likely many times that. Clinics purporting to provide Title XIX-Medicaid and other subsidized healthcare services must be held accountable through proper audits of their entire clinic networks.

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[1] Alliance Defending Freedom is an alliance-building legal ministry advocating for religious liberty, the sanctity of life, and marriage and family.

Members of Congress have begun to take notice of Planned Parenthood's oversized coffers. Most recently, a February 21, 2013, letter from Representative Diane Black and Representative Pete Olson and signed by seventy other Members of Congress was directed to the Comptroller General of the United States requesting that the U.S. Government Accountability Office conduct a comprehensive audit of the receipt and use of federal taxpayer dollars – more than $542 million in FY 2012 – by Planned Parenthood Federation of America and its related entities.

On September 15, 2011, U.S. Representative Cliff Stearns, chairman of the Oversight and Investigations Subcommittee of the United States House of Representatives Energy and Commerce Committee, sent a letter to PPFA President Cecile Richards seeking to examine PPFA and its affiliates' "institutional practices and policies . . . and its handling of federal funding," and particularly as regards its compliance with federal restrictions on the funding of abortion.[2] The subcommittee demanded that Planned Parenthood produce its documents relating to audits, abortion funding, and sexual abuse reporting policies.

In response to this investigation, seven former Planned Parenthood employees, including clinic directors and an "abortion doctor" wrote to the Energy and Commerce Committee supporting the investigation, "not only . . . with respect to the use of tax dollars but also . . . to serve the best interest of women . . . ."[3] In addition to attesting to their knowledge of Planned Parenthood's use of abortion as a method of family planning, biased abortion counseling, and failure to report statutory rape, coerced abortion, and human trafficking, they stated that "PPFA failed to properly account for and maintain separation between government funds prohibited from use for elective abortions and [other, unrestricted] funds . . . ."[4] Further, "PPFA failed to engage in appropriate financial controls and billing practices to ensure compliance with applicable state and federal

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[2] Letter available at http://www.scribd.com/doc/66564569/Stearns-Planned-Parenthood.

[3] Letter available at http://www.sba-list.org/sites/default/files/content/shared/12.7.11_former_employees_of_planned_parenthood_letter_to_congress_0.pdf.

[4] This form of waste, abuse, and potential fraud was also documented in the HHS-OIG audit of Tapestry Health Systems, Inc., described below in the Federal Audits of State Family Planning Programs section.

laws." The former employees expressed concern that the "American people . . . are underwriting the growth of Planned Parenthood and its potent outreach to the young and the poor," even as the organization acted and "operated as a law unto itself . . . exempt[] from the normal standards of accountability . . . ."

Coupled with this report, the recent letter from seventy-two Members of Congress, the Oversight and Investigation letter and investigation, and the former employees letter calling for a "check and balance" on Planned Parenthood, highlight the need for meaningful Congressional oversight in order to have any hope of achieving openness, transparency, integrity, and accountability in all federal family planning programs, including Title V, Title X, Title XIX, and Title XX programs, as well as for Planned Parenthood to be held accountable for the federal taxpayer dollars it receives and expends.

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EXECUTIVE SUMMARY

It is the purpose of this memorandum to outline our experiences in identifying waste, abuse, and potential fraud by Planned Parenthood affiliates and other abortion providers, particularly with respect to federal and state Title XIX-Medicaid reimbursements.

The weight of evidence indicates widespread waste, abuse, and potential fraud by Planned Parenthood affiliates nationwide, and suggests that such policies may be the result of an orchestrated scheme by Planned Parenthood Federation of America's headquarters in New York City.

In our experience, based on the publicly available audits summarized herein and confirmed by our confidential sources, Planned Parenthood's primary motivation is to take advantage of "overbilling" opportunities to maximize its revenues in complex, well-funded federal and state programs that are understaffed and rely on the integrity of the provider for program compliance.[5] Thus, Planned Parenthood's primary motivation appears not to be to provide quality healthcare to patients who seek family planning services, but rather to enhance its profits.

There are twelve known audits or other reviews of Planned Parenthood affiliates' financial data and practices: one in California, one in Connecticut, one in Illinois, seven in New York State, one in Texas, and one in Washington State. All the audits are summarized below.

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[5] The lack of oversight of these state-run healthcare programs is supported by the U.S. Government Accountability Office's September 2011 report to congressional committees entitled "Drug Pricing: Manufacturer Discounts in the 340B Program Offer Benefits, but Federal Oversight Needs Improvement" (GAO-11-836). This report concluded that the Health Resources and Services Administration (HRSA, within the Department of Health and Human Services, HHS) oversight of the 340B drug program was inadequate and that, "[t]o ensure appropriate use of the 340B program, GAO recommend[ed] that HRSA take steps to strengthen oversight regarding program participation and compliance with program requirements." HRSA agreed with GAO's recommendations that HRSA strengthen its compliance enforcement and not rely solely on self-policing by covered entities.

The audit further determined that between thirteen and nineteen of the twenty-nine covered entities audited were actually generating revenue through the 340B program, rather than merely covering the costs of the drugs as planned.

These twelve state audits found numerous improper practices resulting in significant Title XIX-Medicaid overpayments of over $8 million[6] to Planned Parenthood affiliates for family planning and reproductive health services claims.

Furthermore, forty-five federal audits of state family planning programs by HHS-OIG found between nearly $100 million in overbilling ($99,718,852). The federal audits detailed "unbundling" billing schemes related to pre-abortion examinations, counseling visits, and other services performed in conjunction with an abortion; and improper billing for the abortions themselves.[7] In New York alone during

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[6] The total is between $8,273,338.15 and $8,393,371.02, depending on the true amount of the outstanding billings in Texas.

[7] One federal audit (Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program, A-02-07-01037, Nov. 2008) noted that 27 of the 119 claims in the sample were abortion procedures, and one provider was responsible for 25 of them. Based on the procedure codes used, the auditors believed that this provider billed for at least 3,900 abortions during the audit claim, but only reviewed the 25 claims in the sample. Some were associated with no order at all; some orders had expired or had been signed only by a Registered Nurse (RN), without countersignature by a clinician. This practice is often associated with HOPE (Hormones with Optional Pelvic Exam) visits.

Another federal audit (Review of Abortion-Related Laboratory Claims Billed as Family Planning Under the New York State Medicaid Program, A-02-05-01009, July 2007) found that 98 out of the 100 sample claims, of a universe of 633,968 abortion-related claims, were improper. One laboratory provider, which specialized in examining abortion-related specimens, had submitted ninety-five of the ninety-eight improper claims. Forty-two involved abortion-related laboratory tests for which no federal funding is available, e.g., tests performed on the aborted fetus and tests performed before the abortion to assess the risk to the patient, such as complete blood counts, electrolytes, and blood typing. The remaining fifty-six improper claims related to abortion-related laboratory tests that are allowable at the applicable federal medical assistance percentage rate, but not at the enhanced ninety-percent federal financial participation (FFP) rate, e.g., pap smears, urinalysis, and tests for pregnancy and sexually transmitted diseases.

FFP is the federal portion of the shared federal-state contributions to the Medicaid program; the precise share is determined by the federal medical assistance percentage (FMAP). *See generally* Title XIX of the Social Security Act. In New York, the FMAP was 50% from January 1, 2000 through March 31, 2003, and 52.95% from April 1, 2003 through December 31, 2003. However, Social Security Act § 1903(a)(5) and 42 C.F.R. §§ 433.10, 433.15 provide for an enhanced 90% FFP for family planning services, which are defined in the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual. While a state may determine the specific services and supplies to be covered as Medicaid family planning services, such procedures and items must adhere to certain CMS guidelines. CMS State Medicaid Manual § 4270 also provides that an abortion may not be claimed as a family planning service. Further, based on the Supplemental Appropriations and Recession Act of 1981, P.L. No. 97-12 and 42 C.F.R. § 441.203, federal funds may only be used for an abortion in cases where the life of the mother is endangered. Therefore, many laboratory services related to an abortion are ineligible for federal funding. However, FFP is available at the applicable FMAP for the costs of certain services

one four-year audit period, it appeared that *hundreds of thousands* of abortion-related claims were billed illegally to Medicaid.

Two of these federal audits specifically identified Planned Parenthood – and only Planned Parenthood – as the problem in state family planning program overbilling.

Seven of the federal HHS-OIG audits were of New York State and found federal overpayments in excess of $32 million[8] to the New York State Medicaid family planning program. These audits likely led to the seven state audits of New York Planned Parenthood affiliates; thirteen months after the federal audit of New York State that identified "especially Planned Parenthoods" as incorrectly claiming services as family planning,[9] New York State released its first known audit report of a Planned Parenthood affiliate.[10]

The scope of each audit detailed or listed herein was very limited, examining only a fraction of the types of claims and only for a limited window of time, which varied by audit. Thus, in order to understand the scope of what monies may be regained through audits of Planned Parenthood and other family planning / abortion clinics and of state

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associated with the provision of a non-federally funded abortion if the same services would have been provided to a pregnant woman not seeking an abortion, CMS State Medicaid Manual § 4432, but these services will not be reimbursable at the enhanced ninety-percent rate, CMS Financial Management Review Guide Number 20, Family Planning Services, Medicaid State Operations Letter 91-9.

[8] The true amount may be $35,381,352 or even higher, as HHS-OIG set aside certain amounts in question for further review, and as the scope of the audits was limited.

[9] Other audits may single out Planned Parenthood affiliates, as well, without referring to them by name. For example, in the November 2008 New York State audit A-02-07-01037, HHS-OIG found that New York improperly received enhanced ninety-percent federal reimbursement for 102 out of 119 sample claims. Of these, 96 were for services unrelated to family planning, and 33 were for services for which no reimbursement was available - including twenty-seven abortion procedures, and four services performed in conjunction with an abortion. HHS-OIG found that one provider was responsible for twenty-five of the twenty-seven abortion claims; this provider billed at least 3,900 abortion claims during the audit period.

[10] It is logical to presume that New York State, after being audited and charged over $32 million, would attempt to recover this loss from the Planned Parenthood family planning clinics that would have been a primary source of the overpayments. One of the 2008 federal audits of New York State (Review of Federal Medicaid Claims Made for Beneficiaries in the Family Planning Benefit Program in New York State, A-02-07-01001, May 2008) specifically noted Planned Parenthood (and only Planned Parenthood) as a major offender in incorrectly claiming services as family planning: "[M]any provider officials (especially Planned Parenthoods) stated that they billed most of their claims to Medicaid as related to 'family planning.'"

family planning programs, it is useful to calculate the average amount of overbilling by year found in the audits conducted to date. Of the twelve audits of Planned Parenthood, the audited dates are known for nine audits. Of these audits, as much as $5,213,645.92 was overbilled in one audited year; the average overbilled amount in one audited year was $631,737.56. Of the forty-five audits of state family planning programs, the audited dates are known for forty-four audits. Of these audits, as much as $4,410,900.70 was overbilled in one audited year; the average overbilled amount in one audited year was $689,352.34.

Additionally, we understand that the Internal Revenue Service's criminal division is in the process of auditing the former PPFA affiliate Planned Parenthood Golden Gate (PPGG). This audit was reportedly instigated by a former employee who lodged a complaint about an improper relationship between that PPGG and its related political organization, and also about PPGG's financial dealings. Other audits of state family planning services are forthcoming, as well.[11]

In defense to a 2009 audit's findings of gross overbilling, one Planned Parenthood affiliate objected to the draft audit report, claiming that it was "unfair" for the State to request repayment or documentation "four to five years after the fact."

[11] *See, e.g.*, https://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP03-Mcaid.pdf.

TYPES OF FRAUD IDENTIFIED

1. In a process known as "unbundling," billing and being reimbursed by Title XIX agencies for medications and/or services provided in connection with an abortion procedure;
2. Dispensing prescription drugs, including oral contraceptives, without an authorizing order by a physician or other approved healthcare practitioner;[12]
3. Dispensing prescription drugs, including oral contraceptives, to patients who have moved or have not been seen by the clinic for more than a year;
4. Billing in excess of actual acquisition cost or other statutorily approved cost for contraceptive barrier products, oral contraceptives, and emergency contraceptive-Plan B (i.e., § 340B drugs) products;
5. Billing for services, including a pregnancy test, that were not medically necessary;
6. Billing for multiple initial prenatal care visits;
7. Incorrectly billing initial, follow-up, and postpartum services;
8. Billing included products and services as fee for service;
9. Lacking documentation to support the service billed and paid;
10. Not signing medical entries;
11. Billing incorrect rate codes; and
12. Not paying subcontractors for one affiliate for services rendered, despite the fact that the amounts had been included in requests for state health department reimbursement.

[12] In some cases, oral contraceptives were dispensed to patients with no order at all; some orders had expired or had been signed only by a Registered Nurse (RN), without countersignature by a licensed clinician or medical doctor. This practice is often associated with HOPE (Hormonal Option without Pelvic Examination) visits. Typically, in a HOPE examination, a non-licensed staff person takes a patient's blood pressure and obtains a brief medical history and, in lieu of a physical examination by a licensed clinician or medical doctor, thereupon provides the patient with contraceptives.

FEDERAL AND STATE AUDITS OF PLANNED PARENTHOOD AFFILIATES

There are twelve known audits or other reviews of Planned Parenthood affiliates' financial data and practices: one in California, one in Connecticut, one in Illinois, seven in New York State, one in Texas, and one in Washington State.

The audited dates are known for nine audits. Of these audits, as much as $5,213,645.92 was overbilled in one audited year; the average overbilled amount in one audited year was $631,737.56.

California Audit

A 2004 State of California audit of Planned Parenthood of San Diego and Riverside Counties (PPSDRC) revealed payment in excess of cost for contraceptive barrier products, oral contraceptives, and Plan B products, totaling $5,213,645.92.

The California Health and Human Services Agency, Department of Health Services conducted the audit of paid claims from July 1, 2002 to June 30, 2003 for Codes X1500 (contraceptive barrier products) and X7706 (oral contraceptives), and February 2, 2003 to May 30, 2004 for Code X7722 (Plan B products).

The audit found that during the audit review period, PPSDRC did not comply with the published billing requirements. It found a total payment in excess of cost during the audit period of $5,213,645.92:

Billing Code	**Code Description**	**Amount Paid**	**Provider's Cost**	**Payments in Excess of Cost**
X1500	contraceptive barrier products	$35,117.30	$12,318.71	$22,798.59
X7706	oral contraceptives	$5,030,347.00	$859,569.10	$4,170,777.90
X7722	Plan B products	$1,119,351.53	$99,282.10	$1,020.069.43
Total		**$6,184,815.83**	**$971,169.91**	**$5,213,645.92**

In the case of oral contraceptives and Plan B products, Planned Parenthood Affiliates of California (PPAC) claimed that it had a longstanding relationship with manufacturers that allowed them to purchase these products at deeply discounted rates, i.e., "nominal prices." By then billing Medi-Cal at a "usual and customary rate," which is higher than what PPAC had paid for the Plan B product, but somewhat lower than the normal retail price for the product, PPAC defended its improper practices by deeming

that PPAC was "sharing the profits" of the "nominal price" arrangements with the State of California. No such "nominal pricing" arrangement existed with respect to condoms. The health department rejected this justification and required repayment of amounts billed over acquisition cost.

Connecticut Audit

The U.S. HHS-OIG conducted an audit[13] of Planned Parenthood of Connecticut Inc. & Subsidiar., finding $18,791 of overbilling.

Illinois Audit

As the result of an audit (case number 1074160) conducted of the period January 1, 2006, to December 31, 2007, by the Illinois Department of Healthcare and Family Services's Inspector General, Planned Parenthood of Illinois (PPI) and its medical director, Caroline Hoke, agreed to pay the state $367,000 to settle findings of overbilling Medicaid and not documenting services allegedly provided, primarily contraceptives.[14] Separately, Planned Parenthood's Westside Clinic agreed to pay the state $20,000 for its portion of the overbilling. Hoke had been banned from reimbursement by and threatened with termination from the Medicaid program since May 2010, when these overbillings were uncovered.[15]

Specifically, this audit found 641 missing records, 31 instances of billing for non-covered services, and 10 instances of billing for services actually performed by someone else, as well as improper procedure codes.

During the fiscal year ending June 30, 2011 (the most recent fiscal year for which data is available), PPI received approximately half its $25 million revenue from Medicaid. In 2009, Hoke received over $3 million from Medicaid – the second-highest amount of 30,000 physicians – but in 2011 received nothing. However, the other PPI providers have seen their reimbursements grow accordingly – in fiscal year 2009, fifty-

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[13] A-01-99-59104, released Aug. 1999. *See* https://oig.hhs.gov/publications/docs/semiannual/2000/00ssemi.pdf.

[14] http://www.modernhealthcare.com/article/20120906/INFO/309069993; http://www.chicagobusiness.com/article/20120707/ISSUE01/307079977/medicaid-probes-planned-parenthood-fees.

[15] http://www.modernhealthcare.com/article/20120906/INFO/309069993.

two other PPI providers received $2.8 million in reimbursements, but in 2011, a total of sixty-two providers received $7 million.[16]

New York Audits

The seven New York State audits of New York Planned Parenthood affiliates were likely conducted due to seven federal audits of New York Medicaid family planning program claims. The first known New York State audit of New York Planned Parenthood affiliates was released thirteen months after a federal audit identified "especially Planned Parenthoods" as incorrectly claiming services as family planning, as detailed in the Federal Audits of State Family Planning Programs and Other Organizations section below.

New York Audit I - Hudson Peconic, June 2009

A June 2009 audit[17] of Medicaid payments for family planning and reproductive health services paid to Planned Parenthood Hudson Peconic, Inc. (PPHP) on behalf of Medicaid beneficiaries while they were enrolled in Community Choice Health Plan and Health Insurance Plan of New York found significant overpayments for family planning and reproductive health services claims, resulting in an overpayment of $15,723.91, inclusive of interest.

The New York State Office of the Medicaid Inspector General (OMIG) conducted this audit to ensure that PPHP was in compliance with 18 NYCRR § 515.2, which addresses unacceptable practices under the medical assistance program, and § 540.6, which addresses recovery of third-party reimbursement and repayment to the medical assistance program.

OMIG found overpayments of $12,173.63 for family planning and reproductive health services claims during the audit period; as a result, § 515.2 and § 540.6 requirements were violated. Inclusive of $3,550.28 in interest, 18 NYCRR § 518.4, the repayments total $15,723.91.

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[16] http://www.chicagobusiness.com/article/20120707/ISSUE01/307079977/medicaid-probes-planned-parenthood-fees.

[17] The audit (Family Planning Chargeback to Managed Care Network Providers, 09-1415, June 10, 2009) was conducted of the period Jan. 1, 2004 through Dec. 31, 2004.

In PPHP's April 23, 2009 response to OMIG's March 23, 2009 draft report, it indicated (1) that PPHP considered it unfair to request repayment or documentation "four to five years after the fact"; (2) that it considered the Electronic Medicaid Eligibility Verification System (EMEVS) to be inaccurate for verifying that clients are enrolled in a managed care plan; and (3) an expression of doubt as to why Medicaid would pay the fee for service claim if the client was a managed care member. OMIG responded to each of these concerns.

New York Audit II - Hudson Peconic, May 2010

A May 2010 audit[18] of PPHP found six categories of overbilling, resulting in an overpayment of $112,490.31, inclusive of interest.

The Prenatal Care Assistance Program (PCAP) is a comprehensive prenatal care program that offers complete pregnancy care and other services to women. Facilities that enter into a contract with DOH to become a PCAP provider agree to provide these services, directly or indirectly, to pregnant women who are eligible for Medicaid and are reimbursed via all-inclusive, enhanced PCAP rates established by DOH. The provider agrees to establish procedures, internally and externally, to ensure that ancillary services such as lab and ultrasound procedures related to prenatal care are not billed directly to Medicaid.

OMIG reviewed PPHP billings for PCAP patients to ensure that (1) clinic services were billed appropriately and in accordance with DOH rules and regulations, and provider billing guidelines; and (2) other Medicaid-enrolled providers who performed PCAP-covered services did not bill Medicaid.

The audit uncovered six improper practices:

1. Multiple initial prenatal care visits: Initial visits receive the highest PCAP clinic reimbursement, and only one initial visit may be billed per patient per pregnancy, PCAP Billing Guidelines Booklet, May 2005. The audit found multiple PCAP recipients for whom more than one initial visit was billed, resulting in no overpayment.

[18] The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

2. Initial, follow-up, and postpartum services billed incorrectly after delivery: Only one postpartum visit may be billed; if additional visits are needed, claims should be submitted with the clinic's general medicine rate codes, PCAP Billing Guidelines Booklet, May 2005. The audit found PCAP initial and follow-up visits reduced to the lower postpartum visit rate or, in some instances with multiple postpartum visits, reduced to the general medicine clinic rate, resulting in an overpayment of $162.96.
3. Laboratory services billed fee for service that are included in the PCAP rate: The PCAP services are comprehensive and cover services provided both at the clinic and at other locations, 10 NYCRR 85.40(i)(1)(ii)(iii); Medicaid Provider Manual for Physicians, Policy Guidelines, Section II, Physician Services, PCAP Billing Guidelines Booklet, May 2005. PPHP billed laboratory services ordered during PCAP visits in addition to the PCAP clinic rates, resulting in duplicate payments totaling $3,117.75.
4. Ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed: Ultrasounds, whether performed at a PCAP facility or not, should not be billed fee for service by facilities due to the comprehensive nature of PCAP, PCAP Billing Guidelines Booklet, May 2005; PCAP Medicaid Policy Guidelines Manual, January 2007; DOH Medicaid Update, September 2008, Vol. 24, No. 10. The audit identified obstetrical ultrasounds and diagnostic procedures performed within 30 days of a PCAP visit, excluding any procedures associated with visits to other facilities or non-obstetrical providers, resulting in duplicate billing and an overpayment of $25,802.60.
5. Ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed: Similarly, ultrasounds, whether performed at a PCAP facility or not, should not be billed fee for service by physicians due to the comprehensive nature of PCAP, DOH Medicaid Update, September 2008, Vol. 24, No. 10; 18 NYCRR 518.3(a). Using the same procedures as with claims improperly filed by facilities, the

audit identified obstetrical ultrasounds and diagnostic procedures that were billed in duplicate, resulting in an overpayment of $68,105.40.

6. Vitamin and iron supplement services billed fee for service that are included in the PCAP rate: Similarly, vitamin and iron supplements as defined by drug therapeutic codes are included in the PCAP reimbursement and should not be billed fee for service, New York State Department of Health, PCAP Services Description, March 2003; the PCAP provider is responsible for providing these services. PPHP, however, billed for these supplements separately from the comprehensive PCAP rate, resulting in an overpayment of $3,995.86.

The total base amount of overpayment is $108,494.45. OMIG then calculated interest on this amount totaling $3,995.86, 18 NYCRR §§ 518.4, 518.1(c). The total amount of overpayment and restitution is therefore $112,490.31.

New York Audit III - Nassau, February 2010

A February 2010 audit[19] of Planned Parenthood of Nassau County, Inc. (PPNC) found six improper practices, resulting in an overpayment of $12,031.29, inclusive of interest.

OMIG reviewed PPHP billings for PCAP patients to ensure that (1) clinic services were billed appropriately and in accordance with DOH rules and regulations, and provider billing guidelines; and (2) other Medicaid-enrolled providers who performed PCAP-covered services did not bill Medicaid.

The audit uncovered the same six improper practices as were discovered in the May 2010 audit[20] of PPHP. In PPNC, (1) the multiple initial prenatal care visits resulted in an overpayment of $0; (2) the initial, follow-up, and postpartum services billed incorrectly after delivery resulted in an overpayment of $0; (3) the laboratory services billed fee for service that are included in the PCAP rate resulted in an overpayment of $169.55; (4) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed resulted in an overpayment of

[19] The audit (Prenatal Care Assistance Program, 2009Z33-083W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

[20] The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

$0; (5) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed resulted in an overpayment of $9,045.00; and (6) the vitamin and iron supplement services billed fee for service that are included in the PCAP rate resulted in an overpayment of $1,315.62.

The total amount of restitution due was $10,530.17 without interest; after $1,501.12 in interest was added, the total was $12,031.29.

New York Audit IV - NYC, January 2009

A January 2009 audit[21] of Planned Parenthood of New York City, Inc. (PPNYC) / Margaret Sanger Center resulted in PPNYC electing to repay the amount of $207,809.00.

New York Audit V - NYC, June 2009

A June 2009 audit[22] of payments to PPNYC / Margaret Sanger Center for diagnostic and treatment center services paid by Medicaid found five improper practices, with sample overpayments of $7,960.01 and total overpayments of at least $1,254,603.00.

OMIG conducted this audit to ensure that (1) Medicaid reimbursable services were rendered for the dates billed; (2) appropriate rate or procedure codes were billed for the services rendered; (3) patient-related records contained the documentation required by the regulations; and (4) claims for payment were submitted in accordance with the DOH regulations and the Provider Manuals for Clinics.

During the audit period, $11,818,856.30 was paid for services rendered to 21,413 patients. The review consisted of a random sample of 100 patients with Medicaid payments of $53,977.99.

OMIG found five improper practices:

1. Missing documentation: In thirty-four instances pertaining to twenty patients, the services were not documented as required by 18 NYCRR §§ 504.3, 517.3, 540.7(a)(8), resulting in a sample overpayment of $3,629.63.

[21] Audit # 08-3045. No further information on this audit is readily available.
[22] The audit (06-6696) was conducted of the period Jan. 1, 2004 through Dec. 31, 2005.

2. Inadequate documentation of HIV pre-test counseling visit: In thirty-three instances pertaining to twenty-seven patients, the justification for the service billed was incomplete in the record, and the case record form was not completed as required by 18 NYCRR § 504.3(a), 517.3, 540.7(a)(8); Department of Health Memorandum 93-26 – HIV Primary Care Provider Agreement – Attachment I, resulting in an overpayment of $2,973.96.
3. Visit billed for managed care client within network: In nine instances pertaining to four patients, PPNYC billed Medicaid for services provided to patients enrolled in PPNYC's HMO network, contrary to 18 NYCRR § 360-7.2; MMIS Provider Manual for Clinics § 2.1.9, resulting in an overpayment of $1,109.38. (MMIS is a computerized payment and information reporting system that is used to process and pay Medicaid claims.)
4. Medical entry not signed: In one instance, the practitioner did not sign the entry in the medical record as required by 10 NYCRR § 751.7(f), resulting in an overpayment of $164.02.
5. Incorrect rate code billed: In six instances pertaining to five patients, the incorrect rate code was billed, contrary to 18 NYCRR §§ 504.3(e), 504.3(h); MMIS Provider Manual for Clinics § 2.1.14, resulting in a higher reimbursement than indicated in the fee schedule for the proper rate code and an overpayment of $83.02.

The total sample overpayment for this audit was $7,960.01.

Using statistical sampling methodology to extrapolate from the sample findings to the universe of cases, 18 NYCRR § 519.18, the mean per unit point estimate of the amount overpaid was $1,704,477.00, and the lower confidence limit, with a ninety-five percent confidence interval, was $1,254,603.00.

New York Audit VI - NYC, December 2009

A December 2009 audit[23] of Medicaid payments for family planning and reproductive health services paid to PPNYC/Margaret Sanger Center on behalf of

[23] The audit (Family Planning Chargeback to Managed Care Network Providers, 09-4845, Dec. 16, 2009) was conducted of the period Jan. 1, 2005 through Dec. 31, 2005.

Medicaid beneficiaries while they were enrolled in VidaCare Inc. SNP found overpayments, inclusive of interest, of $886.26.

The audit found that PPNYC had improperly billed Medicaid $719.55 for family planning and reproductive health services that were rendered to VidaCare enrollees; as a result, 18 NYCRR § 515.2 and § 540.6 requirements were violated. OMIG then calculated $166.71 in interest, resulting in $886.26 in required restitution.

As of December 16, 2009, OMIG had not yet received a response to the November 2, 2009 draft report from PPNYC.

New York Audit VII - South Central, February 2010

A February 2010 audit[24] of Planned Parenthood of South Central New York, Inc. (PPSCNY) found six improper practices, resulting in an overpayment of $11,539.48, inclusive of interest.

OMIG reviewed PPHP billings for PCAP patients to ensure that (1) clinic services were billed appropriately and in accordance with DOH rules and regulations, and provider billing guidelines; and (2) other Medicaid-enrolled providers who performed PCAP-covered services did not bill Medicaid.

The audit uncovered the same six improper practices as were discovered in the May 2010 audit[25] of PPHP. In PPNC, (1) the multiple initial prenatal care visits resulted in an overpayment of $0; (2) the initial, follow-up, and postpartum services billed incorrectly after delivery resulted in an overpayment of $24.30; (3) the laboratory services billed fee for service that are included in the PCAP rate resulted in an overpayment of $291.77; (4) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed resulted in an overpayment of $4,272.09; (5) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed resulted in an overpayment of $3,804.56; and (6) the vitamin and iron supplement services billed fee for service that are included in the PCAP rate resulted in an overpayment of $1,895.16.

[24] The audit (Prenatal Care Assistance Program, 2009Z33-048O, Feb. 24, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

[25] The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

The total amount of restitution due was $10,287.88 without interest; after $1,251.60 in interest was added, the total was $11,539.48.

Texas Audit

A 2009 audit[26] of the 501(c)(3) and Texas Department of State Health Services (DSHS) contractor Planned Parenthood Center of El Paso (PPCEP) revealed numerous instances of subcontractors remaining unpaid for services rendered, despite the fact that the amounts had been included in PPCEP's requests for DSHS reimbursement. The total amount of the outstanding billings was likely between $409,675.10 and $529,707.97.

Founded in 1937,[27] PPCEP closed its seven centers[28] on June 30, 2009 for financial reasons.[29] Due to published reports of this closure, DSHS became concerned about the availability of PPCEP resources and records, and DSHS General Counsel requested that the Texas Health and Human Services Commission (HHSC), OIG conduct an audit of PPCEP.

This summer 2009 audit was to determine if PPCEP was in compliance with its payments to subcontractors for services rendered. Its goals were to determine:

1. The validity of allegations that PPCEP's subcontractors had not been paid for services rendered;
2. Whether such amounts or payments were rendered pursuant to a contract executed between DSHS and PPCEP; and
3. Whether DSHS had reimbursed PPCEP for the amounts that were alleged by the subcontractor to be unpaid (this was to be tied to the DSHS contract number).
4. Finally, if subcontractors were determined to be unpaid for services rendered, then OIG was to test a random sample of the expenditures that

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[26] The audit (Attestation – Agreed-Upon Procedures Report on Planned Parenthood Center of El Paso, 09-56-00001-SP-19 Aug. 31, 2009) was conducted July 20-24, 2009.

[27] The center was founded in 1937 as Mothers Health Center, *see* http://www.prochoicetexas.org/news/headlines/200906271.shtml.

[28] PPCEP had six locations in El Paso and one in Sierra Blanca, *see* http://www.prochoicetexas.org/news/headlines/200906271.shtml.

[29] *See* http://www.plannedparenthood.org/about-us/newsroom/politics-policy-issues/el-paso-closing-information-30208.htm.

> comprised the unpaid billings in order to ensure that they were allowable and in compliance with federal and state regulations and contract requirements.

During the audit, OIG collected both PPCEP's subcontractor billings and PPCEP's own accounts payable balances for subcontractors.

OIG determined that PPCEP was not in compliance with the applicable DSHS contracts, since it had requested DSHS reimbursement for subcontractor billings it had never paid. Subcontractors identified the outstanding billings as totaling $529,707.97; PPCEP's records indicated a total of $409,675.10. However, neither amount was verifiable due to the incomplete condition of PPCEP's accounting records, and issues with patient confidentiality. Further, PPCEP had issued checks to subcontractors against the outstanding payable balances, as opposed to paying specific subcontractor invoice numbers. PPCEP's own records listed that most subcontractor billings as more than 90 days overdue.

Washington State Audit

A 2007-2009 audit[30] of the Planned Parenthood of the Inland Northwest (PPINW) affiliate[31] found numerous instances of overbilling or other irregularities, resulting in an overpayment of $629,142.88, inclusive of interest.

The audit began after Washington Department of Social and Health Services grew suspicious of the frequency of clinic visits by Medicaid patients.[32] It was conducted by the Medical Audit Unit, Office of Payment Review and Audit, within the Department of Social and Health Services (DSHS) to determine provider compliance with applicable federal, state, and departmental regulations[33] relative to claims paid from Mar. 15, 2004 to Feb. 26, 2007 for services provided under the Health & Recovery Services

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30 The audit (MA 07-13, July 20, 2009) was conducted May 8-10, 2007.

31 Doing business as Planned Parenthood of Spokane – Take Charge.

32 *See* http://www.spokesman.com/stories/2009/aug/12/audit-clinic-overbilled-medicaid/.

33 Specifically, compliance with regulations stated in the Revised Code of Washington (RCW), Washington Administrative Code (WAC), the provider's Core Provider Agreement with DSHS, the Schedule of Maximum Allowances, Billing Instructions, and Numbered Memoranda.

Administration (HRSA) programs.[34] A total of 267,840 procedures, totaling $7,697,613.86, met these criteria.

The audit conducted (1) probability sampling of 308 randomly selected procedures, totaling $26,117.32, which were then extrapolated to the total number of procedures; (2) a claim-by-claim audit of the 25 procedures with the highest reimbursement, totaling $11,728.50; and (3) an on-site documentation review. Thus, a total of 333 procedures were audited.

The audit found:

1. In seventeen instances, prescription drugs were dispensed without an authorizing order. In ten audited instances, the dispenser did not have a current, valid authorizing order (prescription) to dispense and bill for the prescription drug on the date of service, for example, where the prescription was outdated. In seven audited instances, there was no valid authorizing order at all to dispense the prescription drug billed; for instance, in one case there was no documentation from the office visit of the medication being prescribed, and additionally, a licensed clinician had not signed the exam form.
2. In sixteen instances, documentation was missing or did not support the level of evaluation and management (E/M) service billed and paid by HRSA. There was one instance of incorrect coding, fourteen instances in which the visit was to pick up medication and there were no chart notes to substantiate that a face-to face office visit with a licensed clinical staff member occurred, and one instance in which there was no chart note or other signed documentation to substantiate a billed pregnancy test visit.
3. In thirteen instances, PPINW billed HRSA for more than the acquisition cost of the contraceptive supply, i.e., condom, contrary to the fee schedule.
4. In one instance, PPINW billed for a pregnancy test that was not medically necessary. The patient had been receiving contraceptive “shot[s]” and was not due for another, and on her HOPE (Hormones with Optional Pelvic Exam)

[34] Procedures paid at $0 and Medicare crossover claims were excluded.

form had indicated that there was no need for a test; no other chart note or documentation supported the test.

5. In one instance, PPINW billed separately for a medication included in a bundled service for an abortion that was covered under a different contract with the provider and a different provider number, thus engaging in "unbundling" and billing for medication not covered by the Family Planning or Take Charge programs.
6. In two instances, the Registered Nurse (RN) wrote an oral contraceptive order for a new patient without countersignature by a clinician, contrary to the Department of Health Nursing Commission's Telehealth/Telenursing guidelines for Registered Nurses that require a prior patient-practitioner relationship for such an order.
7. In those same two cases, the RN did not identify the order as following the standing order protocol, so it was unclear where the order originated. The order could have originated over the telephone or by fax.

Overpayments associated with the probability sample totaled $1,743.59; extrapolated to the universe of 267,840 procedures, totaling $7,697,613.86, the calculated overpayment was $628,692.88. Overpayments associated with the claim-by-claim audit of the highest reimbursed twenty-five claims totaled $450.00. The total overpayment was $629,142.88.

PPINW was directed to comply with all federal, state, and departmental regulations, rules, and billing instructions provided under the Medical Assistance program; continued violations could result in suspension or termination of their eligibility to receive services. Further, PPINW was instructed to repay $629,142.88, plus interest.

FEDERAL AUDITS OF STATE FAMILY PLANNING PROGRAMS AND OTHER ORGANIZATIONS

Forty-five federal audits of state family planning programs by HHS-OIG found nearly $100 million in overbilling ($99,718,852), at a minimum. The audited dates are known for forty-four audits. Of these audits, as much as $4,410,900.70 was overbilled in one audited year; the average overbilled amount in one audited year was $689,352.34.

Two of these audits specifically identified Planned Parenthood – and only Planned Parenthood – as the problem in state family planning program overbilling.

(1) In the June 2008 New Jersey audit A-02-06-01010, HHS-OIG determined that the overpayment occurred in part because "many" family planning clinics ("especially Planned Parenthood providers") improperly billed *all* services as family planning, and eligible for 90-percent Federal funding.

(2) In the May 2008 New York State audit A-02-07-01001, HHS-OIG determined that the resultant overpayment occurred in part because some providers – "especially Planned Parenthoods" – incorrectly claimed services as family planning ("[M]any provider officials (especially Planned Parenthoods) stated that they billed most of their claims to Medicaid as related to 'family planning.'"). **Thirteen months later, New York State released its first known audit report of a Planned Parenthood affiliate.**

Additionally, in the November 2008 New York State audit A-02-07-01037, HHS-OIG found that New York improperly received enhanced ninety-percent federal reimbursement for 102 out of 119 sample claims. Of these, 96 were for services unrelated to family planning, and 33 were for services for which no reimbursement was available - including twenty-seven abortion procedures, and four services performed in conjunction with an abortion. HHS-OIG found that one provider was responsible for twenty-five of the twenty-seven abortion claims; this provider billed at least 3,900 abortion claims during the audit period.

In the July 2007 New York State audit A-02-05-01009, HHS-OIG noted that one "laboratory provider [which specialized in examining abortion-related specimens] submitted 95 of the 98 improper sample claims" out of the 100 claims sampled. Forty-two of the improper claims involved abortion-related laboratory tests for which no federal

funding is available, e.g., tests performed on the aborted fetus and tests performed before the abortion to assess the risk to the patient, such as complete blood counts, electrolytes, and blood typing.

In the September 2009 New York State audit A-02-09-01015, the 105 sample claims had been submitted by a total of fourteen providers. Six of them coded approximately ninety-nine percent of their claims as family planning during the audit period, improperly claiming, inter alia, treatment for sexually transmitted diseases and pre-abortion counseling visits unrelated to family planning services.

Finally, one audit not included in the table below examined the financial management systems related to the Title X family planning program of Tapestry Health Systems, Inc., a nonprofit human service organization located in Western Massachusetts. Tapestry provides: (1) Family Planning/Health Services; (2) Education and Training/Community Support Services; and (3) HIV/AIDS Services. The Family Planning/Health Services division performs physical exams, counseling, testing and referrals to other health service providers.[35] HHS-OIG conducted the audit to determine whether Tapestry has adequate financial management systems to ensure accurate and complete disclosure of the financial results of the Federal Title X award. HHS-OIG found that Tapestry was commingling funds and space, and recommended that Tapestry implement systems that: 1) provide for identification of Title X expenses (which it had not been doing as required); 2) ensure that family planning surplus revenues are used for family planning; 3) provide that requests for Title X funds be related to minimum amounts needed; and 4) ensure that space costs are allocated to all benefiting programs on an equitable basis. In addition, HHS-OIG recommended that Tapestry continue to monitor support of payroll charges to ensure proper allocation of salaries of employees working in family planning. In response, Tapestry stated that it was grateful that the audit found no cause to question the quality of its services or to request disallowance or return of federal funds. However, as HHS-OIG noted in reply, "these conclusions cannot be drawn from this report as this audit did not include a review of services provided by Tapestry or the allowability of claimed costs."

[35] Audit of Tapestry Health Systems, Inc., Financial Management Systems Related to the Title X Family Planning Program, A-01-00-01504, May 2000.

	HHS-OIG Audit #	Audited Period	Total Overbilling
Arizona	A-09-04-00027	10/1/1999 – 9/30/2002	undetermined[36]
Arkansas	A-06-11-00022	10/1/2005 – 9/30/2010	$1,906,657[37]
California	A-09-11-02040	10/1/2008 – 9/30/2010	$5,671,216
Colorado	A-07-04-01005	10/1999 – 12/2003	$1,587,305
Colorado	A-07-04-01008	7/1/1998 – 6/30/1999	$454,786
Colorado	A-07-11-01095	10/1/2005 – 9/30/2009	$617,999
Colorado	A-07-11-01096	10/1/2005 – 9/30/2009	$1,975,800
Colorado	A-07-11-01097	10/1/2005 – 9/30/2009	$2,295
Delaware	A-03-03-00220	10/2000 – 06/2004	$2,916,288[38]
Illinois	A-05-10-00053	10/1/2007 – 9/30/2009	$869,273
Kansas	A-07-09-04146	7/1/2005 – 6/30/2009	$589,355
Kansas	A-07-10-04156	7/1/2005 – 6/30/2009	$2,447,414
Kansas	A-07-10-04157	7/1/2005 – 6/30/2009	$151,526
Kansas	A-07-10-04162	7/1/2005 – 6/30/2009	$485,982
Louisiana	A-06-10-00075	unknown	undetermined[39]
Louisiana	A-06-10-00076	10/1/2007 – 9/30/2009	$0
Maryland	A-03-03-00218	7/2000 – 3/2004	$228,643

[36] HHS-OIG recommended that the Medicaid agency work with Centers for Medicare and Medicaid Services (CMS) to determine the eligibility of $558,093 in payments. However, another HHS-OIG audit, A-03-06-00200 included this figure in its entirety in its total amount of claimed unallowable family planning costs.

[37] Further, HHS-OIG recommended that the State agency "work with CMS to determine the allowable portion of the [additional] $929,019 in family planning Federal share that it received for allocated sterilization costs."

[38] Alternatively, Delaware could provide support for the family planning service costs claimed.

[39] This audit was not available online; Alliance Defending Freedom is currently attempting to obtain it.

Michigan	A-05-08-00064	10/1/2005 – 9/30/2007	$1,000,519
Michigan	A-05-09-00050	10/1/2005 – 9/30/2007	$838
Missouri	A-07-04-01004	10/1/2000 – 9/30/2003	$0
Missouri	A-07-04-01012	10/1/1995 – 9/30/2001[40]	$6,467,583
Missouri	A-07-12-01121	1/1/2009 – 12/31/2010	$862,398
New Jersey	A-02-05-01016	7/1/1997 – 3/31/2002	$314,446[41]
New Jersey	A-02-05-01019	2/1/2001 – 1/31/2005	$2,219,746
New Jersey	A-02-06-01010	2/1/2001 – 1/31/2005	$597,496
New Jersey	A-02-06-01020	2/1/2001 – 1/31/2005	$162,548
New York	A-02-05-01001	1/1/2000 – 12/31/2003	$1,566,740
New York	A-02-05-01009	1/1/2000 – 12/31/2003	undetermined[42]
New York	A-02-05-01018	1/1/2000 – 12/31/2003	$6,132,366[43]
New York	A-02-06-01007	1/1/2000 – 6/30/2005	$2,603,128
New York	A-02-07-01001	10/1/2002 – 6/30/2006	$918,816
New York	A-02-07-01037	4/1/2003 – 3/31/2007	$17,151,156
New York	A-02-09-01015	4/1/2007 – 9/30/2008	$3,773,506
North Carolina	A-04-10-01089[44]	10/1/2004 – 9/30/2007	$1,387,378
North Carolina	A-04-10-01091	10/1/2005 – 9/30/2007	$666,826
North Carolina	A-04-10-01092	10/1/2004 – 9/30/2007	$541,513
Ohio	A-05-10-00035	10/1/2007 – 9/30/2009	$320,774
Oklahoma	A-06-10-00047	1/1/2005 – 12/31/2009	$3,356,074
Oregon	A-09-10-02043	10/1/2006 – 9/30/2009	$1,487,974
Oregon	A-09-11-02010	10/1/2006 – 9/30/2009	$1,692,956[45]

[40] These were retroactive claims that were submitted in the quarter ending March 31, 2001.

[41] Additionally, HHS-OIG set aside $4,346,987 in unsupported claims for resolution with CMS.

[42] HHS-OIG set aside $3,235,640 for consideration by CMS and the State because qualified practitioners had not performed a medical review of the sample claims.

[43] This audit did not question the medical necessity of the services or their eligibility for Medicaid reimbursement. Thus, the audit questioned and calculated only the difference between the applicable FMAP and the enhanced ninety-percent federal funding rate, which is either 40% (for the 50% FMAP, 90% - 50%) or 37.05% (for the 52.95% FMAP, 90% - 52.95%). Thus, the actual amount of overbilling may have been even higher.

[44] This audit uncovered improperly billed pharmacy claims and sterilizations performed without obtaining proper consent.

[45] Additionally, HHS-OIG set aside 27,405 claims totaling $3,310,404 ($2,979,364 federal share) for resolution for clients for whom the State agency did not verify client incomes and/or social security numbers.

Pennsylvania	A-03-03-00214	10/2000 – 2/2004	$15,070,548
Vermont	A-01-05-00002	10/1/2003 – 9/30/2004	$323,367
Virginia	A-03-04-00209	04/2001 – 03/2004	$1,388,506
Washington	A-09-09-00049	10/1/2005 – 9/30/2008	$8,458,169
Wyoming	A-07-11-01100	1/1/2006 – 12/31/2010	$1,348,942
TOTAL			**$99,718,852**[46]

[46] Including the amounts set aside, which HHS-OIG elected to include in additional audits as part of the total amount of overbilling, the total amount of overbilling could be well over $100 million.

Further, HHS-OIG estimated these amounts, where applicable, using the lower limit at the ninety-percent confidence level, and not all audits questioned the medical necessity of the services or their eligibility for Medicaid reimbursement, thus questioning and calculating only the difference between the applicable FMAP and the enhanced ninety-percent federal funding rate, rather than zero reimbursement and the enhanced ninety-percent federal funding rate.

FEDERAL *QUI TAM* LAWSUITS AGAINST PLANNED PARENTHOOD AFFILIATES

There are five unsealed federal qui tam lawsuits pending against Planned Parenthood affiliates.

Bloedow v. Planned Parenthood of the Great Northwest

Alliance Defending Freedom attorneys represent federal False Claims Act whistleblower Jonathan Bloedow, a Washington resident who discovered the alleged frauds through state open records requests and filed suit against Planned Parenthood of the Great Northwest in July 2011. Planned Parenthood submitted "repeated false, fraudulent, and/or ineligible claims for reimbursement" to the state of Washington's Department of Social and Health Services.

Federal law allows "whistleblowers" with inside information to expose fraudulent billing by government contractors. By law, such cases must initially be filed under seal and may not be made public while federal authorities decide whether to join the case.

The suit alleges that Planned Parenthood submitted false claims to Washington's Department of Social and Health Services and its Health and Recovery Services Administration. HRSA runs the state's Title XIX Medicaid program.

The lawsuit alleges that Planned Parenthood of the Great Northwest filed at least 25,000 false claims with HRSA for reimbursements in excess of the amount allowed for oral contraceptive pills and at least another 25,000 for reimbursements in excess of the amount allowed for "emergency contraceptive" ("Plan B") pills under the federal government's 340B drug reimbursement program. Total damages could be as much as $377,134,130.

The allegations of Bloedow's complaint are consistent with a 2011 Government Accountability Office report[47] that concluded that HRSA monitoring of the 340B program was inadequate and recommended that "HRSA take steps to strengthen oversight regarding program participation and compliance with program requirements."

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[47] Report available at http://adfmedia.org/files/GAOReport.pdf.

Johnson v. Planned Parenthood Gulf Coast

Alliance Defending Freedom is representing former Planned Parenthood clinic director Abby Johnson in her federal False Claims Act lawsuit against Planned Parenthood's Houston and Southeast Texas affiliate in July 2010 and unsealed by a federal court in March 2012. This suit alleges that Planned Parenthood knowingly committed Medicaid fraud from 2007 to 2009 by submitting "repeated false, fraudulent, and ineligible claims for Medicaid reimbursements" through the Texas Women's Health Program for products and services not reimbursable by that program.

The lawsuit alleges that Planned Parenthood of Houston and Southeast Texas, now known as Planned Parenthood Gulf Coast, filed at least 87,075 false, fraudulent, or ineligible claims with the Texas Women's Health Program. As a result, Planned Parenthood wrongfully received and retained reimbursements totaling more than $5.7 million.

Johnson's lawsuit, *Johnson v. Planned Parenthood of Houston and Southeast Texas*, was recently dismissed on the "first-to-file bar" procedural grounds, since another former employee with knowledge of Planned Parenthood's business practices and alleging fraud had unbeknownst to Johnson already filed a sealed lawsuit alleging fraud in another area of Planned Parenthood finances. The case will be appealed to the U.S. Court of Appeals for the Fifth Circuit.

Thayer v. Planned Parenthood of the Heartland

In a federal lawsuit filed in March 2011 by Alliance Defending Freedom attorneys and made public on July 9, 2012, former Planned Parenthood clinic manager Sue Thayer alleged that Planned Parenthood's Iowa affiliate knowingly committed Medicaid fraud from 2002 to 2009 by filing nearly one half million false claims with Medicaid for products and services not legally reimbursable, from which Planned Parenthood received and retained nearly $28 million, and additionally failed to meet acceptable standards of medical practice.

Planned Parenthood submitted "repeated false, fraudulent, and/or ineligible claims for reimbursements" to Medicaid and failed to meet acceptable standards of medical practice according to a federal lawsuit made public on July 9, 2012. Alliance Defending

Freedom attorneys representing former Planned Parenthood clinic director Sue Thayer filed the lawsuit against the abortion giant's Iowa affiliate in March 2011 under a federal law that allows "whistleblowers" with inside information to expose fraudulent billing by government contractors. By law, such cases may not be made public until a court unseals them.

Thayer, former manager of Planned Parenthood's Storm Lake and LeMars clinics, alleges in the suit that Planned Parenthood knowingly committed Medicaid fraud from 2002 to 2009 by improperly seeking reimbursements from Iowa Medicaid Enterprise and the Iowa Family Planning Network for products and services not legally reimbursable by those programs. The lawsuit alleges that Planned Parenthood of Greater Iowa, an affiliate now known as Planned Parenthood of the Heartland, filed nearly one half million false claims with Medicaid, from which Planned Parenthood received and retained nearly $28 million. If Thayer prevails, Planned Parenthood could be ordered to pay the United States and Iowa as much as $5.5 billion in False Claims Act damages and penalties.

The lawsuit explains that, to enhance revenues, Planned Parenthood implemented a "C-Mail" program that automatically mailed a year's supply of birth control pills to women who had only been seen once at a Planned Parenthood clinic and usually by personnel who were not qualified healthcare professionals. Thereafter, thousands of unrequested birth control pills were mailed to these clients. Planned Parenthood's cost for a 28-day supply of birth control pills mailed to clients was $2.98. In turn, Planned Parenthood was reimbursed $26.32 for the birth control pills by the taxpayers through Medicaid. In some cases, birth control pills were returned to Planned Parenthood by the Postal Service. Instead of crediting Medicaid or destroying the returned pills, Planned Parenthood resold the same birth control pills and billed Medicaid twice for the same pills.

The suit also claims that Planned Parenthood coerced "voluntary donations" for services and then billed Medicaid for them. In effect, the lawsuit explains, Planned Parenthood both falsely billed Medicaid and took money from low-income women by getting them to pay for services Medicaid was intended to cover in full.

The lawsuit *Thayer v. Planned Parenthood of the Heartland* is on appeal on procedural grounds in the U.S. Court of Appeals for the Eighth Circuit.

Reynolds* and *Gonzalez

Two additional False Claims Act lawsuits are also currently pending in the federal court system: *United States and Texas ex rel. Karen Reynolds v. Planned Parenthood Gulf Coast*, formerly known as Planned Parenthood of Houston and Southeast Texas, Inc., in the U.S. District Court for the Eastern District of Texas, Lufkin Division, and *United States and California ex rel. P. Victor Gonzalez v. Planned Parenthood of Los Angeles* in the Ninth Circuit Court of Appeals. Both relators are represented in their False Claims Act complaints by American Center for Law and Justice.

Reynolds was employed as a Health Care Assistant at the Lufkin, TX, Planned Parenthood clinic from October 1999 to February 2009. Her complaint alleges that Planned Parenthood's clinics were required "to constantly increase their 'pay per visit' goals which were the bills charged to Medicaid for every patient visit." The policies were intended to maximize "the financial payments and grants made by Medicaid, either directly or through Texas' programs." Reynolds' complaint alleges that Planned Parenthood billed Medicaid for services that individual patients did not need, request, or warrant and that were not originally attested to by entries made in each individual patient's chart, and then Planned Parenthood employees altered patients' charts to reflect that all such services had actually been rendered. No damages are specified in the complaint.

Gonzalez was employed as Vice President of Finance and Administration (CFO) by Planned Parenthood of Los Angeles from December 2002 to March 2004. His complaint alleges that Planned Parenthood billed Medicaid for oral contraceptive pills and contraceptive devices far in excess of reimbursement limits set by federal and state law and received improper reimbursements far in excess of $200,000,000.

REPORT ON PLANNED PARENTHOOD AFFILIATES' MISUSE OF GRANTS FOR BREAST HEALTH TREATMENT AND EDUCATION

On April 3, 2013, Alliance Defending Freedom released a report identifying an additional area of waste, abuse, and potential fraud, this time in connection with the Susan G. Komen for the Cure breast health foundation's controversial grant program. Over the last several years, this program distributed nearly $3 million in grants to Planned Parenthood affiliates for the primary purpose of providing breast cancer screening and education services to low-income, Medicaid-eligible women. During this controversy and as detailed in the report, Planned Parenthood repeatedly claimed that it used Komen's grant funds to provide mammograms, clinical breast exams, and breast health education for low-income women. However, during the entire length of the grant program, not a single Planned Parenthood facility had mammography equipment on site or performed any mammograms. Nor was any Planned Parenthood clinic capable of or licensed for mammography, since no Planned Parenthood facility was licensed to perform mammograms.

Furthermore, the Komen report determined that, while the services Planned Parenthood did provide to Medicaid-eligible women were underwritten by Komen grants, Planned Parenthood nonetheless routinely sought reimbursement for these same services from Medicaid authorities without reflecting offsets for the amounts received from Komen, as it was required to do. In essence, Planned Parenthood affiliates were "double-dipping": accepting grant money to provide, in part, services they did not provide, then billing the "payor of last resort" Medicaid for the entire amount rather than reducing the bill by the amount already paid for by other insurance or a grant.

In the Komen report, Alliance Defending Freedom urged congressional oversight committees to:

1. Investigate whether Planned Parenthood is double-dipping by billing Medicaid (and thus federal taxpayers) for services that Komen and its donors are already paying it to provide.
2. Continue the investigation begun in September 2011 by the House Energy and Commerce Committee's Oversight and Investigations Subcommittee into

PPFA and its affiliates' use of federal funding and compliance with federal abortion funding restrictions.[48]

3. Vigorously pursue the February 21, 2013, request by Representative Dian Black, Representative Pete Olson, and seventy other Members of Congress requesting, among other things, "up-to-date information regarding federal funding of Planned Parenthood and other specific organizations."
4. Insist on greater transparency in reports maintained by federal and state Medicaid authorities on family planning program claims for reimbursements and reimbursements therefor.

This audit report only adds to the urgency and necessity of such oversight.

[48] *See* Medicaid Contractor Beneficiary and Provider Communications Manual, 60.3.2.4-Congressional Inquiries Timeliness, Mar. 3, 2010 (congressional inquiries must be responded to within ten business days).