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on Behalf of Himself, the United States of America,
6 and the State of California

7
8 **UNITED STATES DISTRICT COURT**
9 **FOR THE CENTRAL DISTRICT OF CALIFORNIA**

10
11 **P. VICTOR GONZALEZ, QUI TAM**
PLAINTIFF, ON BEHALF OF
12 **HIMSELF, THE UNITED STATES**
13 **OF AMERICA, AND THE STATE**
OF CALIFORNIA,

14 **Plaintiff,**

15 vs.

16 **PLANNED PARENTHOOD OF**
LOS ANGELES; PLANNED
17 **PARENTHOOD SHASTA-**
DIABLO; PLANNED
18 **PARENTHOOD GOLDEN GATE;**
PLANNED PARENTHOOD MAR
19 **MONTE; PLANNED**
PARENTHOOD OF SAN DIEGO &
20 **RIVERSIDE COUNTIES;**
PLANNED PARENTHOOD
21 **ORANGE & SAN BERNARDINO**
COUNTIES, INC.; PLANNED
22 **PARENTHOOD PASADENA AND**
SAN GABRIEL VALLEY, INC.;
23 **PLANNED PARENTHOOD SANTA**
BARBARA, VENTURA & SAN
24 **LUIS OBISPO COUNTIES, INC.;**
SIX RIVERS PLANNED
25 **PARENTHOOD; PLANNED**
PARENTHOOD AFFILIATES OF
26 **CALIFORNIA; MARY-JANE**
WAGLE; MARTHA SWILLER;
27 **KATHY KNEER; and DOES 1**
through 100,

28 **Defendants.**

Case No. CV05-8818 AHM
(FMOx)

FIRST AMENDED COMPLAINT
FOR:

- 1) **DAMAGES; AND**
- 2) **CIVIL PENALTY**

(FALSE CLAIMS ACTION)

[DEMAND FOR JURY TRIAL]

1 COMES NOW P. Victor Gonzalez, Qui Tam Plaintiff, on behalf of
2 himself, The United States of America and the State of California and alleges as
3 follows:

4 **INTRODUCTION**

- 5
- 6 1. Qui Tam Plaintiff/Relator P. Victor Gonzalez was the Chief Financial
7 Officer at Planned Parenthood of Los Angeles (PPLA) from December 9,
8 2002 to March 9, 2004. During his tenure, he became aware of rampant
9 over-billing and other violations of State and Federal law. Accordingly,
10 he tried to take corrective measures including urging reforms. Rather than
11 appropriately addressing these serious issues, Defendants terminated Mr.
12 Gonzalez' employment.
- 13
- 14 2. In January 2004, California state auditors began a statewide audit of all
15 Planned Parenthood affiliates to determine compliance with billing
16 regulations for drugs reimbursed by the Family Planning, Access, Care
17 and Treatment (FPACT) federal/state program. When the auditors started
18 at the Planned Parenthood San Diego/Riverside site and announced their
19 concerns regarding over-billing, Planned Parenthood notified their
20 lobbyists in Sacramento who in turn contacted state health officials in an
21 effort to stop the audits. This intervention proved successful as the
22 statewide audits were halted.
- 23
- 24 3. In November 2004 the Department of Health Services Audits and
25 Investigations Division issued an audit report which revealed findings of
26 over-billings greater than \$5 million during a two year period at the
27 Planned Parenthood/San Diego/Riverside affiliate alone. Planned
28 Parenthood was never held accountable for the extensive over-billing.

STATEMENT OF FACTS

1
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3 4. Qui Tam Plaintiff/Relator P. Victor Gonzalez was employed as the Vice
4 President of Finance & Administration with Planned Parenthood of Los
5 Angeles (PPLA) between December 9, 2002 and March 9, 2004. His job
6 duties required him to take initiative to ensure compliance with all
7 financial rules and regulations governing the financial activities of the
8 Defendants.

9
10 5. In the months preceding the termination of Mr. Gonzalez's employment
11 with PPLA, he raised various serious financial concerns directly related to
12 conduct violative of Federal and State statutes by the defendants. These
13 concerns about the illegal accounting, billing, and donations practices of
14 Planned Parenthood were conveyed via writing, e-mails and orally to
15 various Planned Parenthood personnel. The written concerns related
16 directly to Planned Parenthood's ability to remain qualified to legally
17 receive continued funding from public and private sources. Rather than
18 appropriately addressing these concerns, the response of the defendants
19 was to terminate Relator's employment.

20
21 6. Reviews of the subject matter of these concerns had been undertaken from
22 time to time by Planned Parenthood, its affiliates, and a number of
23 consultants. However, other than the memorialization of these concerns
24 during various meetings, there was no effective action to stem these
25 continuing patterns of illicit corporate misconduct. Mr. Gonzalez had led
26 numerous efforts in identifying and enumerating these considerable
27 problems and illicit activities, locating consultants, looking for viable
28 solutions, presenting these solutions to all necessary parties, and

1 procuring the employees to formulate the solutions.
2

3 7. Planned Parenthood affiliates in California are providers under several
4 federal/state programs which give reimbursement for drugs purchased
5 either through independent drug wholesalers or through the federal
6 340B¹ Drug program and then dispensed by Planned Parenthood's
7 clinics. Planned Parenthood provides services and dispenses
8 contraceptives and drugs to indigent people who have incomes under
9 the poverty level.
10

11 8. All ten Planned Parenthood affiliates had signed contracts with the
12 California FPACT program and it is this state run federal match
13 program (financed 10% by the State of California & 90% by Federal
14 funds) that Planned Parenthood must bill for reimbursement of drugs
15 bought and then dispensed. **The FPACT Manual of August 2001, the**
16 **manual that is given to every Planned Parenthood in California,**
17

18 ¹ When drugs such as contraceptives are purchased through the federal 340B program,
19 Section 340B of the Public Health Service Act requires drug manufacturers to provide
20 outpatient drugs to eligible health care centers, clinics and hospitals (termed "covered
21 entities.") at a reduced price. The 340B price is a "ceiling price", meaning it is the
22 highest price the covered entity would have to pay for select out-patient and over-the-
23 counter drugs. The entities, including Planned Parenthood, which are eligible to receive
24 federally discounted drugs are subject to various state and federal regulatory schemes
dictating their ability to dispense and seek reimbursement for these drugs. In 1992,
through enactment of section 340B of the Public Health Service Act, 42 U.S.C. § 256b,
Congress established the 340B Drug Discount Program (the "340B Program"). The purpose of
the 340B Program was to reduce drug prices for community health centers, public hospitals,
and others that provide healthcare to the homeless, the disabled, children, and the poor ("340B
Providers").

25 To reduce prescription drug prices for 340B Providers, section 340B requires
26 pharmaceutical manufactures to ensure that 340B Providers pay no more for any
27 pharmaceutical product than any other public or private purchaser of that product. Congress
28 intended the savings achieved by requiring pharmaceutical manufacturers to give 340B
Providers their best price to help "stretch Federal resources as far as possible, to reach more
eligible patients and provide more comprehensive services." H.R. Rpt. 102-384, 102d Cong.,
2d session, pt 2, at 12 (1992).

1 clearly states: "Family PACT requires that drugs and supplies
2 dispensed by the Family PACT provider must be billed at 'cost'."

3 (Exhibit "1a.") This unambiguous proscription prohibits Defendants
4 and any other eligible provider from buying at deeply discounted
5 prices and then billing at "usual and customary" rates rather than "at
6 cost."²

7
8 9. California and Federal law, including but not limited to the FFACT
9 rules and regulations, during all times pertinent to the within
10 complaint, clearly prohibit payment of dispensing fees for 340B drugs
11 dispensed to patients by clinics and prohibits reimbursement except
12 for "at cost" even when contraceptives are purchased outside the 340B
13 program and at even greater discount from wholesalers. All entities,
14 including Planned Parenthood, are subject to various state and federal
15 regulatory laws dictating their ability to dispense and seek
16 reimbursement for these drugs.

17
18 10. This would prohibit covered entities like Planned Parenthood from
19 buying contraceptives at deeply discounted prices and then asking for
20 reimbursement at a price higher than the purchase or "acquisition"
21 price.

22
23 11. The FFACT program has been in operation since January 6, 1997.
24 FFACT states that it provides family planning drugs and services for
25 those who have income under the poverty level. FFACT operates
26 under the authority of Section 1115(a)(2) of the Social Security Act

27
28 ² Explicit executed agreements entered into by all Planned Parenthoods specify that providers will comply with all laws. This includes the requirement to bill "at cost." (See, Exhibit "1b.")

1 and the State's Title XIX plan.

2
3 12. Rebates for drugs and services became effective in December 1999 when
4 California family planning programs became eligible for federal
5 reimbursement. Contraceptives dispensed by Planned Parenthood are
6 financed 10% by the state of California and 90% by federal financial
7 participation. In California, unless otherwise specified in the FPACT
8 manual, FPACT providers must comply with Medi-Cal rules and
9 regulations including those related to billing and reimbursement. The
10 State Medi-Cal regulation, adopted in 1994, states that: “(3)
11 Reimbursement for take-home drugs dispensed by clinics that have
12 obtained permits pursuant to Business and Professions Code Section 4063
13 et seq. shall not exceed the amounts payable for drug ingredient costs
14 under Section 51513. No dispensing fee or markup shall be paid.” Title
15 22 California Code of Regulations (CCR) Section 51509.1(c)(3).

16
17 13. The foregoing billing mandates are further outlined in the following:

18
19 A. 58 F.R. 27293 specifying that when a covered entity submits a bill
20 to the State Medicaid agency for a drug purchase by or on behalf of a
21 Medicaid beneficiary, the amount billed shall not exceed the entity’s
22 actual acquisition cost.

23
24 B. 22 C.C.R. 51509.1 specifying that “[r]eimbursement rates for take-
25 home drugs dispensed by clinics that have obtained permits pursuant to
26 Business and Professions Code Section 4063 et seq. shall not exceed the
27 amounts payable for drug ingredient cost under Section 51513. (22 C.C.R.
28 51513, Regulatory definitions of cost.)

1 C. Family PACT Manual specifying that "Family PACT requires that
2 drugs and supplies dispensed by Family PACT provider must be billed 'at
3 cost.'" (page 2.)
4

5 D. Medi-Cal Update: Medical Services Bulletin 353 referencing the 'at
6 cost' requirement.
7

8 14. Defendants were aware of the foregoing as this was specified in
9 correspondence between Planned Parenthood and the California
10 Department of Health Services dating as far back as 1997. This
11 correspondence, attached hereto as Exhibit "2", evidences
12 Defendants' knowledge of State and Federal billing mandates. This
13 correspondence includes:
14

15 A. A letter from Jane Boggess, Chief of the California State Office of
16 Family Planning (OFP), dated, May 5, 1997, in response to a letter from
17 Kathy Kneer, Executive Director of Planned Parenthood Affiliates of
18 California (PPAC), stating that there has been no change in Medi-Cal
19 reimbursement policy, and that the policy requires that providers bill at
20 cost. Ms. Boggess attached page 200-45-5 of the Medical Services
21 Provider Manual to the letter. ³ (Exhibit "2a.")
22

23 B. A letter from Darryl B. Nixon, Chief of the California State Medi-
24 Cal Benefits Branch, dated October 3, 1997, to Kathy Kneer clarifying
25

26 ³ Page 200-45-5 provides guidance to providers for "other contraceptive supplies and
27 medications (code X1500)," while the prior page 200-45-4 sets forth the requirements
28 specifically for filling oral contraceptives (code X7706). Additionally, community
clinics are prohibited, under Business and Professions Code §4063.7, from charging a
dispensing fee.

1 Medi-Cal policy regarding reimbursement for oral contraceptives
2 dispensed by clinics. Mr. Nixon states that “Medi-Cal claims for any drug
3 dispensed by physicians and clinics must be for ‘cost’, not ‘usual and
4 customary’” as has been billed by Planned Parenthood. (**Exhibit “2b.”**)
5

6 C. A letter from Kathy Kneer to Darryl B. Nixon, dated October 6,
7 1997, requesting clarification of the term “cost” as used in his letter of
8 October 3, 1997. This letter cites various provisions of Medi-Cal
9 regulations, claiming that the term “cost” as regards Medi-Cal billing is
10 ambiguous. (**Exhibit “2c.”**)
11

12 D. A letter from Darryl B. Nixon to Kathy Kneer, dated January 9,
13 1998, in response to the aforementioned October 6, 1997 letter wherein
14 Mr. Nixon cites the “Veterans Health Care Act of 1992” and Section
15 340B of the Public Health Service Act as the legal bases for directing
16 clinics to pass on cost savings for nominally priced and reduced price oral
17 contraceptive purchases by billing “at cost” for these drugs. Mr. Nixon
18 further notes that clinics with special pharmacy permits are prohibited
19 from charging a dispensing fee [B&P Code §4063.7]. (**Exhibit “2d.”**)
20

21 15. In fact, Planned Parenthood admitted that it billed at “usual & customary”
22 rates rather than “at cost.” The correspondence and documents attached
23 hereto as **Exhibit “3”** and referenced below evidence this billing scheme:
24

25 A. A letter from Mark Salo, President and CEO of Planned Parenthood
26 San Diego and Riverside counties to Assemblywoman Hannah-Beth
27 Jackson, dated August 9, 2004, indicating that Planned Parenthood uses
28 “usual Charge” rates rather than billing at cost. (**Exhibit “3a.”**)

1 B. A letter from Mark Salo to Assemblywoman Hannah-Beth Jackson,
2 dated August 16, 2004, asking that Planned Parenthood be allowed to
3 continue receiving reimbursements from the state at the “usual charge” for
4 contraceptives. (**Exhibit “3b.”**)

5
6 C. A letter from Mark Salo to Assemblywoman Debora Ortiz, dated
7 August 16, 2004, asking that Planned Parenthood be allowed to continue
8 receiving reimbursements from the state at the “usual charge” for
9 contraceptives. (**Exhibit “3c.”**)

10
11 D. Planned Parenthood Affiliates of California (PPAC) document
12 entitled FACT SHEET: AB 2151 (Jackson) admitting that “Planned
13 Parenthood clinics have been billing DHS at usual and customary for oral
14 contraceptives since the 1970s.” (**Exhibit “3d.”**)

15
16 16. California and Federal law provided payment for drugs be based on
17 acquisition cost. As further detailed below, Planned Parenthood violated
18 these regulations and vastly overbilled for reimbursements.

19
20 17. From late 2003 through the actual date of his termination, Mr. Gonzalez
21 had specifically complained about the following problems which
22 jeopardized PPLA’s ability to continue receiving government funding and
23 monies and to maintain its continuing status as a nonprofit organization.
24 Mr. Gonzalez complained, went on record on this matter, and, in an effort
25 to address these serious issues, participated in numerous phone calls with
26 the defendants, including PPLA, the other Planned Parenthood affiliates
27 in California, and the Sacramento based PPAC, under the direction of
28 Kathy Kneer.

- 1 18. The defendants had a practice of marking up drugs (oral contraceptives,
2 NuvaRing etc.) acquired at deep discounts and then significantly over-
3 billing the government. The effect of this was the defendants
4 overcharging the Federal Government, the State of California, and self-
5 pay patients.
6
- 7 19. For one of the defendants, PPLA, this resulted in overcharging over
8 \$2,000,000 per year. This has been going on for a number of years, and is
9 prevalent with the other California Planned Parenthood affiliates. As a
10 result the overcharging exceeds \$10,000,000.00 per year. During his
11 employment with PPLA, Mr. Gonzalez was requested by Mary-Jane
12 Wagle, CEO of PPLA, to perform an assessment of the impact of these
13 over-billing practices, and the other Planned Parenthood affiliates were
14 asked to do likewise. The result of this assessment report for PPLA
15 revealed approximately \$2,144,313.17 in over-billing. This reflects the
16 financial impact for only one of the then ten Planned Parenthood affiliates
17 in California and only for one year. (Attached hereto as **Exhibit "4"**, is a
18 copy of this assessment.)
19
- 20 20. In early February 2004, the California Department of Health Services
21 Audit and Investigations Branch began an audit of all ten Planned
22 Parenthood Affiliates in California starting with the Planned Parenthood
23 of San Diego & Riverside Counties affiliate. State officials intervened on
24 behalf of Defendants and stopped the statewide audits of Planned
25 Parenthood affiliates from being conducted. (Attached hereto as **Exhibit**
26 **"5"** is an email from Mark Salo referencing said audits.) The final audit
27 report of November 2004 was limited to the Planned Parenthood of San
28 Diego & Riverside Counties affiliate. The audit found extensive and

1 illegal markups of medications/contraceptives. Specifically, for the
2 approximately one year period subject to review, the audit uncovered at
3 least \$5,213,545.92 of illegal billing at Planned Parenthood of San Diego
4 & Riverside Counties alone. State officials within the California
5 Department of Health Services (DHS) chose to ignore these findings
6 notwithstanding the serious violations implicated thereby allowing the
7 illegal activity to continue unchecked. This is in spite of the fact that
8 Defendants had been continually counseled that they were required to bill
9 "at cost." On February 5, 2004, Kathy Kneer, President of Planned
10 Parenthood Affiliates of California (PPAC), Planned Parenthood's public
11 affairs operation, sent an e-mail to key Planned Parenthood personnel
12 informing them that "Kim [Belshe] (Secretary of the California Health
13 and Human Services Agency (CHHS)) is willing to discuss the policy
14 implications of requiring clinics to bill at acquisition cost-however, she
15 did state that DHS legal office has advised her that the law requires us to
16 bill at acquisition cost." (Attached hereto as **Exhibit "6"** is a copy of this
17 Feb. 5, 2004 email.) [Emphasis Added.]
18

19 21. Consequently, with full knowledge of the law, both on the part of State
20 officials and Defendants, and in spite of the audit verified violations, no
21 punitive, remedial, or even corrective actions were taken against
22 Defendants.
23

24 22. Contrary to their national reputation as a prominent charity organization
25 and as a health care provider for reproductive services, there is evidence
26 to show that Planned Parenthood's ten California affiliates have
27 systematically engaged in fraudulent over-billing against government
28 funded programs. Since at least 1997 the California Planned Parenthood

1 affiliates have bought drugs at discount prices and rather than selling the
2 drugs to their indigent clientele at the required Acquisition Cost, they
3 illegally marked-up the drugs and billed them to both clients and
4 government sometimes at greater than 12 times the acquisition cost. The
5 estimated illegal billing over six years, beginning in at least 1997, exceeds
6 \$180,000,000.00. This conservative figure only takes into account the
7 illegal and unscrupulous billing practices of Defendants within the state of
8 California.

10 THE FALSE CLAIMS ACT

11
12 23. The False Claims Act ("FCA") provides, in pertinent part that:

13 (a) Any person who (1) knowingly presents, or causes to be presented, to
14 an officer or employee of the United States Government or a member of
15 the Armed Forces of the United States a false or fraudulent claim for
16 payment or approval; (2) knowingly makes, uses or causes to be made or
17 used a false record or statement to get a false or fraudulent claim paid or
18 approved by the Government;... or (7) knowingly makes, uses, or causes
19 to be made or used, a false record or statement to conceal, avoid, or
20 decrease an obligation to pay or transmit money or property to the
21 Government,... is liable to the United States Government for a civil
22 penalty of not less than \$5,000 and not more than \$10,000 plus 3 times
23 the amount of damages which the Government sustains because the act of
24 the person...

25 (b) For purposes of this section, the terms "knowing" and "knowingly"
26 mean that a person, with respect to information (1) has actual knowledge
27 of the information; (2) acts in deliberate ignorance of the truth or falsity of
28 the information; or (3) acts in reckless disregard of the truth or falsity of

1 the information, and no proof of specific intent to defraud is required.
2 False Claims Act, 31 U.S.C. Section 3729
3

4 **JURISDICTION AND VENUE**

5
6 24. This action is brought under the False Claims Act ("FCA" or "Act"), 31
7 U.S.C. § 3729 et seq., by P. Victor Gonzalez ("Relator"), on behalf of the
8 United States of America, under the qui tam provisions of the Act. The
9 case also includes pendent state law claims for violations of the California
10 False Claims Act ("State False Claims Act"), Gov. Code § 12650 et seq.,
11 and the California Insurance Frauds Prevention Act, Ins. Code § 1871.7 et
12 seq., both of which permit interested persons to bring civil actions on
13 behalf of the State of California.

14
15 25. This Court has jurisdiction over this matter under 28 U.S.C. §§ 1331 and
16 28 U.S.C. § 1345, for the United States is a party to this matter and certain
17 of the causes of action set forth herein are founded upon a law of the
18 United States of America.

19
20 26. Venue lies in this District pursuant to 28 U.S.C. § 1391(b) and 31 U.S.C.
21 § 3732, for the defendants conduct business in this District, and a
22 substantial part of the events or omissions giving rise to the claims
23 occurred in this District.

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PARTIES

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27. Defendant PLANNED PARENTHOOD LOS ANGELES (PPLA) is a California nonprofit corporation that regularly conducts its business at 1920 Marengo Street, Los Angeles, California 90033-1317.

28. Defendant PLANNED PARENTHOOD SHASTA-DIABLO is a California nonprofit corporation that regularly conducts its business at 2185 Pacheco Street, Concord, California 94520.

29. Defendant PLANNED PARENTHOOD GOLDEN GATE is a California nonprofit corporation that regularly conducts its business at 815 Eddy Street #300, San Francisco, California 94109.

30. Defendant PLANNED PARENTHOOD MAR MONTE is a California nonprofit corporation that regularly conducts its business at 1691 The Alameda, San Jose, California 95126.

24. Defendant PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTIES is a California nonprofit corporation that regularly conducts its business at 1075 Camino Del Rio South, San Diego, California 92108.

25. Defendant PLANNED PARENTHOOD OF ORANGE & SAN BERNARDINO COUNTIES, INC. is a California nonprofit corporation that regularly conducts its business at 700 S. Tustin Street, Orange, California 92866.

26. Defendant PLANNED PARENTHOOD PASADENA AND SAN

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GABRIEL VALLEY, INC. is a California nonprofit corporation that regularly conducts its business at 1045 N. Lake Avenue, Pasadena, California 91104.

27. Defendant PLANNED PARENTHOOD OF SANTA BARBARA, VENTURA & SAN LUIS OBISPO COUNTIES, INC. is a California nonprofit corporation that regularly conducts its business at 518 Garden Street, Santa Barbara, California 93101.

28. Defendant SIX RIVERS PLANNED PARENTHOOD is a California nonprofit corporation that regularly conducts its business at 2316 Harrison Avenue, Eureka, California 95501.

29. Defendant PLANNED PARENTHOOD AFFILIATES OF CALIFORNIA (PPAC) is a California nonprofit corporation that regularly conducts its business at 555 Capitol Mal, Suite 510, Sacramento, California 95814.

30. Defendant MARY JANE WAGLE was at all times relevant to this complaint an individual and an employee of PPLA in the capacity of chief executive officer (CEO).

31. Defendant MARTHA SWILLER was at all times relevant to this complaint an individual and an employee of PPLA formerly in the capacity of chief executive officer (CEO) and currently Vice President.

32. Defendant KATHY KNEER was at all times relevant to this complaint an individual and an employee of PPAC in the capacity of President.

1 33. Defendants Does 1 through 100 are PLANNED PARENTHOOD (PP)
2 districts, and individual PLANNED PARENTHOOD affiliates/clinics;
3 employees and agents of PLANNED PARENTHOOD districts and
4 individual PLANNED PARENTHOOD affiliates/clinics; and individuals,
5 persons, associations and organizations, whose identity and capacity are
6 presently unknown to Relator. Relator is informed and believes and
7 thereon alleges that Defendants Does 1 through 100 are legally
8 responsible and liable for the acts, omissions, injuries, damages and false
9 claims hereinafter set forth and that each of said Defendants legally and
10 proximately caused the injuries and damages herein alleged by reason of
11 the conduct hereinafter set forth, or by reason of direct or imputed
12 negligence or vicarious fault or breach of duty arising out of the matters
13 herein alleged. Relator will seek leave to amend this Complaint to set
14 forth the true names, capacities and identities of Does 1 through 100,
15 when same are ascertained.

16
17 34. Qui Tam Plaintiff/Relator, P. Victor Gonzalez is an individual
18 residing/domiciled in San Diego County, State of California. Relator was
19 employed as the Vice President of Finance & Administration with
20 Defendant PPLA between December 9, 2002 and March 9, 2004.

21
22 35. This action by Relator is not based upon a "public disclosure" as defined
23 by 31 U.S.C. § 3730(e)(4)(A), and even if there were a public disclosure
24 in this case, Relator would qualify as an "original source" as defined by
25 31 U.S.C. § 3730(e)(4)(A). P. Victor Gonzalez relayed the information
26 contained herein to the DHS services auditor by e-mail correspondence,
27 and further relayed the information contained herein to the Department of
28 Justice, the Health and Human Services Office of the Inspector General,

1 the Federal Bureau of Investigations, and the Los Angeles County District
2 Attorney as the "original source" of this information. (Attached hereto as
3 Exhibit "7" are true and correct copies of correspondence directed to the
4 aforementioned Entities/Individuals)

5
6 36. Relator is informed and believes and thereon alleges that at all times
7 relevant, some or all of the Defendants, including each and every Doe
8 Defendant, were agents and/or employees of some or all of the remaining
9 Defendants, and in doing each of the things alleged hereinafter were
10 acting within the course and scope of said agency and/or employment.

11
12 37. Relator is informed and believes and thereon alleges that at all times
13 relevant, Defendants, and each of them, including each and every Doe
14 Defendant, authorized and ratified some or all of the acts and omissions
15 alleged hereinafter.

16
17 38. Relator is informed and believes and thereon alleges that at all times
18 relevant, Defendants, and each of them, including each and every Doe
19 Defendant, conspired with some or all of the remaining Defendants
20 herein, including Doe Defendants, to commit the acts and omissions
21 hereinafter alleged, and are therefore jointly and severally liable pursuant
22 to Federal and State law for some or all of the acts and omissions
23 hereafter alleged, and are liable for the injuries, damages and penalties
24 hereinafter alleged.

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GENERAL ALLEGATIONS

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3 39. At all times relevant to this Complaint, the Defendants provided care and
4 prescription medications including contraceptives to Patients and/or
5 clients at one or more of the facilities referenced above. Defendants
6 receive funding from State and Federal governments, from private donors,
7 certain insurance plans, and from fees received from patients.

8
9 40. At all times relevant to this Complaint, Defendants were under signed
10 contract with both federal and state government programs and were
11 authorized providers of services to patients insured by Medicare,
12 Medicaid, the Family Planning, Access, Care and Treatment (FPACT)
13 program under the authority of section 1115(a)(2) of the Social Security
14 Act, and other federally funded programs. All of these federally funded
15 programs are collectively referred to hereinafter as "Federal Insurers."
16 Defendants also received benefits pursuant to Section 340B of the Public
17 Health Service Act.

18
19 41. Relator was employed as the Vice President of Finance & Administration
20 with Defendant PPLA between December 9, 2002 and March 9, 2004.
21 His job duties statutorily required him to report violations to the various
22 State and Federal Agencies and regulators, and take initiative to ensure
23 compliance with all financial rules and regulations governing the business
24 activities of the Defendant.

25
26 42. In the months preceding Relator's employment termination, he had raised
27 various serious financial concerns directly related to conduct violative of
28 Federal and State statutory schemes. These concerns about the illegal

1 accounting, billing, and donations practices of the Defendant were
2 conveyed via writing, e-mails or orally. The written concerns related
3 directly to Planned Parenthood's ability to remain qualified to legally
4 receive continued funding from public and private sources. (Attached
5 hereto as Exhibit "8" are true and correct copies of e-
6 mails/correspondence regarding Relator's concerns)
7

8 43. A review of these problems had been undertaken from time to time by
9 PPLA, its affiliates, a number of consultants, and internal reviews
10 conducted by PPLA employees and Board members. Relator had led the
11 effort in identifying and enumerating these considerable problems and
12 illicit activities, locating consultants, looking for viable solutions,
13 presenting these solutions to all necessary parties, and procuring the
14 employees to formulate the solutions. Attached hereto is a true and
15 correct copy of the original draft report that mentions the various
16 problems that existed at PPLA during Plaintiff's employment. (See
17 Exhibit "9"). This report was subsequently altered by Mary-Jane Wagle.
18 (See Exhibit "10").
19

20 44. From late 2003 through the actual date of his employment termination,
21 Plaintiff had specifically complained about the following problems which
22 jeopardized the defendants' ability to continue receiving government
23 funding and monies and to maintain continuing status as nonprofit
24 organizations. Many of these complaints are mentioned in Exhibit "11",
25 a true and correct copy of a memorandum provided to upper management
26 at Planned Parenthood.
27

28 45. PPLA had a practice of marking up drugs (oral contraceptives, NuvaRing

1 etc) over and above acquisition cost. The effect of this at PPLA is
2 overcharging the Federal Government, the State of California, and self-
3 pay patients approximately \$2,000,000.00 per year. This has been going
4 on for a number of years, and is prevalent with all the other California PP
5 affiliates. As a result the overcharging exceeds \$10,000,000.00 per year.
6

7 46. Relator complained, went on record on this matter, and, in an effort to
8 address these serious issues, participated in numerous phone calls with
9 both PPLA and the Sacramento based PPAC (political action committee).
10

11 47. In early February 2004, The California Department of Health Services
12 began an audit of all ten Planned Parenthood affiliates in California
13 beginning with the Planned Parenthood of San Diego & Riverside
14 Counties affiliate. The final audit report was limited to the Planned
15 Parenthood of San Diego & Riverside Counties affiliate. The audit found
16 extensive and illegal markups of medications/contraceptives in excess of
17 cost. Specifically, the audit uncovered at least \$5,213,545.92 of illegal
18 billing at Planned Parenthood of San Diego & Riverside Counties alone in
19 one fiscal year. (Attached hereto as **Exhibit "12"** is a true and correct
20 copy of the audit and letter detailing the illegal activity.) The Audit
21 Report found extensive and illegal markups of
22 medications/contraceptives "in excess of cost" for a total of
23 \$5,213,545.92 in one fiscal year. The Audit Report also documented
24 that the requirement (to bill at cost) " was in effect for the entire audit
25 period," and "In December 2003 the Department issued a Medi-Cal
26 Update, Medical Services bulletin 353 which reminded providers of the
27 existing policy that contraceptive supplies must be billed at cost."
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1 48. The California Department of Health Services, following intervention by
2 Defendants, chose to ignore these findings notwithstanding the serious
3 violations implicated allowing for this illegal activity to continue
4 unchecked.

5
6 49. During all times pertinent to this complaint, there were ten separate
7 Planned Parenthood affiliates in California each of which also engaged in
8 the same unscrupulous billing practices. These Nine affiliates are part of
9 a nationwide organization consisting of 103 affiliates forming the Planned
10 Parenthood Federation of America. The estimated illegal billing of the
11 defendants over six years, beginning in approx. 1997, exceeds
12 \$180,000,000.00. This conservative figure only takes into account the
13 illegal and unscrupulous billing practices of Defendants within the state of
14 California.

15
16 50. The actions of PPLA and other Defendants resulted in violations of the
17 public policy set forth in or furthered by OMB Circular A-133, FPACT
18 Written Regulations, 61 CFR 4359, Section 340B of Public Law 102-585
19 (Veterans Health Care Act of 1992), regulations of the Office of
20 Pharmacy Affairs, and US Department of Health & Human Services
21 regulations, California Government Code §§ 12650-12655, 31 U.S.C. §
22 3729 et seq., and various other statutes and regulations.

23
24 51. While applicable regulations are designed to protect the most vulnerable
25 of patient populations by reducing the costs of drugs, a fundamental
26 public policy, PPLA and other Defendants have instead undercut this
27 policy by overcharging, creating excess inventory, and other acts designed
28 to generate revenue for themselves at the expense of the public.

- 1 52. Relator additionally complained of filing, providing doctored and rosy
2 financial projections, and suppression of Single Audit Report (OMB 133)
3 findings to California Health Facilities Financing Authority (CHFFA)
4 with the intention of inducing CHFFA to approve a loan of \$400,000 to
5 save PPLA's South Los Angeles clinic.
6
- 7 53. PPLA intentionally did not disclose the Single Audit findings and
8 material weaknesses to CHFFA or other regulatory agencies, even though
9 it pointed out failures in management and financial controls. This Single
10 Audit report covered precisely the period under review and being
11 questioned by CHFFA officials. In fact, the Single Audit report's
12 findings likely disqualified PPLA from many other government programs.
13
- 14 54. PPLA also sought to hide the losses and the funding freeze from the
15 California Family Health Council (CHFC)—over half a million dollars in
16 the same 2002 period. Mary-Jane Wagle sent an email advising Relator
17 to be deliberately vague in these disclosures. The chairman of the PPLA
18 finance committee was copied in this email. True and correct copies of
19 emails evidencing the scheme to suppress and camouflage as well as
20 continue the aforementioned illegal activity are attached as Exhibit "13".
21
- 22 55. Rather than remedying the multiple serious problems identified by
23 Relator, Defendants instead terminated his employment.
24
- 25 56. At and before the time of Relator's termination it was the intent of PPLA
26 to suppress information relating to illegal billing from the government,
27 potential auditors, and members of the public. Moreover, Defendants
28 knew that false and misleading information had been provided to the State

1 of California, private funding sources, and the federal government, and
2 that billing codes used by PPLA were creating problems that would affect
3 funding. (See Exhibit "14").

4
5 57. The violations of normally accepted financial practices, rules and
6 regulations by Defendants placed the State of California, the United
7 States, and private grant sources at risk of serious financial loss.
8 Defendants disregarded these policies by suppressing Relator's findings,
9 by terminating his employment in order to further prevent the lawfully
10 required disclosure of damaging facts known by Relator and Defendants,
11 and by intentionally failing to disclose the facts discovered by Relator to
12 funding sources such as the State of California, and the federal
13 government by and through its agents within the State of California.

14
15 58. Relator's negative findings and reports to management were known to
16 Defendants and their leadership throughout the latter part of 2003 and up
17 until the time that Relator was terminated in March 2004.

18
19 59. Relator is informed and believes that at all times relevant to this
20 Complaint, Defendants submitted, or caused to be submitted, claims for
21 reimbursement for prescription medications/contraceptives and services
22 provided to Medicare, Medicaid, and FPACT patients to the Health Care
23 Financing Administration ("HCFA"), an agency of the Department of
24 Health and Human Services ("HHS"), for payment.

25
26 60. At all times relevant to this Complaint, Defendants were authorized
27 providers of services to patients insured by Medi-Cal and other State
28 funded programs. All of these state funded programs are collectively

1 referred to hereinafter as "State Insurers."

2
3 61. Relator is informed and believes and thereon alleges that, at all times
4 relevant to this Complaint, Defendants submitted, or caused to be
5 submitted, claims for reimbursement for services provided to individuals
6 insured by Medi-Cal to Electronic Data Systems, Inc., which then
7 forwarded those claims to the Department of Health Services for ultimate
8 payment by the Controller of the State of California. Relator is informed
9 and believes and thereon alleges that, at all times relevant to this
10 Complaint, the State of California received at least 90% of its funding
11 from HHS for payments made on behalf of Medi-Cal patients.

12
13 62. Between at least 1997 and the present, Defendants have knowingly
14 engaged in a series of fraudulent billing practices that have damaged State
15 and Federal Insurers. Defendants have been unjustly enriched by these
16 practices, directly or indirectly, in the form of excessive payments for the
17 services provided.

18
19 63. At all times relevant to this Complaint, defendants billed, or caused to be
20 billed, State and Fiscal Intermediaries who act on behalf of the State and
21 the Federal Government, well in excess of allowable rates as prescribed
22 by the various statutes, regulations, and guidelines outlined above.

23
24 64. This was widely known to the Defendants and was the subject of emails
25 with PPAC. The alleged justification for this misconduct, as evident in
26 the subject emails, was that the entire system was compensating for the
27 shortfall in the basic visits charge that the State and by derivation the
28 Federal government allowed. Complying with proper billing practices

1 would have meant that Defendants' entire healthcare delivery system
2 would have had to be significantly reshaped adopting more austere
3 budgets and forestalling its expansion. It follows that complying with
4 proper billing practices was not in Defendants' best interests and therefore
5 was disregarded.

6
7 65. A report of PPLA's billing practices was performed on or about January
8 2004. (See **Exhibit "4"**) The report, which focused on the provision of
9 contraceptives and subsequent reimbursements, showed that the extent of
10 defendants' fraud was pervasive. The report indicates that defendants
11 routinely engaged in numerous other improper billing practices and
12 collected substantially higher reimbursement amounts for these
13 contraceptives than if they had billed correctly.

14
15 66. The internally prepared study, responsive to a call to action by PPAC, was
16 based on PPLA records from 2002 through 2003. It represented a 12
17 month projection and it is representative of the general billing practices
18 and exorbitant over-billing by Defendants. Based on his experience
19 working at PPLA, Relator is informed and believes that other defendants
20 were at least equally aggressive, if not more so, when billing on behalf of
21 patients insured by State and Federal Insurers.

22
23 67. Relator is further informed and believes that the Defendants' aggressive
24 billing practices with State and Federal Insurers were in place from as
25 early as 1997 and persisted consistently thereafter. Previous auditing had
26 revealed similar patterns of over-billing on the part of Defendants dating
27 back to 1997 and earlier, yet the problems were not corrected by
28 defendants.

1
2 68. Defendants were made aware of the various aforementioned
3 improprieties. Nonetheless, Relator is informed and believes that
4 Defendants have not reimbursed State or Federal Insurers for the amounts
5 that have been improperly and falsely billed. Relator is further informed
6 and believes that Defendants continued to engage in the unlawful
7 practices described herein even after the problems were brought to their
8 attention.
9

10 **COUNT I**

11 (Submission of False Claims in Violation of 31 U.S.C, § 3729(a)(1))

12 (All Defendants)
13

14 69. Relator realleges and incorporates all allegations including paragraphs 1
15 through 68 of this Complaint as if fully set forth herein.
16

17 70. Between at least 1997 and the present, Defendants have knowingly
18 submitted, or caused to be submitted, claims for payment by Federal
19 Insurers, FPACT, and Medi-Cal for higher levels of Evaluation and
20 Management (E&M) services than were actually provided to patients as
21 well as reimbursements for medications/contraceptives in excess of
22 allowable limits.
23

24 71. Relator is informed and believes that, between at least 1997 and the
25 present, Defendants have knowingly over-billed Federal Insurers, FPACT,
26 and Medi-Cal.
27

28 72. Defendants thus knowingly caused the submission of false claims to the

1 United States in violation of the False Claims Act. The exact amount of
2 the United States' harm has not yet been determined. The precise amount
3 of damage caused by defendants will be ascertained at trial.
4

5 **COUNT II**

6 (Use of False Statements or Records or Statements in Violation of 31 U.S.C.
7 § 3729(a)(2)) (All Defendants)
8

9 73. Relator realleges and incorporates all allegations including paragraphs 1
10 through 72 of this Complaint as if fully set forth herein.
11

12 74. Between at least 1997 and the present, Defendants knowingly prepared or
13 caused to be prepared false records and/or statements in connection with
14 Evaluation and Management (E&M) services provided to patients.
15

16 75. Relator is informed and believes that, between at least 1997 and the
17 present, Defendants also knowingly prepared false records and/or
18 statements in connection with billing for medications/contraceptives.
19

20 76. Defendants thus knowingly used false records or statements to get false or
21 fraudulent claims paid or approved by the United States in violation of the
22 False Claims Act. The exact amount of the United States' harm has not yet
23 been determined. The precise amount of damage caused by defendants
24 will be ascertained at trial.

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COUNT III

(Conspiracy to Get False Claims Paid - 31 U.S.C. § 3729(a)(3))

(All Defendants)

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77. Relator realleges and incorporates all allegations including paragraphs 1 through 76 of this Complaint as if fully set forth herein.

78. Between at least 1997 and the present, Defendants agreed on the submission of claims that were known by each to be false by reason of the practices described herein.

79. Defendants thus knowingly conspired to defraud the United States by getting false claims paid in violation of the False Claims Act. The exact amount of the harm has not yet been determined. The precise amount of damage caused by Defendants will be ascertained at trial.

COUNT IV

(Conspiracy to defraud the Government with respect to claims in Violation of

18 USC Section 286) (All Defendants)

80. Relator realleges and incorporates all allegations including paragraphs 1 through 79 of this Complaint as if fully set forth herein.

81. Between at least 1997 and the present, Defendants agreed on the submission of claims for services, which were known by each to be false by reason of the practices described herein, to Federal Insurers.

82. Defendants thus knowingly conspired to defraud the State of California

1 and the United States by getting false claims paid in violation of the False
2 Claims Act and the within statute. Relator is informed and believes and
3 thereon alleges that the United States and the State of California were
4 damaged by Defendants in an amount as yet unknown. The exact amount
5 of the United States' harm has not yet been determined. The precise
6 amount of damage caused by Defendants will be ascertained at trial.
7

8 **COUNT V**

9 (False, fictitious or fraudulent claims in Violation of 18 USC Section 287) (All
10 Defendants)
11

12 83. Relator realleges and incorporates all allegations including paragraphs 1
13 through 82 of this Complaint as if fully set forth herein.
14

15 84. Between at least 1997 and the present, Defendants have knowingly
16 submitted, or caused to be submitted, claims for payment by Federal
17 Insurers, FPACT, and Medi-Cal for higher levels of Evaluation and
18 Management (E&M) services than were actually provided to patients as
19 well as reimbursements for medications/contraceptives in excess of
20 allowable limits.
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22 85. Relator is informed and believes that, between at least 1997 and the
23 present, Defendants have knowingly overbilled Federal Insurers, FPACT,
24 and Medi-Cal.
25

26 86. Defendants thus knowingly caused the submission of false claims to the
27 United States and the State of California in violation of the False Claims
28 Act and the within statute. Relator is informed and believes and thereon

1 alleges that the United States and the State of California were damaged by
2 Defendants in an amount as yet unknown. The exact amount of the harm
3 has not yet been determined. The precise amount of damage caused by
4 Defendants will be ascertained at trial.

5
6 **COUNT VI**

7 (Conspiracy to commit offense or to defraud United States in Violation of 18
8 USC Section 371) (All Defendants)
9

10 87. Relator realleges and incorporates all allegations including paragraphs 1
11 through 86 of this Complaint as if fully set forth herein.
12

13 88. Between at least 1997 and the present, Defendants agreed on the
14 submission of claims for services, which were known by each to be false
15 by reason of the practices described herein.
16

17 89. Defendants thus knowingly conspired to defraud the State of California
18 and the United States by getting false claims paid in violation of the False
19 Claims Act and the within statute. Relator is informed and believes and
20 thereon alleges that the United States and the State of California were
21 damaged by Defendants in an amount as yet unknown. The exact amount
22 of the harm has not yet been determined. The precise amount of damage
23 caused by Defendants will be ascertained at trial.

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COUNT VII

(False statements relating to health care matters in Violation of 18 USC Section 1035) (All Defendants)

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90. Relator realleges and incorporates all allegations including paragraphs 1 through 89 of this Complaint as if fully set forth herein.

91. Between at least 1997 and the present, Defendants made and used materially false writings and documents knowing the same to contain materially false, fictitious, or fraudulent statements and/or entries, in connection with the delivery of or payment for health care benefits.

92. In so doing, Relator is informed and believes that, between at least 1997 and the present, Defendants have knowingly overbilled Federal Insurers, FPACT, and Medi-Cal.

93. Defendants thus knowingly caused the submission of false claims to the United States and the State of California in violation of the False Claims Act and the within statute. Relator is informed and believes and thereon alleges that the United States and the State of California were damaged by Defendants in an amount as yet unknown. The exact amount of the harm has not yet been determined. The precise amount of damage caused by Defendants will be ascertained at trial.

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1 **COUNT VIII**

2 (Submission of False Claims - Violation of California Government Code
3 Section 12651(a)(1)) (All Defendants)
4

5 94. Relator realleges and incorporates all allegations including paragraphs 1
6 through 93 of this Complaint as if fully set forth herein.
7

8 95. Between at least 1997 and the present, Defendants have knowingly
9 submitted, or caused to be submitted, claims for payment by State
10 Insurers (including Medi-Cal) for higher levels of E&M services and
11 other types of services, medications, and drugs, than were actually
12 provided to patients.
13

14 96. Relator is informed and believes that, between at least 1997 and the
15 present, Defendants have knowingly over-billed State Insurers (including
16 Medi-Cal) for medications/contraceptives.
17

18 97. Defendants thus knowingly caused the submission of false claims to the
19 State of California in violation of the California False Claims Act. The
20 exact amount of the State of California's harm has not yet been
21 determined. Relator is informed and believes and thereon alleges that the
22 State of California was damaged by Defendants in an amount as yet
23 unknown. The precise amount of damage caused by Defendants will be
24 ascertained at trial.

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COUNT IX

(Use of False Statements or Records - California Government Code Section
12651(a)(2)) (All Defendants)

98. Relator realleges and incorporates all allegations including paragraphs 1 through 97 of this Complaint as if fully set forth herein.

99. Between at least 1997 and the present, Defendants knowingly prepared or caused to be prepared false records and/or statements in connection with Evaluation and Management (E&M) services provided to patients.

100. Relator is informed and believes that, between at least 1997 and the present, Defendants also knowingly prepared false records and/or statements in connection with billing for medications/contraceptives.

101. Defendants thus knowingly used false records or statements to get false or fraudulent claims paid or approved by the State of California in violation of the California False Claims Act. The exact amount of the State of California's harm has not yet been determined. The precise amount of damage caused by Defendants will be ascertained at trial.

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COUNT X

(Inadvertent Submission of False Claims - California Government Code Section
12651(a)(8)) (All Defendants)

102. Relator realleges and incorporates all allegations including paragraphs 1 through 101 of this Complaint as if fully set forth herein.

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1 103. By virtue of the acts and omission described above, Defendants are the
2 beneficiary of inadvertent submissions of false claims to the State of
3 California and failed to disclose the false claims to the State of California
4 within a reasonable time after their subsequent discovery of the falsity of
5 the claims.

6
7 104. The exact amount of the State of California's harm has not yet been
8 determined. Relator is informed and believes and thereon alleges that the
9 State of California was damaged by Defendants in an amount as yet
10 unknown. The precise amount of damage caused by Defendants will be
11 ascertained at trial.

12
13 **COUNT XI**

14 (Conspiracy to Submit False Claims - Government Code Section 12651(a)(3))

15 (All Defendants)

16
17 105. Relator realleges and incorporates all allegations including paragraphs 1
18 through 104 and all preceding paragraphs of this Complaint as if fully set
19 forth herein.

20
21 106. Between at least 1997 and the present, Defendants agreed on the
22 submission of claims for services, which were known by each to be false
23 by reason of the practices described herein, to Federal and State Insurers.

24
25 107. Defendants thus knowingly conspired to defraud the State of California by
26 getting false claims paid in violation of the State False Claims Act. The
27 exact amount of the State's harm has not yet been determined. The
28 precise amount of damage caused by Defendants will be ascertained at

1 trial.

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COUNT XII

4

(Unjust Enrichment) (All Defendants)

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108. Relator realleges and incorporates all allegations including paragraphs 1 through 107 and all preceding paragraphs of this Complaint as if fully set forth herein.

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109. This is a claim for the recovery of monies and the reasonable value of benefits such as improper and excessive reimbursement by which Defendants have been unjustly enriched through the fraud committed against the United States and the State of California.

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110. By directly or indirectly obtaining government funds and benefits to which they were not entitled Defendants were unjustly enriched and are liable to account and pay such amounts or the proceeds therefrom. The exact amount of harm to United States and the State of California has not yet been determined. The precise amount of damage caused by Defendants will be ascertained at trial.

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PRAYER FOR RELIEF

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3 112. WHEREFORE, Plaintiff/Relator prays for judgment against Defendants
4 as follows:

5
6 A. On Count I (Submission of False Claims), an order holding each of the
7 Defendants liable for treble the single damages they caused, the amount of
8 which is to be established at trial, penalties of \$10,000 for each false
9 claim, the number of which is to be established at trial, plus such other
10 relief as this Court deems just and appropriate;

11
12 B. On Count II (Use of False Statements or Records), an order holding each
13 of the Defendants liable for treble the single damages they caused, the
14 amount of which is to be established at trial, penalties of \$10,000 for each
15 false statement or record, the number of which is to be established at trial,
16 plus such other relief as this Court deems just and appropriate;

17
18 C. On Count III (Conspiracy to Get False Claims Paid), an order holding
19 each of the Defendants liable for treble the single damages they caused,
20 the amount of which is to be established at trial, penalties of \$10,000 for
21 each false statement or claim, the number of which is to be established at
22 trial, plus such other relief as this Court deems just and appropriate;

23
24 D. On Count IV (Conspiracy to defraud the Government with respect to
25 claims in Violation of 18 USC Section 286) an order holding each of the
26 Defendants liable for treble the single damages they caused, the amount of
27 which is to be established at trial, penalties of \$10,000 for each false
28 statement or record, the number of which is to be established at trial, Any

1 applicable fines pursuant to Title 18, plus such other relief as this Court
2 deems just and appropriate;

3
4 E. On Count V (False, fictitious or fraudulent claims in Violation of 18 USC
5 Section 287) an order holding each of the Defendants liable for treble the
6 single damages they caused, the amount of which is to be established at
7 trial, penalties of \$10,000 for each false statement or record, the number
8 of which is to be established at trial, Any applicable fines pursuant to Title
9 18, plus such other relief as this Court deems just and appropriate;

10
11 F. On Count VI (Conspiracy to commit offense or to defraud United States
12 in Violation of 18 USC Section 371) an order holding each of the
13 Defendants liable for treble the single damages they caused, the amount of
14 which is to be established at trial, penalties of \$10,000 for each false
15 statement or record, the number of which is to be established at trial, Any
16 applicable fines pursuant to Title 18, plus such other relief as this Court
17 deems just and appropriate;

18
19 G. On Count VII (False statements relating to health care matters in
20 Violation of 18 USC Section 1035) an order holding each of the
21 Defendants liable for treble the single damages they caused, the amount of
22 which is to be established at trial, penalties of \$10,000 for each false
23 statement or record, the number of which is to be established at trial, Any
24 applicable fines pursuant to Title 18, plus such other relief as this Court
25 deems just and appropriate;

26
27 H. On Count VIII (Submission of False Claims in Violation of California
28 Government Code Section 12651(a)(1)), an order holding each of the

1 Defendants liable for treble the single damages they caused, the amount of
2 which is to be established at trial, penalties of \$10,000 for each false
3 claim, the number of which is to be established at trial, plus such other
4 relief as this Court deems just and appropriate;

5
6 I. On Count IX (Use of False Statements or Records in Violation of
7 California Government Code Section 12651(a)(2)), an order holding each
8 of the Defendants liable for treble the single damages they caused, the
9 amount of which is to be established at trial, penalties of \$10,000 for each
10 false statement or record, the number of which is to be established at trial,
11 plus such other relief as this Court deems just and appropriate;

12
13 J. On Count X (Inadvertent Submission of False Claims in Violation of
14 California Government Code Section 12651(a)(8)), an order holding each
15 of the Defendants liable for treble the single damages they caused, the
16 amount of which is to be established at trial, penalties of \$10,000 for each
17 false statement or claim, the number of which is to be established at trial,
18 plus such other relief as this Court deems just and appropriate;

19
20 K. On Count XI (Conspiracy to Get False Claims Paid in Violation of
21 California Government Code Section 12651(a)(3)), an order holding each
22 of the Defendants liable for treble the single damages they caused, the
23 amount of which is to be established at trial, penalties of \$10,000 for each
24 false statement or claim, the number of which is to be established at trial,
25 plus such other relief as this Court deems just and appropriate.

26
27 L. On Count XII (Unjust Enrichment) disgorgement of unjustly obtained
28 funds, plus such other relief as this Court deems just and appropriate;

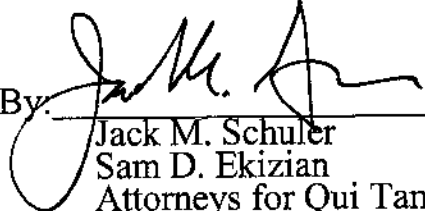
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M. That Qui Tam Plaintiff/Relator be awarded all costs of this action, including attorneys' fees and costs;

N. That the United States, State of California, and Qui Tam Plaintiff/Relator receive such other relief as the Court deems just and proper.

DATED: APRIL 30, 2008

SCHULER & BROWN

By: 

Jack M. Schuler
Sam D. Ekizian
Attorneys for Qui Tam
Plaintiff, On Behalf of
Himself, the United States &
the State of California

(All CA Planned Parenthoods contract with the state and federal reimbursement programs under FPACT)

FPACT MANUAL August 2001

Family Planning Planning Access Care and Treatment:
a State of California program that is also federally funded
The program is meant to serve poor people, and is under
the auspices of the fiscal authority of the Medi-Cal
Benefits Branch

MEDI-CAL / FAMILY PACT RULES FOR DRUG REIMBURSEMENT Regulatory Definitions of "Cost" Title 22 Section 51513

familyfact22

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Prior Authorization Requirements

Family PACT clients may require drugs not included in this Drug and Supply List for complication services. All additional drugs for complication management require prior authorization.

Note: Drugs not located on this list and needed for management of complications require prior authorization using the Medi-Cal Treatment Authorization Request (TAR) process. Drugs and supplies available for core services are limited to those items on the Family PACT Pharmacy Formulary.

Claim Form Completion

HCFA 1500 claim form: Providers must document the name of the medication/supply and the provider's cost per unit for the following procedure codes: X7706, X1500 and all other individual medication or injection codes in the *Reserved For Local Use* field (Box 19).

UB-92 Claim Form: Providers must document the name of the medication/supply and the provider's cost per unit for the following procedure codes: Z7610, X7706, X1500 and all other individual medication or injection codes in the *Remarks* area (Box 84).

Note: Family PACT requires that drugs and supplies dispensed by the Family PACT provider must be billed "at cost."

Family PACT: Drug and Supply List

Family PACT
August 2001

EXHIBIT | a .



FAMILY PACT (PLANNING, ACCESS, CARE, AND TREATMENT) PROGRAM PROVIDER AGREEMENT

(To Accompany Applications for Enrollment or Continued Enrollment)*
(Section 24005, Welfare and Institutions Code)

Legal name of applicant or provider (last)		(first)	(middle)	Medi-Cal provider number
Business name, if different				Business telephone number ()
Service address (number, street)		City	State	Nine-digit ZIP code
Mailing address (number, street)		City	State	Nine-digit ZIP code
Social security number or individual Taxpayer Identification Number (ITIN) (If Sole Proprietor not using a FEIN, you must disclose this number and attach a legible copy of either the social security card or the ITIN verification.) (See Privacy Statement on page 7.)		Federal Employer Identification Number (FEIN) (Attach a legible copy of the IRS form.)		

EXECUTION OF THIS PROVIDER AGREEMENT IS MANDATORY FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE FAMILY PACT PROGRAM PURSUANT TO WELFARE AND INSTITUTIONS CODE, SECTION 24005. AS A CONDITION FOR PARTICIPATION OR CONTINUED PARTICIPATION AS A PROVIDER IN THE FAMILY PACT PROGRAM, APPLICANT OR PROVIDER AGREES WITH THE DEPARTMENT OF HEALTH SERVICES (HEREINAFTER "DHS") TO COMPLY WITH ALL OF THE FOLLOWING TERMS AND CONDITIONS, AND WITH ALL OF THE TERMS AND CONDITIONS INCLUDED ON ANY ATTACHMENT(S) HERETO, WHICH IS/ARE INCORPORATED HEREIN BY REFERENCE:

1. **Term and Termination.** This Agreement will be effective from the date Applicant is enrolled as a Family PACT Provider by DHS, or, from the date Provider is approved for continued enrollment. Provider may terminate this Agreement by providing DHS with written notice of intent to terminate, which termination shall result in Provider's immediate disenrollment and exclusion (without formal hearing under the Administrative Procedures Act) from further participation in the Family PACT program unless and until such time as Provider is re-enrolled by DHS in the Family PACT program. DHS may terminate provider for cause as set forth in this agreement or in law. DHS may disenroll a provider without cause upon 60 days prior written notice. Disenrollment by DHS is not subject to administrative appeal.
2. **Compliance With Laws and Regulations.** Provider agrees to comply with all applicable revisions of Section 24005 of the Welfare and Institutions Code or any applicable regulations promulgated by DHS pursuant to that Chapter. Provider further agrees that it may be subject to all sanctions or other remedies available to DHS if it violates any of the provisions of Section 24005 of the Welfare and Institutions Code, or any of the regulations promulgated by DHS pursuant to that Chapter. Provider further agrees to comply with all federal laws and regulations governing and regulating Providers.
3. **Forbidden Conduct.** Provider agrees that it shall not engage in conduct inimical to the public health, morals, welfare, and safety of any Family PACT beneficiary, or the fiscal integrity of the Family PACT program.
4. **Nondiscrimination.** Provider agrees that it shall not exclude or deny aid, care, service, or other benefits available under the Family PACT program or in any other way discriminate against a person because of that person's race, color, ancestry, marital status, sexual orientation, national origin, gender, age, economic status, physical or mental disability, political or religious affiliation or beliefs in accordance with California and federal laws. Provider further agrees that it shall provide aid, care, service, or other benefits available under the Family PACT program to Family PACT beneficiaries in the same manner, by the same methods, and at the same scope, level, and quality as provided to the general public.
5. **Licensing.** Provider agrees to possess at the time this Agreement becomes effective, and to maintain in good standing throughout the term of this Agreement, valid and unexpired license(s), certificate(s), or other approval(s) to provide health care services, which is appropriate to the services, goods, supplies, and merchandise being provided, if required by the state or locality in which Provider is located, or by the Federal Government. Provider further agrees that DHS shall automatically disenroll Provider as a Provider in the Family PACT program pursuant to Welfare and Institutions Code, Section 24005, if Provider has license(s), certificate(s), or other approval(s) to provide health care services, which are revoked or suspended by a federal, California, or another state's licensing, certification, or approval authority, has otherwise lost that/those license(s), certificate(s), or approval(s), or has surrendered that/those license(s), certificate(s), or

* Every applicant and Provider entity must execute this Provider Agreement, who completed the "Family PACT Application," DHS 4468.

Welfare and Institutions Code, Section 24005, which shall include deactivation of all Provider numbers used by Provider to obtain reimbursement from the Family PACT program, if it is discovered by DHS that Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse. Failure to cooperate shall result in disenrollment from the Family PACT program.

14. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider agrees that pursuant to Section 24005 it and its officers, directors, employees, and agents, has not: (a) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (b) been convicted of any felony or misdemeanor involving the abuse of any patient; or (c) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a Provider; or (d) entered into a settlement in lieu of conviction for fraud or abuse, within the last five years; or, (e) been found liable for fraud or abuse in any civil proceeding, within the last five years. Provider further agrees that DHS shall not enroll Provider if, within the last ten years, Provider has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding. In addition, the Department may deny enrollment to any Applicant that, at the time of application, is under investigation by the Department or any local, state, or federal government law enforcement agency for fraud or abuse. If it is discovered that a Provider is under investigation for fraud or abuse, that Provider shall be subject to immediate disenrollment from the program pursuant to Welfare and Institutions Code, Section 24005.
15. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Family PACT program current by informing DHS, in writing on a form or forms to be specified by DHS, of any significant changes to the information contained in its Application for Enrollment, Practitioner Agreement, Disclosure Statement, this Agreement, and any attachments to these documents within 35 days of the change (e.g., location, tax ID change, change of ownership, CLIA number, change of practitioners, etc.).
16. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Family PACT beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Family PACT beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law. Failure to follow this paragraph shall result in disenrollment from the Family PACT program.
17. **Payment From Other Health Coverage Prerequisite to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Family PACT beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, except when the client has requested that services be kept confidential from spouse, partner, or parents, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by Provider, Provider may submit a claim to DHS. Provider agrees not to claim any other source of health care coverage for reimbursement for services.
18. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Family PACT beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Family PACT program's scope of benefits.
19. **Payment From Family PACT Program Shall Constitute Full Payment.** Provider agrees that payment received from DHS in accordance with Family PACT fee structures shall constitute payment in full, except that Provider, after making a full refund to DHS of any Family PACT payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary.
20. **Compliance With Billing and Claims Requirements.** Provider agrees that it shall comply with all of the billing and claims requirements set forth in the Welfare and Institutions Code. Family PACT is a state program separate from Medi-Cal. The Medi-Cal claims process and claim type (HCFA 1500, UB-92 or electronic software submission) is used for reimbursement for Family PACT. Refer to the Family PACT Policy, Procedures, and Billing Instruction manual for diagnosis code and method indicators that are distinctive to the Family PACT program.
21. **Provider Disenrollment.** Provider agrees that it is to be subject to immediate disenrollment for the following actions: (a) automatic suspension/mandatory exclusion from the Medi-Cal program; (b) permissive suspension from the Medi-Cal program; (c) being under investigation for fraud or abuse; (d) having a revoked or suspended license to practice; (e) making false declarations on the Family PACT Application or failure to abide by Provider Agreement Provisions. Provider further agrees that the disenrollment by DHS of Provider shall include deactivation of all of Provider's Provider numbers and shall preclude Provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Family PACT program for any services or supplies Provider has provided to the program, except for services or supplies provided prior to the disenrollment.

Provider is under investigation for fraud or abuse. Provider further agrees to cooperate with and assist DHS and any state or federal agency charged with the duty of identifying, investigating, sanctioning, or prosecuting suspected fraud and abuse.

16. **Provider Fraud or Abuse Convictions and/or Civil Fraud or Abuse Liability.** Provider agrees that it and its owners, officers, directors, employees, and agents, has not: (1) been convicted of any felony or misdemeanor involving fraud or abuse in any government program, within the last ten years; or (2) been convicted of any felony or misdemeanor involving the abuse of any patient; or (3) been convicted of any felony or misdemeanor substantially related to the qualifications, functions, or duties of a provider; or (4) entered into a settlement in lieu of conviction for fraud or abuse, within the last ten years; or (5) been found liable for fraud or abuse in any civil proceeding, within the last ten years. Provider further agrees that DHS shall not enroll Provider if, within the last ten years, Provider has been convicted of any felony or misdemeanor involving fraud or abuse in any government program, has entered into a settlement in lieu of conviction for fraud or abuse, or has been found liable for fraud or abuse in any civil proceeding.
17. **Changes to Provider Information.** Provider agrees to keep its application for enrollment in the Medi-Cal program current by informing DHS, Provider Enrollment Branch, in writing on a form or forms to be specified by DHS within 35 days, of any changes to the information contained in its application for enrollment, its disclosure statement, this Agreement, and any attachments to these documents.
18. **Prohibition of Rebate, Refund, or Discount.** Provider agrees that it shall not offer, give, furnish, or deliver any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it shall not solicit, request, accept, or receive, any rebate, refund, commission preference, patronage dividend, discount, or any other gratuitous consideration, in connection with the rendering of health care services to any Medi-Cal beneficiary. Provider further agrees that it will not take any other action or receive any other benefit prohibited by state or federal law.
19. **Payment From Other Health Coverage Prerequisites to Claim Submission.** Provider agrees that it shall first seek to obtain payment for services provided to Medi-Cal beneficiaries from any private or public health insurance coverage to which the beneficiary is entitled, where Provider is aware of this coverage and to the extent the coverage extends to these services, prior to submitting a claim to DHS for the payment of any unpaid balance for these services. In the event that a claim submitted to a private or public health insurer has not been paid within 90 days of billing by Provider, Provider may submit a claim to DHS.
20. **Beneficiary Billing.** Provider agrees that it shall not submit claims to or demand or otherwise collect reimbursement from a Medi-Cal beneficiary, or from other persons on behalf of the beneficiary, for any service included in the Medi-Cal program's scope of benefits in addition to a claim submitted to the Medi-Cal program for that service, except to: (1) collect payments due under a contractual or legal entitlement pursuant to Welfare and Institutions Code, Section 14000(b); (2) bill a long-term care patient for the amount of higher liability; and, (3) collect a co-payment pursuant to Welfare and Institutions Code, Sections 14134 and 14134.1. Provider further agrees that, in the event that a beneficiary willfully refuses to provide current other health care coverage billing information as described in Section 50763(a)(5) of Title 22, California Code of Regulations, Provider may, upon giving the beneficiary written notice of intent, bill the beneficiary as a private pay patient.
21. **Payment From Medi-Cal Program Shall Constitute Full Payment.** Provider agrees that payment received from DHS in accordance with Medi-Cal fee structures shall constitute payment in full, except that Provider, after making a full refund to DHS of any Medi-Cal payments received for services, goods, supplies, or merchandise, may recover all of Provider's fees to the extent that any other contractual entitlement, including, but not limited to, a private group or indemnification insurance program, is obligated to pay the charges for the services, goods, supplies, or merchandise provided to the beneficiary.
22. **Return of Payment for Services Otherwise Covered by the Medi-Cal Program.** Provider agrees that any beneficiary who has paid Provider for health care services, goods, supplies, or merchandise otherwise covered by the Medi-Cal program received by the beneficiary shall be entitled to a prompt return from Provider of any part of the payment which meets any of the following: (1) was rendered during any period prior to the receipt of the beneficiary's Medi-Cal card, for which the card authorizes payment under Welfare and Institutions Code, Sections 14018 or 14019; (2) was reimbursed to Provider by the Medi-Cal program, following audits and appeals to which Provider is entitled; (3) is not payable by a third party under contractual or other legal entitlement; (4) was not used by the beneficiary to satisfy higher paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

DEPARTMENT OF HEALTH SERVICES

744 P STREET
 BOX 942732
 SACRAMENTO, CA 94234-7320
 (916) 654-0357



May 5, 1997

Ms. Kathy Kneer
 Executive Director
 Planned Parenthood Affiliates of California
 555 Capitol Mall, Suite 510
 Sacramento, CA 95814

Dear Kathy:

I have reviewed your letter requesting a delay in implementation of the policy that providers bill at cost for drugs and supplies. This policy does not represent a change from long-standing Medi-Cal reimbursement policy. Current Medi-Cal policy requires that providers bill at cost (see the enclosed Medical Services Provider Manual, Page 200-45-5).

Family PACT policy around reimbursement has generally been consistent with Medi-Cal, with a few exceptions. Family PACT does offer a dispensing fee to providers to help defray overhead costs.

It is expected that reimbursement from Medi-Cal for Family PACT medications, including oral contraceptives, not exceed the actual purchase cost, place a justifiable ("auditable") charge for overhead.

I look forward to meeting with you on May 19th to discuss this issue.

Sincerely,

Jane E. Boggess, Ph.D., Chief
 Office of Family Planning

Enclosure

cc: Planned Parenthood Affiliates
 Margie Fites-Seigle
 Erin Aaberg

EXHIBIT 2a

DEPARTMENT OF HEALTH SERVICES



714/744 P Street
P. O. Box 942732
Sacramento, California 94234-7320
#916) 854-7171

October 3, 1997

Ms. Kathy Kneer
Executive Director
Planned Parenthood Affiliates of California
555 Capitol Mall, Suite 510
Sacramento, CA 95814-4502

Dear Ms. Kneer:

This letter is to clarify Medi-Cal policy regarding reimbursement for drugs dispensed by physicians and clinics, specifically oral contraceptives. Medi-Cal claims for any drug dispensed by physicians or clinics must be for "cost", not "usual and customary". The Department recognizes that some providers may have nominal or reduced pricing agreements with drug manufacturers or significantly reduced drug and supply prices pursuant to U.S. Public Health Service contracts. It is the Department's expectation that these reduced costs be reflected in the Medi-Cal billings for these drugs or supplies. For oral contraceptives, there is a maximum reimbursement rate of \$12.00 per cycle. It is our understanding that the Medi-Cal fee-for-service reimbursement policy is also being applied under Family PACT.

You have indicated that you were billing oral contraceptives at "usual and customary" based on your understanding of billing procedures for a "service". The billing code of X7706 is described as "drugs, oral contraceptive medications". This billing code is not descriptive of a service, but for billing of the oral contraceptive drugs issued to the patient at the time of an office visit.

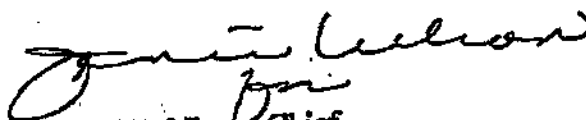
For your information, the Department is exploring the feasibility of allowing physicians and clinics to be reimbursed for oral contraceptives when cost is above the current \$12.00 maximum allowable reimbursement. If such a policy were to be adopted, it would likely require a distinctive billing code or system change. Also, such a policy would be applied on a prospective basis and would not involve a review of previous claims submitted by providers.

EXHIBIT 2 b.

Ms. Kathy Kneer
Page 2

I hope that this has answered your questions regarding reimbursement for oral contraceptives. However, if you have any further questions, please do not hesitate to contact me at (916) 654-7171.

Sincerely,



Darryl B. Nixon, Chief
Medi-Cal Benefits Branch

cc: Jane E. Boggess, Ph.D., Chief
Office of Family Planning
714 P Street, Room 440
Sacramento, CA 95814

Roberto B. Martinez, Chief
Rate Development Branch
714 P Street, Room 1550
Sacramento, CA 95814



Planned Parenthood
Affiliates of California

55 Capitol Mall, Suite 510
Sacramento, California 95814-4502
916.446.5247 phone
916.441.0632 fax

October 6, 1997

Darryl B. Nixon, Chief
Medi-Cal Benefits Branch
Department of Health Services
714 P Street
P.O. Box 942732
Sacramento, CA 94234-7320

Dear Mr. Nixon:

Thank you for responding to our inquiry. We appreciate the efforts you are undertaking to allow providers to be reimbursed for oral contraceptives when the cost exceeds \$12.00. We believe this policy change is important to ensure patients' access to the formulary that best meets their medical needs.

Your letter indicates that clinics that have nominal or reduced price agreements must pass along the "reduced drug and supply cost." Specifically we would like the Department to clarify the definition it is using for cost as referenced in your first paragraph. Our review of current regulations is as follows:

The State Medi-Cal regulation, adopted in 1994, provides that:

"(3) Reimbursement for take-home drugs dispensed by clinics that have obtained permits pursuant to Business and Professions Code Section 4063 et seq. shall not exceed the amounts payable for *drug ingredient costs* under Section 51513. No dispensing fee or markup shall be paid." Title 22 California Code of Regulations (CCR)§51509.1(c)(3).

Section 51513(b)(1) provides in part, that:

".....Payment for legend generic drug type codes dispensed by a clinic with a special permit.....and provided in compliance with Section 51313 shall consist of the cost of the legend generic drug code dispensed.

- A. The price charged to the program shall not exceed the charge to the General Public...."

EXHIBIT 2c

Section 51513(a)(13) defines "cost of drugs" as the lesser of the Estimated Acquisition Cost (EAC), the Federal Allowable Cost (FAC), or the Maximum Allowable Ingredient Cost (MAIC). The term "cost" as used by this section does not mean "actual cost"; instead it means the "cost" as determined by one of the three allowable methods of setting the "ingredient cost" of the drug.

The Medi-Cal Pharmacy Manual provides that (a) payment of the lesser of EAC, FAC, or MAIC applies to all drugs and not just generic drugs. Additionally, the manual provides that average wholesale price (used to compute the EAC) shall be the DHHS "First Data Bank," or if not listed in the DHHS data bank, the "Red Book." See: Medi-Cal Pharmacy Manual §200-25.

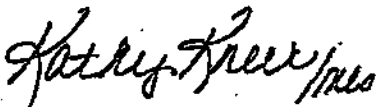
For example, if we were billing the State as indicated above instead of our usual and customary of \$10.00 to \$15.00 per cycle, the charge billed to the State would be \$25.05 or \$25.17 per cycle.
Example:

Norgestimate and Ethinyl Estradiol (Ortho-Cyclen)	MAIC	FAC	AWP
Oral-21 1mg/50mcg	n/a	n/a	\$25.05
Oral-28 1mg/50mcg	n/a	n/a	\$25.17

It would be helpful if the Department could tell us what law, regulation or other provision you are using to determine "reduced cost."

We wish to continue working with the Department on clarifying this issue.

Sincerely,



Kathy Kneer
Chief Executive Officer

Attachments (Regulations)

cc: Jane E. Boggess, Ph.D., chief
Office of Family Planning
714 P Street, Room 440
Sacramento, CA 95814

Roberto B. Martinez, Chief
Rate Development Branch
714 P Street, Room 1550
Sacramento, CA 95814

DEPARTMENT OF HEALTH SERVICES

714/744 P Street
P. O. Box 942732
Sacramento, California 94234-7320
(916) 857-1480

January 9, 1998



Ms. Kathy Kneer
Executive Director
Planned Parenthood Affiliates of California
555 Capitol Mall, Suite 510
Sacramento, CA 95814-4502

Dear Ms. Kneer:

This is in response to your October 6, 1997, letter asking for clarification of information provided in our letter to you dated October 3, 1997. In our letter we advised you that providers who have nominal or reduced pricing agreements with drug manufacturers or significantly reduced drug and supply prices pursuant to U.S. Public Health Service contracts must reflect these reduced costs when submitting billings for Medi-Cal reimbursement. You ask that our Department tell you what law, regulation or other provision is being used to determine reduced cost.

Section 602 of Public Law 102-585, the "Veterans Health Care Act of 1992," enacted Section 340B of the Public Health Service Act, "Limitation on Prices of Drug Purchased by Covered Entities." The definition of "covered entities" includes family planning clinics.

According to information provided to us by Office of Drug Pricing, the attached list of Planned Parenthood clinics are participating in the 340B program. Planned Parenthood clinics purchasing drugs at discount prices from drug manufacturers cannot be reimbursed by Medi-Cal for an amount more than the cost of the drug. The law states "If a drug is purchased by or on behalf of a Medicaid beneficiary, the amount billed may not exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with the Veterans Health Care Act of 1992, plus a reasonable dispensing fee established by the State Medicaid Agency".

In accordance with Business and Professions Code, Section 4063.7, payment of dispensing fees for drugs dispensed to Medi-Cal patients by clinics with special permits is prohibited.

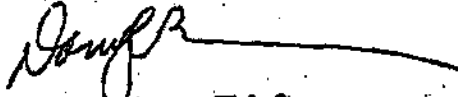
EXHIBIT 2d.

Ms. Kathy Kneer

Page 2.

I hope your question has been adequately answered. If you have any questions, please feel free to contact Mr. Jim Cicconetti, Chief, Professional Services Unit, at (916) 657-0564.

Sincerely,



Darryl Nixon, Chief
Medi-Cal Benefits Branch

Attachment

cc: Jim Cicconetti, Chief
Professional Services Unit
714 P Street, Room 1640
Sacramento, CA 95814

Richard Morita, Pharm. D.
Pharmaceutical Unit
714 P Street, Room 1786
Sacramento, CA 95814

LIST OF PROVIDER NAMES

<u>PROVIDER NAME & STATUS #</u>	<u>ADDRESS</u>	<u>CITY</u>
Planned Parenthood CMM70497F	916 W. Burbank Blvd.	Burbank
Planned Parenthood CMM70243F	7933 Wren Avenue	Gilroy
Planned Parenthood CMM70413F	598 Walnut Avenue	Greenfield
Planned Parenthood ZZR11493G	1866 B Street	Hayward
Planned Parenthood CMM70355F	1014 1/2 N. Vermont A.	Los Angeles
Planned Parenthood ZZT12118F	1057 Kingston Avenue	Los Angeles
Planned Parenthood CMM70350F	2660 Solace Place	Mountain View
Planned Parenthood EAP11495G	10 Eastmont Mall	Oakland
Planned Parenthood ZZR11517G	482 W. MacArthur Blvd.	Oakland
Planned Parenthood CMM70409F	1370 Medical Center	Robert Park
Planned Parenthood CMM70385G	5550 Franklin Blvd.	Sacramento
Planned Parenthood CMM70558G	1125 10th Street	Sacramento
Planned Parenthood ZZR11843G	1507 21st Street	Sacramento
Planned Parenthood CMM70251F	316 North Main Street	Salinas
Planned Parenthood EAP11495G	815 Eddy Street	San Francisco
Planned Parenthood CMM70118F	5440 Thornwood Drive	San Jose
Planned Parenthood CMM70316F1	1691 The Alameda	San Jose
Planned Parenthood CMM70351F	3131 Alum Rock Avenue	San Jose
Planned Parenthood ZZR11445F	2211 Palm Avenue	San Mateo
Planned Parenthood CMM70327G	1119 Pacific Avenue	Santa Cruz
Planned Parenthood EAP70003F	415 E. Chapel Street	Santa Maria
Planned Parenthood CEA11505G	625 Hilby Avenue	Seaside
Planned Parenthood CMM70515F	604 E. Evelyn Avenue	Sunnyvale
Planned Parenthood CMM70417F	918 W. Foothill Blvd.	Upland
Planned Parenthood CMM70080G	90 Mariposa Avenue	Watsonville
Planned Parenthood CMM70456G	353 W. Main Street	Woodland
Planned Parenthood CMM70364G	430 North Palora Avenue	Yuba City



August 9, 2004

VIA FACSIMILE: (916) 319-2135

The Honorable Hannah-Beth Jackson
State Capitol, Room 4140
Sacramento, CA 95814
Fax: (916) 319-2135

Dear Assemblywoman Jackson:

Planned Parenthood of San Diego & Riverside Counties strongly supports AB 2151 (Jackson). This bill would codify current Medi-Cal regulations to provide that community and free clinics must be reimbursed for take-home drugs and supplies at their "usual charges made to the general public" so long as those usual charges are lower than the reimbursement rates for retail pharmacies.

Community and free clinics have the narrowest financial cushion of all Medi-Cal providers. Our funding comes through programs such as Medi-Cal, Healthy Families and Family PACT, but these reimbursements rarely cover the cost of providing services.

Safety net providers, such as Planned Parenthood, negotiate deeply discounted contracts with drug manufacturers for pharmaceuticals such as birth control pills. We then pass along these savings to the state by billing for reimbursement at half the rate of retail pharmacies ("usual charges"). Medi-Cal regulations, in turn, authorize providers to be reimbursed at "usual charges" rather than the discount price. This allows clinics to fund their operations to see more patients at a lower cost.

California taxpayers benefit from these reimbursement practices because our clinics are able to pass along millions of dollars in savings to the state by billing at our "usual charges," which are significantly lower than the reimbursements the state would make to retail pharmacies for the identical product. We also are able to provide patients with birth control pills for little or no cost at the time of service. And most importantly, the practice allows Planned Parenthood and other clinics to keep our doors open by subsidizing the services for which we are under-reimbursed.

By maintaining current Medi-Cal reimbursements the state, patients, and clinics win. That's why we urge your "AYE" vote on AB 2151.

Sincerely,

A handwritten signature in black ink that reads 'Mark Salo'.

Mark Salo
President & CEO



Planned Parenthood
of San Diego & Riverside Counties

August 16, 2004

VIA FACSIMILE: (916) 319-2135

The Honorable Hannah Beth Jackson
State Capitol Room 4140
Sacramento, CA 95814

Dear Assemblywoman Jackson:

Planned Parenthood of San Diego & Riverside Counties would like to thank you for authoring AB 2151. As you know Planned Parenthood is significantly under-reimbursed by the state for the services we provide to our patients. Allowing us to continue receiving reimbursements from the state at the "usual charge" for birth control pills enables us to continue funding our operations and see more patients at a lower cost.

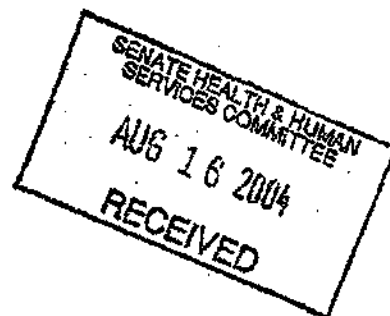
Once again thank you for authoring AB 2151. You never fail to amaze us with your dedication to reproductive rights issues.

Best regards,

A handwritten signature in cursive script that reads "Mark Salo".

Mark Salo
President & CEO

EXHIBIT 3b.



August 16, 2004

VIA FACSIMILE: (916) 323-2263

The Honorable Deborah Ortiz
 Chair, Senate Health Committee
 State Capitol Room 5114
 Sacramento, CA 95814

Dear Senator Ortiz:

Planned Parenthood of San Diego & Riverside Counties would like to thank you for your support on AB 2151 by Assemblywoman Hannah Beth Jackson. This bill would allow us to continue receiving reimbursements from the state at the "usual charge" for birth control pills as long as they are lower than rates at retail pharmacies.

As you know, Planned Parenthood is significantly under-reimbursed by the state for the services we provide to our patients. A recent survey of Planned Parenthood clinics shows that Medi-Cal and Family PACT reimbursements for patient visits are 40% to 50% below the cost of patient care. In order to offset this, Planned Parenthood has been able to negotiate directly with pharmaceutical companies to receive deeply discounted prices on birth control pills. We then pass these savings on to the state by billing for reimbursement at half the rate of retail pharmacies (our "usual charge"). Medi-Cal regulations, in turn, authorize us to be reimbursed at our "usual charges"-rather than the discounted price we pay. This allows clinics to fund their operations and to see more patients at a lower cost.

Once again, thank you for supporting AB 2151.

Best regards,

Mark Salo
 President & CEO

EXHIBIT 3c



Planned Parenthood®

Affiliates of California, Inc.

Providing responsible choices through advocacy and political action.

FACT SHEET

AB 2151 (Jackson)

What Does AB 2151 Do?

AB 2151 codifies current Medi-Cal regulations (Title 22 California Code of Regulations section 51509.1) regarding reimbursements to clinics. The law would provide that community and free clinics must be reimbursed for take-home drugs and supplies at their "usual charges made to the general public" so long as they are lower than the reimbursement rates for retail pharmacies.

Why Legislation is Needed

The Department of Health Services (DHS) is in discussions regarding changes to the Medi-Cal and Family PACT billing and reimbursement requirements for clinics. Their plan would eliminate the "financial cushion" to community and free clinics. Planned Parenthood is working with DHS to bring clarity to the various federal and state statutes, regulations and policies that set out the billing and reimbursement standards for clinics.

While discussions between DHS and Planned Parenthood are continuing, we believe the consequences of changing current practices are so egregious the Legislature should be involved in determining the appropriate policy.

Background

Community and free clinics have the narrowest financial cushion of all Medi-Cal providers. A recent survey of Planned Parenthood clinics shows that Medi-Cal and Family PACT reimbursements for patient visits are 40% to 50% below the cost of patient care.

Because of our significant volume, we are able to negotiate deeply discounted contracts with pharmaceutical companies, including long-standing, low-cost contracts with birth control pill manufacturers. We pass on these savings to the state by billing for reimbursement at half the rate of retail pharmacies (our "usual charges"). Medi-Cal regulations, in turn, authorize us to be reimbursed at our "usual charges" rather than the discount price we pay. This allows clinics to fund their operations to see more patients at a lower cost.

How California Benefits

1. Planned Parenthood passes on millions of dollars in savings to the State by billing at our "usual charges," which are significantly lower than the reimbursements to retail pharmacies for the identical product
2. Eliminates the barrier to care that is created when patients have to go to a pharmacy rather than receiving their birth control pills at the time of service
3. Planned Parenthood provides birth control pills to uninsured patients at little or no cost
4. Clinic doors stay open by subsidizing the services for which we are under-reimbursed

Sponsoring Organization

Planned Parenthood Affiliates of California (PPAC)

EXHIBIT 3d



cell:
799-0345

Require them to
script out -
then 15% discount
get another letter...
for lowballing...
for any other...

Community Clinics At Risk - Medi-Cal Reimbursements Must Remain at Current Levels

What would the amendments do?

The new provision would codify current Medi-Cal regulations (Title 22 California Code of Regulations section 51509.1) regarding reimbursements to clinics. The law would provide that community and free clinics must be reimbursed for take-home drugs and supplies at their "usual charges made to the general public" so long as they are lower than the reimbursement rates for retail pharmacies.

Background

Community and free clinics have the narrowest financial cushion of all Medi-Cal providers. The majority of funding for these clinics comes from reimbursements for services provided through government programs such as Medi-Cal, Healthy Families and Family PACT. These reimbursements, however, rarely cover the cost of providing services. A recent survey of Planned Parenthood clinics shows that Medi-Cal and Family PACT reimbursements for patient visits are 40% to 50% below the cost of patient care.

As a safety net provider, Planned Parenthood, because of our significant volume, is able to negotiate deeply discounted contracts with pharmaceutical companies, including long-standing, low-cost contracts with birth control pill manufacturers. We pass on these savings to the state by billing for reimbursement at half the rate of retail pharmacies (our "usual charges"). Medi-Cal regulations, in turn, authorize us to be reimbursed at our "usual charges" rather than the discount price we pay. This allows clinics to fund their operations to see more patients at a lower cost.

How California Benefits

Because of Planned Parenthood's investment in the complex process of seeking out and negotiating the low-cost contracts for pharmaceuticals, we have been able to:

1. Pass on millions of dollars in savings to the State by billing at our "usual charges," which are significantly lower than the reimbursements to retail pharmacies for the identical product;
2. Eliminate the barrier to care for the patients that is created when patients have to go to a pharmacy rather than receiving their birth control pills at the time of service;
3. Provide birth control pills to uninsured patients at little or no cost; and
4. Keep clinic doors open by subsidizing the services for which we are under-reimbursed.

By maintaining current Medi-Cal reimbursements the state, patients, and clinics win.

Why Legislation is Needed

While discussions between DHS and Planned Parenthood are continuing, we believe the consequences of changing current practices will have devastating financial consequences for safety-net providers and a major impact on FFACT clients. A change of this magnitude should be handled by the legislature.

Sponsoring Organization

Planned Parenthood Affiliates of California (PPAC).



AB 2151 (Jackson) Q&A

What does AB 2151 do?

AB 2151 codifies current Medi-Cal regulations (Title 22 California Code of Regulations section 51509.1) regarding reimbursements to clinics.

The law would provide that community and free clinics must be reimbursed for take-home drugs and supplies at their "usual charges made to the general public."

Why is legislation needed?

The Department of Health Services (DHS) is in discussions regarding changes to the Medi-Cal and Family PACT billing and reimbursement requirements for clinics. Their plan could eliminate the "financial cushion" to community and free clinics.

The consequences of changing current billing practices are so egregious the Legislature should be involved in determining the appropriate policy. Any change to the existing reimbursement policy would have a devastating effect on clinics and the low-income Californians we serve.

Where is the Department of Health Services on this issue?

DHS is considering cutting the current reimbursement rate for community clinics under Family PACT and Medi-Cal, but they are also weighing the public policy consequences of doing so. We have notified them of this measure, and explained our need to involve the Legislature in such a significant policy issue. There has been no response.

What is the financial impact on Planned Parenthood clinics?

Planned Parenthood clinics stand to lose over \$17 million dollars, if the Department changes the current billing practice.

One of our smallest affiliates, which serves a rural community and has very few health care providers, would have to cut their patient load by 3,800. This is 23% of their patient population. This would mean 317 less visits per month, 80 patients per week or 16 patients per day. Cutting these services, especially in a rural community, would leave a significant number of people without care.

advisory
on
family
planning
clinics
family
PACT

Why don't clinics simply refuse to participate in Family PACT or Medi-Cal if they don't like the reimbursement rates?

Community clinics are "safety net" providers who are required by state law to service low income populations. A majority of our patient population, therefore, are precisely those patients who are eligible for Family PACT and Medi-Cal. As a consequence, the money that clinics take in comes from these government subsidized programs or from uninsured patients who pay for services on a sliding scale based on their ability to pay.

How do we currently bill for reimbursement for oral contraceptives?

Planned Parenthood clinics have been billing DHS at usual and customary for oral contraceptives since the 1970s.

The California Regulation which allows us to bill at usual and customary is Title 22 section 51509.1. The regulation states "reimbursement for organized outpatient clinic services shall be the usual charges made to the general public not exceed the maximum reimbursement rates listed in this section."

*usual
regulation*

Why are you introducing a bill so late?

This has been an ongoing issue that we had hoped to resolve with the Department early in the year. Given the financial and public health impacts will be catastrophic; PPAC believes it is important for the Legislature to be involved in any policy change that will adversely affect the health of low-income women. PPAC is committed to continuing to work with the Department.

Jack: (Don McLaughlin):

no possum =

don't get paid for inpatient cost + dispensing fees

HC (3):

*BIP 4183
section*

*allows direct to dispens
pres. disp. of special
licens.*

Oral Contraceptive Billing Practices

The MediCal and Family PACT provider/billing manuals and California Code of Regulations (CCR) Title 22 §51513 includes many definitions of "cost." (See Attachment #1.) This is not unreasonable since the cost to the pharmacist or provider can be vastly different depending upon the specific drug or supply.

The Average Wholesale Price (AWP), minus 5% (22 CCR 51513(a)(6)(B)) is the primary method for calculating MediCal billing charges of pharmaceuticals, and is a basic element of the billing structure set out in the MediCal regulations. Retail pharmacies receive an additional \$3.95 as a dispensing fee; community clinics with a pharmacy permit are prohibited from receiving a dispensing fee. (22 CCR 51509.1(c)(3).)

In addition to the Title 22 regulations regarding billing requirements, both MediCal and Family PACT publish billing manuals that offer instructions to providers regarding precisely how to submit a bill for reimbursement. These manuals do not necessarily harmonize with the Title 22 regulations, or with each other, despite the fact that the Family PACT "services are reimbursed at MediCal rates."¹

DHS often sets out detailed instructions regarding billing requirements. In some instances these requirements differ for Family PACT vs. MediCal, and on occasion DHS is very clear about how to bill at the provider's purchase price. For example, the MediCal Inpatient/Outpatient Provider Manual sets forth the required billing codes for identified contraceptive intra uterine devices and, at page "fam planning 7," instructs:

HCPCS code X1512 should be billed "By Report." When billing this code, remember to enter a description of the item by name and manufacturer in the *Remarks area/Reserved for Local Use* field (Box 19) of the claim form. A copy of the invoice for the device should also be submitted with the claim.

HCPCS codes X1522 (ParaGard), X1514 (Progestasert) and X1532 (Mirena) should not be billed "By Report." These codes are reimbursed at a fixed rate and do not require the submission of a copy of an invoice with the claim.

These two examples help to demonstrate the confusion surrounding billing and reimbursement for contraceptives. The first descriptor specifies that the invoice is needed in order to determine the actual purchase price and reimburse accordingly, and the term "at cost" is not included or referenced. The second paragraph notes that no invoice is necessary because the codes are "reimbursed at a fixed rate" which is precisely how oral contraceptives are currently reimbursed - Code X7706 at \$12.00 per cycle.

Conversely, when DHS instructs providers to bill "at cost," without referencing a specific regulatory definition of the term "at cost" it undermines the ability of the provider to determine the appropriate cost factors to include.

¹ Family PACT PBBI, familyfact1 at page 1.

Gonzalez, Victor

From: Gonzalez, Victor
Sent: Friday, February 20, 2004 9:34 AM
To: 'tschulte@rbz.com'
Cc: 'mcantrill@rbz.com'
Subject: FW: DHS Cost Audits from Victor Gonzalez PPLA

Tom a very serious matter has reared its ugly head. As you are probably aware, PPLA has been marking up the OCs and the pills dispensed by a hefty markup over cost. This is proscribed by DHS regulations where the prevailing rule is that medicines should be dispensed at cost with a recovery of the dispensing fee (which of course is minimal as compared to normal retail markup)

Please let me be clear about this issue we purchase the meds at \$1 or \$2 and sell them for \$12 \$18 \$48. Here is a



Pharmaceuticals.xls

detailed spreadsheet.

The impact is over \$2million bottom line, and appx \$4million revenues over the course of a typical 12 months. This is the impact on the financial statements at 6/30/03, and obviously we are now into the 8th month of a new fiscal year.

I am proposing to the CEO that adequate legal counsel be obtained in this matter, beyond the PAC counsel as per the emails below, which obviously has been flawed and ineffective. This matter arose 3 or 4 years ago and has not been satisfactorily resolved.

I dont need to remind you that we need to make decisions as a separate entity, PPAC is merely a lobby group that we use to research these matters, their advice has no weight legally. Given what has recently happened to Jeffrey Skillings, we cannot continue to use the "we have experts who told us this or that..."

I am also proposing the booking of a contingency at 50% of the \$2m annual effect on the financial statements for the new fiscal year 6/30/04 at PPLA.

We are probably next in the DHS audit per the email below, given the new enforcement obviously started by the Republican governor.

EXHIBIT 4

Inventory Item#	Description	Base Unit of Measure	Base Unit Cost	YTD Utilization	YTD Expense
CONTRACEPTIVE					
10000	Oral Contraceptive Veridate Com	Bx	\$	0	\$
10128	Oral Contraceptive Modicon	Ea	\$ 1.31	4,087	\$ 5,353.97
10211	Preven (Emer Contra Kit)	Pk	\$ 1.85	2,482	\$ 4,591.70
10328	Oral Cont Ortho Novum 135	Ea	\$ 0.61	6,481	\$ 3,953.41
10528C	Oral Cont Ortho Novum 150	Ea	\$ 3.66	217	\$ 794.22
10628	Oral Cont Ortho-Cyclen 28	Ea	\$ 3.74	15,500	\$ 57,970.00
10728	Oral Cont Ortho Novum 777	Ea	\$ 1.57	21,128	\$ 33,170.96
10828	Oral Cont Micronor	Ea	\$ 2.83	2,652	\$ 7,505.16
20000	Depo-Provera 150MG	VL	\$ 24.16	6,301	\$ 152,232.16
20001	Depo-Provera 150MG W/SRNG	SY	\$ 19.75	2,920	\$ 57,670.00
20002	Plan B	Ea	\$ 4.50	15,747	\$ 70,861.50
20003	Lunelle	VL	\$ 14.93	0	\$
20004	Ortho Evra	Ea	\$ 3.27	5,745	\$ 18,768.92
20005	Nuva-Ring	Ea	\$ 3.00	1,296	\$ 3,888.00
20008	Demulen 1/35	Ea	\$ 6.02	2,088	\$ 12,565.58
20018	Alesse-28	Ea	\$ 3.61	25,563	\$ 92,384.68
20028	Loestrin Fe 1/20 #913-45	Ea	\$ 10.16	9,060	\$ 92,049.60
20085	Diaphragms-All-Flex 85	Ea	\$ 18.50	4	\$ 74.00
20128	Tri-Levlen #43303	Ea	\$ 1.89	7,908	\$ 14,946.12
20160	Diaphragms-All-Flex 160	Ea	\$ 15.25	2	\$ 30.50
20165	Diaphragms-All-Flex 165	Ea	\$ 18.50	24	\$ 444.00
20170	Diaphragms-All-Flex 170	Ea	\$ 18.50	29	\$ 536.50
20175	Diaphragms-All-Flex 175	Ea	\$ 18.50	36	\$ 666.00
20180	Diaphragms-All-Flex 180	Ea	\$ 18.50	8	\$ 148.00
20185	Diaphragms-All-Flex 185	Ea	\$ 6.50	1	\$ 6.50
20190	Diaphragms-All-Flex 190	Ea	\$ 18.50	1	\$ 18.50
20195	Diaphragms-All-Flex 195	Ea	\$ 18.50	2	\$ 37.00
20228	Levlen #41128	Ea	\$ 1.07	17,901	\$ 19,154.07
20255	Diaphragms-Koromex 255	Ea	\$ 15.25	2	\$ 30.50
20260	Diaphragms-Koromex 260	Ea	\$ 15.25	5	\$ 76.25
20265	Diaphragms-Koromex 265	Ea	\$ 15.25	7	\$ 106.75
20270	Diaphragms-Koromex 270	Ea	\$ 15.25	5	\$ 76.25
20275	Diaphragms-Koromex 275	Ea	\$ 15.25	10	\$ 152.50
20280	Diaphragms-Koromex 280	Ea	\$ 15.25	3	\$ 45.75
20285	Diaphragms-Koromex 285	Ea	\$ 18.50	1	\$ 18.50
20290	Diaphragms-Koromex 290	Ea	\$ 15.25	1	\$ 15.25
20295	Diaphragms-Koromex 295	Ea	\$ 18.50	3	\$ 55.50
20428	Ortho Tri-Cyclen Lo	Ea	\$ 2.25	23,664	\$ 53,244.00
25000	Cervical Cap-Fitting Set	Ea	\$ 50.00	10	\$ 500.00
25022	Cervical Cap 22MM	Ea	\$ 46.00	1	\$ 46.00

Revenue

Net Income

49,044.00
47,009.08
77,772.00
2,604.00
186,000.00
253,536.00
31,824.00
294,697.77
136,568.40
328,482.42
63,941.85
47,964.96
25,056.00
306,756.00
108,720.00
52.00
94,896.00
26.00
312.00
377.00
468.00
104.00
13.00
13.00
26.00
214,812.00
26.00
65.00
91.00
65.00
130.00
39.00
13.00
13.00
39.00
283,968.00
130.00
13.00
43,690.03
42,417.38
73,818.59
1,809.78
128,030.00
220,365.04
24,318.84
142,465.61
78,898.40
257,620.92
45,172.94
44,076.96
12,490.42
214,371.32
16,670.40
(22.00)
79,949.88
(4.50)
(132.00)
(159.50)
(198.00)
(44.00)
6.50
(5.50)
(11.00)
195,657.93
(4.50)
(11.25)
(15.75)
(11.25)
(22.50)
(6.75)
(5.50)
(2.25)
(16.50)
230,724.00
(370.00)
(33.00)

39.00 (39.00)
 26.00 (66.00)
 208.00 (208.00)
 918,084.00 692,388.35
 64,141.00 27,440.00
 15,008.00 2,935.20
 2,301.00 2,108.07

3,666.00
 1,924.00
 6,058.00
 36,597.00

Item Code	Description	Unit	Price	Quantity	Total
25025	Cervical Cap 25MM	Ea	\$ 26.00	3	\$ 78.00
25028	Cervical Cap 28MM	Ea	\$ 46.00	2	\$ 92.00
25031	Cervical Cap 31MM	Ea	\$ 26.00	16	\$ 416.00
30028	Ortho Tri-Cyclen	Ea	\$ 2.95	76,507	\$ 225,695.65
30300	IUD-Paragard	Ea	\$ 149.80	245	\$ 36,701.00
30400	IUD-Mirena	Ea	\$ 301.82	40	\$ 12,072.80
40100	Condoms (Lubricated)	Ea	\$ 0.06	611,000	\$ 34,827.00
40102	Reality (Female Condom)	Ea	\$ 1.09	177	\$ 192.93
40103	Condoms (Mini)	Ea	\$ 0.09	2,305	\$ 207.45
40104	Condoms (Vanilla)	Ea	\$ 0.09	3,580	\$ 322.20
40105	Condoms (Strawberry)	Ea	\$ 0.09	6,080	\$ 547.20
40106	Condoms (Chocolate)	Ea	\$ 0.09	5,685	\$ 511.65
40107	Condoms (Banana)	Ea	\$ 0.09	2,607	\$ 234.63
40108	Condoms (Grape)	Ea	\$ 0.09	2,180	\$ 196.20
40109	Condoms (Cola)	Ea	\$ 0.09	1,745	\$ 157.05
40110	Latex Barriers (Vanilla)	Ea	\$ 0.48	45	\$ 21.60
40111	Latex Barriers (Strawberry)	Ea	\$ 0.48	79	\$ 37.92
40114	Slippery Stuff	Ea	\$ 0.20	2,408	\$ 481.60
40117	Condoms, Non-Lubricated	Ea	\$ 0.05	5,000	\$ 265.00
40200	Jelly Contra Koimx #115C	Ea	\$ 2.70	282	\$ 761.40
40300	Applicator (Jelly #K52B)	Ea	\$ 0.60	148	\$ 88.80
40401	Contra. Foam Koimex 635C	Ea	\$ 4.81	466	\$ 2,241.46
40500	Vaginal Contraceptive Fil	Ea	\$ 0.60	2,969	\$ 1,781.40

2,904.60
 1,835.20
 3,816.54
 36,815.60

Gonzalez, Victor

From: Swiller, Martha
Sent: Monday, January 26, 2004 5:38 PM
To: Gonzalez, Victor; Smith, Kathy; Gray, Eldyne; Mary Jane Wagie (E-mail)
Subject: FW: Urgent (DHS Audits)

This is bad.

—Original Message—

From: Salo, Mark
Sent: Monday, January 26, 2004 4:00 PM
To: Dunn, Jon; Estes, Heather; Mackenzie, Tina; Williams, Linda; Harrison, Dian; Swiller, Martha; Pals, Ellen; Rollings, Cheryl
Subject: Urgent (DHS Audits)

Dear Colleagues:

Today DHS came into our affiliate and asked for invoices for our oral contraceptive purchases stating that we were required to charge the state only for what we paid for the product. Our CFO told them that we had resolved the issue years ago, that the current system saves the state money and he declined to give them the info pending discussions with legal counsel. We immediately called Lilly. I am e-mailing you all this because the DHS auditor told our CFO that they were going to conduct these audits on all the affiliates in the state. With reimbursement rates far below the cost of providing services, this could kill many of us.

Mark

APR 20 2004 10:00 AM
COMMUNICATIONS SECTION
STATE OF MISSISSIPPI

EXHIBIT 5

Gonzalez, Victor

From: Kneer, Kathy
Sent: Thursday, February 05, 2004 6:48 PM
To: Spitz, Lilly; Reed, Angela; Berthelsen, Birgitte; Coles, Bob; Eokhardt, Carla; Rollings, Cheryl; Barrera, Diahann; Harrison, Dian; Estes, Heather; Ewy, Jeanne; Giambruno, John; Dunn, Jon; Yarges, Judy; Pinterpe, Karen; Smith, Kathy; Williams, Linda; Schrepfer, Marcia; McKinney, Marie; Salo, Mark; Stanphill, Marsha; Switter, Martha; Low, Marty; Fjerstad, Mary; Wagle, Mary-Jane; Belanger, Monique; Fajardo, Patricia; Schoenwald, Phyllis; Bush-Dean, Regina; Gale, Rose; MacKenzie, Tina; Gonzalez, Victor
Cc: Seeram, Santosh; Sarver, Justine; Trueworthy, Katie
Subject: RE: DHS Cost Audits - contraceptive drugs and supplies

[REDACTED] I want to reiterate that Kim is willing to discuss the policy implications of requiring clinics to bill at acquisition cost - however, she did state that DHS legal office has advised her that the law requires us to bill at acquisition cost. She had this conversation with DHS after her meeting with Linda and my urgent request to stop this aspect of the audit. She understands the critical importance of this issue to our clinics - as Linda said: clinics are built like a house of cards and if this is lost, then clinics can tumble. Which only hurts patient access.

The likely outcome from this development: I do believe that we have a good chance to succeed on a policy basis to allow clinics to bill at usual and customary with a sliding scale fee. This change would need to be codified and our best opportunity will be trailer bill language that could take effect in July (or whenever the budget is resolved).

We have asked each affiliate to provide our office with information about your affiliates billing practice for nominal and 340B priced contraceptive methods. I will assure you that this information will not be used publicly except in a state aggregate and to assure we are accurately reflecting the depth of the impact and to insure we are fully covering ourselves with any statute change. So, in addition to the information requested below, if each affiliate can estimate the Total \$ impact - if not that's okay. You should also begin preparing for discussion sake - what the impact at an affiliate level would be in the event we did not prevail - ie: what type of cuts would you have to do to offset the loss of income.

I know this short notice for the call on Monday, I hope that each affiliate will be able to have at least one representative on the phone.

At this time we are asking that no further public action be taken - quietly resolving this as a policy issue within the administration is the best strategy at this time.

EXHIBIT 6

RIVERSIDE/SAN BERNARDINO
COUNTIES4072 CHESTNUT STREET
RIVERSIDE, CA 92501
(951) 778-0616

LOS ANGELES COUNTY

AIRPORT CENTER BUILDING
7100 HAYVENHURST AVENUE, SUITE 310
VAN NUYS, CA 91406
TELEPHONE: (818) 756-0999
FAX (818) 756-0998
SchulerBrownLaw@aol.comVENTURA/SANTA BARBARA
COUNTIES129 SIMI AVENUE
OXNARD, CA 93035
(805) 985-8951

November 18, 2005

Alberto R. Gonzales, Attorney General
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001Consuelo S. Woodhead, U.S. Attorney
United States Attorney's Office
Central District of California
Criminal Division
312 N. Spring Street
Los Angeles, CA 90012Daniel R. Levinson, Inspector General
Health and Human Services Office
of Inspector General HHS-OIG
Department of HHS
330 Independence Avenue, SW
Washington, D.C. 20201J. Stephen Tidwell, Assistant Director
FBI-Los Angeles
11000 Wilshire Blvd., Suite 1700
Los Angeles, CA 90024Michael B. Enzi, United States Senator
Chairman, Senate Health, Education, Labor
and Pensions Committee
379 Russell Senate Office Building
Washington, D.C. 20510Albert H. Mackenzie
Deputy District Attorney
Fraud Interdiction Program
Suite 1500
201 N. Figueroa Street
Los Angeles, CA 90012

Gentlepersons:

We represent P. Victor Gonzalez who was employed as the Vice President of Finance & Administration with Planned Parenthood of Los Angeles (PPLA) between December 9, 2002 and March 9, 2004. His job duties required him to take initiative to ensure compliance with all financial rules and regulations governing the financial activities of the Defendant. On behalf of Mr. Gonzalez, and pursuant to his request, the following information we have received from him is provided to you.

In the months preceding the termination of Mr. Gonzalez's employment with PPLA, he had raised various serious financial concerns directly related to conduct violative of Federal and State statutory schemes. These concerns about the illegal accounting, billing, and donations practices of Planned Parenthood were conveyed via writing, e-mails and orally to various Planned Parenthood personnel. The written concerns related directly to the qualifications of

EXHIBIT

7

Planned Parenthood to remain qualified as a health care provider and to receive continued funding from governmental and other sources.

A review of these problems had been undertaken by Planned Parenthood, its affiliates, a number of consultants, and internal reviews conducted by Planned Parenthood employees and Board members. Mr. Gonzalez had led the effort in identifying and enumerating these considerable problems and illicit activities, locating consultants, looking for viable solutions, presenting these solutions to all necessary parties, and procuring the employees to formulate the solutions.

In 1992, Section 340B of the Public Health Service Act was enacted. Section 340B requires drug manufacturers to provide outpatient drugs to eligible health care centers, clinics, and hospitals (termed "covered entities") at a reduced price. The 340B price is a "ceiling price", meaning it is the highest price the covered entity would have to pay for select outpatient and over-the-counter drugs and minimum savings the manufacturer must provide. The entities, including Planned Parenthood, which are eligible to receive federally discounted drugs are subject to various state and federal regulatory schemes dictating their ability to dispense and seek reimbursement for these drugs. California and Federal law provided payment for drugs obtained under Section 340B be based on acquisition cost. As further detailed below, Planned Parenthood violated these regulations and vastly overbilled for reimbursements.

From late 2003 through the actual date of his termination, Mr. Gonzalez had specifically complained about the following problems which jeopardized PPLA's ability to continue receiving governmental funding and monies and to maintain its continuing status as a nonprofit organization. Mr. Gonzalez complained, went on record on this matter, and, in an effort to address these serious issues, participated in numerous phone calls with both PPLA, Planned Parenthood of California, and the Sacramento based PPAC (political action committee).

PPLA had a practice of marking up medications (oral contraceptives, nuvaRing etc.) bought under the "PHS 340B" discount program. The effect of this at PPLA is overcharging the Federal Government, the State of California, and self-pay patients approximately \$2,000,000.00 per year. This has been going on for a number of years, and is prevalent with the other California Planned Parenthood affiliates. As a result the overcharging exceeds \$10,000,000.00 per year. During his employment with Planned Parenthood of Los Angeles, Mr. Gonzalez was requested by Planned Parenthood to perform an assessment of the impact of these overbilling practices, and the other many Planned Parenthood affiliates were asked to do likewise. The result of this assessment report for PPLA revealed approximately \$2,144,313.17 in overbilling. This reflects the financial impact for only one of many Planned Parenthood affiliates in California and only for one year. A copy of the report is enclosed.

In early February 2004, the California Department of Health Services began an audit of the San Diego Planned Parenthood affiliate. The audit was limited to the San Diego Planned Parenthood affiliate. The audit found extensive and illegal markups of medications/contraceptives procured through the federal discount drug program under 38 U.S.C. Section 340B. Specifically, the audit uncovered at least \$5,213,545.92 of illegal billing at

November 18, 2005

Page 3

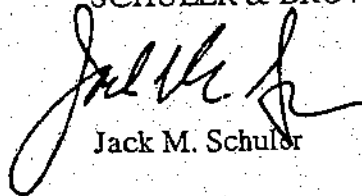
Planned Parenthood San Diego alone. The Department of Health Services chose to ignore these findings notwithstanding the serious violations implicated.

There are many separate Planned Parenthood affiliates in California and there is probable cause to believe that most, if not all of them, also engaged in the same illegal and unscrupulous billing practices. The estimated illegal billing over six years, beginning in 1999, exceeds \$180,000,000.00. This conservative figure only takes into account the illegal and unscrupulous billing practices of Defendants within the state of California.

A preliminary draft of a civil case which will soon be finalized and filed is enclosed for further factual background. Mr. Gonzalez is available to meet with you to provide further documentary evidence and information concerning these fraudulent and illegal overbilling practices.

Very truly yours,

SCHULER & BROWN



Jack M. Schuler

JMS:jpm
Enclosures

Inventory Item#	Description	Base Unit of Measure	Base Unit Cost	YTD Utilization	YTD Expense
CONTRACEPTIVE					
10000	Oral Contraceptive Veridate Com	Bx	\$ -	0	\$ -
10128	Oral Contraceptive Modicon	Ea	1.31	4,087	5,353.97
10211	Preven (Emer Contra Kit)	Pk	1.85	2,482	4,591.70
10328	Oral Cont Ortho Novum 135	Ea	0.61	6,481	3,953.41
10528C	Oral Cont Ortho Novum 150	Ea	3.66	217	794.22
10628	Oral Cont Ortho-Cyclen 28	Ea	3.74	15,500	57,970.00
10728	Oral Cont Ortho Novum 777	Ea	1.57	21,128	33,170.96
10828	Oral Cont Micronor	Ea	2.83	2,652	7,505.16
20000	Depo-Provera 150MG	VL	24.16	6,301	152,232.16
20001	Depo-Provera 150MG W/SRNG	SY	19.75	2,920	57,670.00
20002	Plan B	Ea	4.50	15,747	70,861.50
20003	Lunelle	VL	14.93	0	\$ -
20004	Ortho Evra	Ea	3.27	5,745	18,768.92
20005	Nuva-Ring	Ea	3.00	1,296	3,888.00
20008	Demulan 1/35	Ea	6.02	2,088	12,565.58
20018	Alesse-28	Ea	3.61	25,563	92,384.68
20028	Loestrin Fe 1/20 #913-45	Ea	10.16	9,060	92,049.60
20085	Diaphragms-All-Flex 85	Ea	18.50	4	74.00
20128	Tn-Levlen #43303	Ea	1.89	7,908	14,946.12
20160	Diaphragms-All-Flex 160	Ea	15.25	2	30.50
20165	Diaphragms-All-Flex 165	Ea	18.50	24	444.00
20170	Diaphragms-All-Flex 170	Ea	18.50	29	536.50
20175	Diaphragms-All-Flex 175	Ea	18.50	36	666.00
20180	Diaphragms-All-Flex 180	Ea	18.50	8	148.00
20185	Diaphragms-All-Flex 185	Ea	6.50	1	6.50
20190	Diaphragms-All-Flex 190	Ea	18.50	1	18.50
20195	Diaphragms-All-Flex 195	Ea	18.50	2	37.00
20228	Levlen #41128	Ea	1.07	17,901	19,154.07
20255	Diaphragms-Koromex 255	Ea	15.25	2	30.50
20260	Diaphragms-Koromex 260	Ea	15.25	5	76.25
20265	Diaphragms-Koromex 265	Ea	15.25	7	106.75
20270	Diaphragms-Koromex 270	Ea	15.25	5	76.25
20275	Diaphragms-Koromex 275	Ea	15.25	3	45.75
20280	Diaphragms-Koromex 280	Ea	15.25	10	152.50
20285	Diaphragms-Koromex 285	Ea	15.25	3	45.75
20290	Diaphragms-Koromex 290	Ea	18.50	1	18.50
20295	Diaphragms-Koromex 295	Ea	15.25	1	15.25
20428	Ortho Tri-Cyclen Lo	Ea	18.50	3	55.50
25000	Cervical Cap-Fitting Set	Ea	2.25	23,664	53,244.00
25022	Cervical Cap 22MM	Ea	50.00	10	500.00
		Ea	46.00	1	46.00

Revenue	Net Income
49,044.00	43,690.03
47,009.08	42,417.38
77,772.00	73,818.59
2,604.00	1,809.78
186,000.00	128,030.00
253,536.00	220,365.04
31,824.00	24,318.84
294,697.77	142,465.61
136,568.40	78,898.40
328,482.42	257,620.92
63,941.85	45,172.94
47,964.96	44,076.96
25,056.00	12,490.42
306,756.00	214,371.32
108,720.00	16,670.40
52.00	(22.00)
94,896.00	79,949.88
26.00	(4.50)
312.00	(132.00)
377.00	(159.50)
468.00	(198.00)
104.00	(44.00)
13.00	6.50
13.00	(5.50)
26.00	(11.00)
214,812.00	195,657.93
26.00	(4.50)
65.00	(11.25)
91.00	(15.75)
65.00	(11.25)
130.00	(22.50)
39.00	(6.75)
13.00	(5.50)
13.00	(2.25)
39.00	(16.50)
283,968.00	230,724.00
130.00	(370.00)
13.00	(33.00)

25025	Cervical Cap 25MM	Ea	\$ 26.00	3	\$	78.00
25028	Cervical Cap 28MM	Ea	\$ 46.00	2	\$	92.00
25031	Cervical Cap 31MM	Ea	\$ 26.00	16	\$	416.00
30028	Ortho Tri-Cyclen	Ea	\$ 2.95	76,507	\$	225,695.65
30300	IUD-Paragard	Ea	\$ 149.80	245	\$	36,701.00
30400	IUD-Mirena	Ea	\$ 301.82	40	\$	12,072.80
40100	Condoms (Lubricated)	Ea	\$ 0.06	611,000	\$	34,827.00
40102	Reality (Female Condom)	Ea	\$ 1.09	177	\$	192.93
40103	Condoms (Mint)	Ea	\$ 0.09	2,305	\$	207.45
40104	Condoms (Vanilla)	Ea	\$ 0.09	3,580	\$	322.20
40105	Condoms (Strawberry)	Ea	\$ 0.09	6,080	\$	547.20
40106	Condoms (Chocolate)	Ea	\$ 0.09	5,685	\$	511.65
40107	Condoms (Banana)	Ea	\$ 0.09	2,607	\$	234.63
40108	Condoms (Grape)	Ea	\$ 0.09	2,180	\$	196.20
40109	Condoms (Cola)	Ea	\$ 0.09	1,745	\$	157.05
40110	Latex Barriers (Vanilla)	Ea	\$ 0.48	45	\$	21.60
40111	Latex Barriers (Strawberry)	Ea	\$ 0.48	79	\$	37.92
40114	Slippery Stuff	Ea	\$ 0.20	2,408	\$	481.60
40117	Condoms, Non-Lubricated	Ea	\$ 0.05	5,000	\$	265.00
40200	Jelly Contra Korrmx #115C	Ea	\$ 2.70	282	\$	761.40
40300	Applicator (Jelly #K52B)	Ea	\$ 0.60	148	\$	88.80
40401	Contra. Foam Korormex 635C	Ea	\$ 4.81	466	\$	2,241.46
40500	Vaginal Contraceptive Fill	Ea	\$ 0.60	2,969	\$	1,781.40

39.00	(39.00)
26.00	(66.00)
208.00	(208.00)
918,084.00	692,388.35
64,141.00	27,440.00
15,008.00	2,935.20
2,301.00	2,108.07
3,666.00	2,904.60
1,924.00	1,835.20
6,058.00	3,816.54
38,597.00	36,815.60

