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UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

P. VICTOR GONZALEZ, QUI TAM PLAINTIFF, ON BEHALF OF HIMSELF, THE UNITED STATES OF AMERICA, AND THE STATE OF CALIFORNIA,

Plaintiff,

vs.

PLANNED PARENTHOOD OF LOS ANGELES; PLANNED PARENTHOOD SHASTA-DIABLO; PLANNED PARENTHOOD GOLDEN GATE; PLANNED PARENTHOOD MAR MONTE; PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTIES; PLANNED PARENTHOOD ORANGE & SAN BERNARDINO COUNTIES, INC.; PLANNED PARENTHOOD PASADENA AND SAN GABRIEL VALLEY, INC.; PLANNED PARENTHOOD SANTA BARBARA, VENTURA & SAN LUIS OBISPO COUNTIES, INC.; SIX RIVERS PLANNED PARENTHOOD; PLANNED PARENTHOOD AFFILIATES OF CALIFORNIA; MARY-JANE WAGLE; MARTHA SWILLER; KATHY KNEER; and DOES 1 through 100,

Defendants.

Case No. CV05-8818 AHM (FMOx)

FIRST AMENDED COMPLAINT FOR:

1) DAMAGES; AND
2) CIVIL PENALTY

(FALSE CLAIMS ACTION)

[DEMAND FOR JURY TRIAL]

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

INTRODUCTION

1. Qui Tam Plaintiff/Relator P. Victor Gonzalez was the Chief Financial Officer at Planned Parenthood of Los Angeles (PPLA) from December 9, 2002 to March 9, 2004. During his tenure, he became aware of rampant over-billing and other violations of State and Federal law. Accordingly, he tried to take corrective measures including urging reforms. Rather than appropriately addressing these serious issues, Defendants terminated Mr. Gonzalez' employment.

2. In January 2004, California state auditors began a statewide audit of all Planned Parenthood affiliates to determine compliance with billing regulations for drugs reimbursed by the Family Planning, Access, Care and Treatment (FPACT) federal/state program. When the auditors started at the Planned Parenthood San Diego/Riverside site and announced their concerns regarding over-billing, Planned Parenthood notified their lobbyists in Sacramento who in turn contacted state health officials in an effort to stop the audits. This intervention proved successful as the statewide audits were halted.

3. In November 2004 the Department of Health Services Audits and Investigations Division issued an audit report which revealed findings of over-billings greater than $5 million during a two year period at the Planned Parenthood/San Diego/Riverside affiliate alone. Planned Parenthood was never held accountable for the extensive over-billing.

STATEMENT OF FACTS

4. Qui Tam Plaintiff/Relator P. Victor Gonzalez 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 Defendants.

5. In the months preceding the termination of Mr. Gonzalez's employment with PPLA, he raised various serious financial concerns directly related to conduct violative of Federal and State statutes by the defendants. 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 Planned Parenthood's ability to remain qualified to legally receive continued funding from public and private sources. Rather than appropriately addressing these concerns, the response of the defendants was to terminate Relator's employment.

6. Reviews of the subject matter of these concerns had been undertaken from time to time by Planned Parenthood, its affiliates, and a number of consultants. However, other than the memorialization of these concerns during various meetings, there was no effective action to stem these continuing patterns of illicit corporate misconduct. Mr. Gonzalez had led numerous efforts 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.

7. Planned Parenthood affiliates in California are providers under several federal/state programs which give reimbursement for drugs purchased either through independent drug wholesalers or through the federal 340B[1] Drug program and then dispensed by Planned Parenthood's clinics. Planned Parenthood provides services and dispenses contraceptives and drugs to indigent people who have incomes under the poverty level.

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

[1] When drugs such as contraceptives are purchased through the federal 340B program, Section 340B of the Public Health Service Act 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 out-patient and over-the-counter drugs. 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. 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").

To reduce prescription drug prices for 340B Providers, section 340B requires pharmaceutical manufactures to ensure that 340B Providers pay no more for any pharmaceutical product than any other public or private purchaser of that product. Congress 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).

clearly states: "Family PACT requires that drugs and supplies dispensed by the Family PACT provider must be billed at 'cost'." (**Exhibit** "**1a.**") This unambiguous proscription prohibits Defendants and any other eligible provider from buying at deeply discounted prices and then billing at "usual and customary" rates rather than "at cost.[2]

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

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

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

[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.**")

and the State's Title XIX plan.

12. Rebates for drugs and services became effective in December 1999 when California family planning programs became eligible for federal reimbursement. Contraceptives dispensed by Planned Parenthood are financed 10% by the state of California and 90% by federal financial participation. In California, unless otherwise specified in the FPACT manual, FPACT providers must comply with Medi-Cal rules and regulations including those related to billing and reimbursement. The State Medi-Cal regulation, adopted in 1994, states 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) Section 51509.1(c)(3).

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

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

B. 22 C.C.R. 51509.1 specifying that "[r]eimbursement rates 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 cost under Section 51513. (22 C.C.R. 51513, Regulatory definitions of cost.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

17. 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 government 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 the defendants, including PPLA, the other Planned Parenthood affiliates in California, and the Sacramento based PPAC, under the direction of Kathy Kneer.

18. The defendants had a practice of marking up drugs (oral contraceptives, NuvaRing etc.) acquired at deep discounts and then significantly over-billing the government. The effect of this was the defendants overcharging the Federal Government, the State of California, and self-pay patients.

19. For one of the defendants, PPLA, this resulted in overcharging over $2,000,000 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 PPLA, Mr. Gonzalez was requested by Mary-Jane Wagle, CEO of PPLA, to perform an assessment of the impact of these over-billing practices, and the other Planned Parenthood affiliates were asked to do likewise. The result of this assessment report for PPLA revealed approximately $2,144,313.17 in over-billing. This reflects the financial impact for only one of the then ten Planned Parenthood affiliates in California and only for one year. (Attached hereto as **Exhibit** "**4**", is a copy of this assessment.)

20. In early February 2004, the California Department of Health Services Audit and Investigations Branch began an audit of all ten Planned Parenthood Affiliates in California starting with the Planned Parenthood of San Diego & Riverside Counties affiliate. State officials intervened on behalf of Defendants and stopped the statewide audits of Planned Parenthood affiliates from being conducted. (Attached hereto as **Exhibit** "**5**" is an email from Mark Salo referencing said audits.) The final audit report of November 2004 was limited to the Planned Parenthood of San Diego & Riverside Counties affiliate. The audit found extensive and

illegal markups of medications/contraceptives. Specifically, for the approximately one year period subject to review, the audit uncovered at least $5,213,545.92 of illegal billing at Planned Parenthood of San Diego & Riverside Counties alone. State officials within the California Department of Health Services (DHS) chose to ignore these findings notwithstanding the serious violations implicated thereby allowing the illegal activity to continue unchecked. This is in spite of the fact that Defendants had been continually counseled that they were required to bill "at cost." On February 5, 2004, Kathy Kneer, President of Planned Parenthood Affiliates of California (PPAC), Planned Parenthood's public affairs operation, sent an e-mail to key Planned Parenthood personnel informing them that "Kim [Belshe] (Secretary of the California Health and Human Services Agency (CHHS)) 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." (Attached hereto as **Exhibit** "**6**" is a copy of this Feb. 5, 2004 email.) [Emphasis Added.]

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

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

affiliates have bought drugs at discount prices and rather than selling the drugs to their indigent clientele at the required Acquisition Cost, they illegally marked-up the drugs and billed them to both clients and government sometimes at greater than 12 times the acquisition cost. The estimated illegal billing over six years, beginning in at least 1997, 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.

THE FALSE CLAIMS ACT

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

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

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

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

JURISDICTION AND VENUE

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

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

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

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PARTIES

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

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.

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

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

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

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

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

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

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

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GENERAL ALLEGATIONS

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

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

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

42. In the months preceding Relator's employment termination, 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 the Defendant were conveyed via writing, e-mails or orally. The written concerns related directly to Planned Parenthood's ability to remain qualified to legally receive continued funding from public and private sources. (Attached hereto as **Exhibit** "**8**" are true and correct copies of e-mails/correspondence regarding Relator's concerns)

43. A review of these problems had been undertaken from time to time by PPLA, its affiliates, a number of consultants, and internal reviews conducted by PPLA employees and Board members. Relator 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. Attached hereto is a true and correct copy of the original draft report that mentions the various problems that existed at PPLA during Plaintiff's employment. (See **Exhibit** "**9**"). This report was subsequently altered by Mary-Jane Wagle. (See **Exhibit** "**10**").

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

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

etc) over and above acquisition cost. 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 all the other California PP affiliates. As a result the overcharging exceeds $10,000,000.00 per year.

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

47. In early February 2004, The California Department of Health Services began an audit of all ten Planned Parenthood affiliates in California beginning with the Planned Parenthood of San Diego & Riverside Counties affiliate. The final audit report was limited to the Planned Parenthood of San Diego & Riverside Counties affiliate. The audit found extensive and illegal markups of medications/contraceptives in excess of cost. Specifically, the audit uncovered at least $5,213,545.92 of illegal billing at Planned Parenthood of San Diego & Riverside Counties alone in one fiscal year. (Attached hereto as **Exhibit** "**12**" is a true and correct copy of the audit and letter detailing the illegal activity.) The Audit Report found extensive and illegal markups of medications/contraceptives "in excess of cost" for a total of $5,213,545.92 in one fiscal year. The Audit Report also documented that the requirement (to bill at cost) " was in effect for the entire audit period," and "In December 2003 the Department issued a Medi-Cal Update, Medical Services bulletin 353 which reminded providers of the existing policy that contraceptive supplies must be billed at cost."

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48. The California Department of Health Services, following intervention by Defendants, chose to ignore these findings notwithstanding the serious violations implicated allowing for this illegal activity to continue unchecked.

49. During all times pertinent to this complaint, there were ten separate Planned Parenthood affiliates in California each of which also engaged in the same unscrupulous billing practices. These Nine affiliates are part of a nationwide organization consisting of 103 affiliates forming the Planned Parenthood Federation of America. The estimated illegal billing of the defendants over six years, beginning in approx. 1997, 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.

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

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

52. Relator additionally complained of filing, providing doctored and rosy financial projections, and suppression of Single Audit Report (OMB 133) findings to California Health Facilities Financing Authority (CHFFA) with the intention of inducing CHFFA to approve a loan of $400,000 to save PPLA's South Los Angeles clinic.

53. PPLA intentionally did not disclose the Single Audit findings and material weaknesses to CHFFA or other regulatory agencies, even though it pointed out failures in management and financial controls. This Single Audit report covered precisely the period under review and being questioned by CHFFA officials. In fact, the Single Audit report's findings likely disqualified PPLA from many other government programs.

54. PPLA also sought to hide the losses and the funding freeze from the California Family Health Council (CHFC)—over half a million dollars in the same 2002 period. Mary-Jane Wagle sent an email advising Relator to be deliberately vague in these disclosures. The chairman of the PPLA finance committee was copied in this email. True and correct copies of emails evidencing the scheme to suppress and camouflage as well as continue the aforementioned illegal activity are attached as **Exhibit** "**13**".

55. Rather than remedying the multiple serious problems identified by Relator, Defendants instead terminated his employment.

56. At and before the time of Relator's termination it was the intent of PPLA to suppress information relating to illegal billing from the government, potential auditors, and members of the public. Moreover, Defendants knew that false and misleading information had been provided to the State

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

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

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

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

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

referred to hereinafter as "State Insurers."

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

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

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

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

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

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

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

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

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

COUNT I

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

(All Defendants)

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

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

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

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

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

COUNT II

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

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

74. 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.

75. 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.

76. Defendants thus knowingly used false records or statements to get false or fraudulent claims paid or approved by the United States in violation of the False Claims Act. The exact amount of the United States' harm has not yet been determined. The precise amount of damage caused by defendants 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)

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

and the United States by getting false claims paid 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 United States' harm has not yet been determined. The precise amount of damage caused by Defendants will be ascertained at trial.

COUNT V

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

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

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

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

86. 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.

COUNT VI

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

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

88. 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.

89. Defendants thus knowingly conspired to defraud the State of California and the United States by getting false claims paid 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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COUNT VII

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

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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COUNT VIII

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

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

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

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

97. Defendants thus knowingly caused the submission of false claims to 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. Relator is informed and believes and thereon alleges that the State of California was damaged by Defendants in an amount as yet unknown. The precise amount of damage caused by Defendants will be 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.

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

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

COUNT XI

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

(All Defendants)

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

106. 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 and State Insurers.

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

trial.

COUNT XII

(Unjust Enrichment) (All Defendants)

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.

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

familypact22
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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."

EXHIBIT 1a.

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.

EXHIBIT 1 b.

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 Prerequisite 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 his/her 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 his/her paid or obligated liability for health care services, goods, supplies, or merchandise, or to establish eligibility.

E OF CALIFORNIA—HEALTH AND WELFARE AGENCY
PETE WILSON, Governor

PARTMENT OF HEALTH SERVICES
744 P STREET
BOX 942732
AMENTO, CA 94234-7320
16) 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

OCT 6 1997

Pete Wilson, *Governor*

State Of California - Health and Welfare Agency
DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, California 94234-7320
(916) 654-7171

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 26.

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

PPAC

Planned Parenthood®
Affiliates of California
555 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:

Norgistimate 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 /mes

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

State of California - Health and Welfare Agency
DEPARTMENT OF HEALTH SERVICES
714/744 P Street
P. O. Box 942732
Sacramento, California 94234-7320
(916) 657-1460

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.

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

PROVIDER NAME & STATUS #	ADDRESS	CITY
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 ½ 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	Rohnert 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

Planned Parenthood
of San Diego & Riverside Counties

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 saving 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,

Mark Salo
President & CEO

1075 Camino del Rio South, Ste. 200 • San Diego, CA 92108 • Phone (619) 683-7526 • Fax (619) 291-0255

EXHIBIT 3a

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,

Mark Salo
President & CEO

EXHIBIT 36.

1075 Camino del Rio South, Ste. 200 • San Diego, CA 92108 • Phone (619) 683-7526 • Fax (619) 291-0255

Planned Parenthood
of San Diego & Riverside Counties

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

1075 Camino del Rio South, Ste. 200 • San Diego, CA 92108 • Phone (619) 683-7526 • Fax (619) 291-0255

PPAC

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 saving 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

EXHIBIT 3d

Sponsoring Organization
Planned Parenthood Affiliates of California (PPAC)

555 Capitol Mall, Suite 510 • Sacramento, California 95814-4581 • Phone (916) 446-5247 • Fax (916) 441-0632 • www.ppacca.org

Cell: 799-0345

PPAC Planned Parenthood Affiliates of California, Inc.

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 saving 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 FPACT clients. A change of this magnitude should be handled by the legislature.

Sponsoring Organization

Planned Parenthood Affiliates of California (PPAC).

PPAC

Planned Parenthood
Affiliates of California, Inc.
Providing responsible choices through advocacy and political action.

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.

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."

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 Mclaurell:

no position =

don't get paid for ingredient cost + dispensing fee

H&C) (3):

B&P 4163 section → allows dietz to dispense pres. drugs of special licenses

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, familypact1 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 spreasheet.

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

nventory Item#	Description	Base Unit of Measure	Base Unit Cost	YTD Utilization	YTD Expense	Revenue	Net Income
	CONTRACEPTIVE						
10000	Oral Contraceptive Veridate Com	Bx	$ -	0	$ -		
10128	Oral Contraceptive Modicon	Ea	$ 1.31	4,087	$ 5,353.97	49,044.00	43,690.03
10211	Preven (Emer Contra Kit)	Pk	$ 1.85	2,482	$ 4,591.70	47,009.08	42,417.38
10328	Oral Cont Ortho Novum 135	Ea	$ 0.61	6,481	$ 3,953.41	77,772.00	73,818.59
10528C	Oral Cont Ortho Novum 150	Ea	$ 3.66	217	$ 794.22	2,604.00	1,809.78
10628	Oral Cont Orhto-Cyclen 28	Ea	$ 3.74	15,500	$ 57,970.00	186,000.00	128,030.00
10728	Oral Cont Ortho Novum 777	Ea	$ 1.57	21,128	$ 33,170.96	253,536.00	220,365.04
10828	Oral Cont Micronor	Ea	$ 2.83	2,652	$ 7,505.16	31,824.00	24,318.84
20000	Depo-Provera 150MG	VL	$ 24.16	6,301	$ 152,232.16	294,697.77	142,465.61
20001	Depo-Provera 150MG W/SRNG	SY	$ 19.75	2,920	$ 57,670.00	136,568.40	78,898.40
20002	Plan B	Ea	$ 4.50	15,747	$ 70,861.50	328,482.42	257,620.92
20003	Lunelle	VL	$ 14.93	0	$ -	-	-
20004	Ortho Evra	Ea	$ 3.27	5,745	$ 18,768.92	63,941.85	45,172.94
20005	Nuva-Ring	Ea	$ 3.00	1,296	$ 3,888.00	47,964.96	44,076.96
20008	Demulen 1/35	Ea	$ 6.02	2,088	$ 12,565.58	25,056.00	12,490.42
20018	Alesse-28	Ea	$ 3.61	25,563	$ 92,384.68	306,756.00	214,371.32
20028	Loestrin Fe 1/20 #913-45	Ea	$ 10.16	9,060	$ 92,049.60	108,720.00	16,670.40
20085	Diaphragms-All-Flex 85	Ea	$ 18.50	4	$ 74.00	52.00	(22.00)
20128	Tri-Levlen #43303	Ea	$ 1.89	7,908	$ 14,946.12	94,896.00	79,949.88
20160	Diaphragms-All-Flex 160	Ea	$ 15.25	2	$ 30.50	26.00	(4.50)
20165	Diaphragms-All-Flex 165	Ea	$ 18.50	24	$ 444.00	312.00	(132.00)
20170	Diaphragms-All-Flex 170	Ea	$ 18.50	29	$ 536.50	377.00	(159.50)
20175	Diaphragms-All-Flex 175	Ea	$ 18.50	36	$ 666.00	468.00	(198.00)
20180	Diaphragms-All-Flex 180	Ea	$ 18.50	8	$ 148.00	104.00	(44.00)
20185	Diaphragms-All-Flex 185	Ea	$ 6.50	1	$ 6.50	13.00	6.50
20190	Diaphragms-All-Flex 190	Ea	$ 18.50	1	$ 18.50	13.00	(5.50)
20195	Diaphragms-All-Flex 195	Ea	$ 18.50	2	$ 37.00	26.00	(11.00)
20228	Levlen #41128	Ea	$ 1.07	17,901	$ 19,154.07	214,812.00	195,657.93
20255	Diaphragms-Koromex 255	Ea	$ 15.25	2	$ 30.50	26.00	(4.50)
20260	Diaphragms-Koromex 260	Ea	$ 15.25	5	$ 76.25	65.00	(11.25)
20265	Diaphragms-Koromex 265	Ea	$ 15.25	7	$ 106.75	91.00	(15.75)
20270	Diaphragms-Koromex 270	Ea	$ 15.25	5	$ 76.25	65.00	(11.25)
20275	Diaphragms-Koromex 275	Ea	$ 15.25	10	$ 152.50	130.00	(22.50)
20280	Diaphragms-Koromex 280	Ea	$ 15.25	3	$ 45.75	39.00	(6.75)
20285	Diaphragms-Koromex 285	Ea	$ 18.50	1	$ 18.50	13.00	(5.50)
20290	Diaphragms-Koromex 290	Ea	$ 15.25	1	$ 15.25	13.00	(2.25)
20295	Diaphragms-Koromex 295	Ea	$ 18.50	3	$ 55.50	39.00	(16.50)
20428	Ortho Tri-Cyclen Lo	Ea	$ 2.25	23,664	$ 53,244.00	283,968.00	230,724.00
25000	Cervical Cap-Fitting Set	Ea	$ 50.00	10	$ 500.00	130.00	(370.00)
25022	Cervical Cap 22MM	Ea	$ 46.00	1	$ 46.00	13.00	(33.00)

25025	Cervical Cap 25MM	Ea	$ 26.00	3	$ 78.00	39.00		(39.00)
25028	Cervical Cap 28MM	Ea	$ 46.00	2	$ 92.00	26.00		(66.00)
25031	Cervical Cap 31MM	Ea	$ 26.00	16	$ 416.00	208.00		(208.00)
30028	Ortho Tri-Cyclen	Ea	$ 2.95	76,507	$ 225,695.65	918,084.00		692,388.35
30300	IUD-Paragard	Ea	$ 149.80	245	$ 36,701.00	64,141.00		27,440.00
30400	IUD-Mirena	Ea	$ 301.82	40	$ 12,072.80	15,008.00		2,935.20
40100	Condoms (Lubricated)	Ea	$ 0.06	611,000	$ 34,827.00			
40102	Reality (Female Condom)	Ea	$ 1.09	177	$ 192.93	2,301.00		2,108.07
40103	Condoms (Mint)	Ea	$ 0.09	2,305	$ 207.45			
40104	Condoms (Vanilla)	Ea	$ 0.09	3,580	$ 322.20			
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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 Kormx #115C	Ea	$ 2.70	282	$ 761.40	3,666.00		2,904.60
40300	Applicator (Jelly #K52B)	Ea	$ 0.60	148	$ 88.80	1,924.00		1,835.20
40401	Contra. Foam Koromex 635C	Ea	$ 4.81	466	$ 2,241.46	6,058.00		3,816.54
40500	Vaginal Contraceptive Fil	Ea	$ 0.60	2,969	$ 1,781.40	38,597.00		36,815.60

						3,605,719.48	2,621,409.74
							81.8%
							$2,144,313.17
	FPACT & Medi-Cal			894,464	$ 1,022,119		

Gonzalez, Victor

From: Swiller, Martha
Sent: Monday, January 26, 2004 5:38 PM
To: Gonzalez, Victor; Smith, Kathy; Gray, Eldyne; Mary Jane Wagle (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; Pais, 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

EXHIBIT 5

1/26/2004

onzalez, Victor

From: Kneer, Kathy
Sent: Thursday, February 05, 2004 6:48 PM
To: Spitz, Lilly; Reed, Angela; Berthelsen, Birgitte; Coles, Bob; Eckhardt, 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; Swiller, 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 acquistion cost. She had this conversation with DHSafter 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 affilite to provide our office with information about your affilaites 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 accuarately reflecting the deepth 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 affilaite can estimate the Total $ impact - if not that's okay. You should also begin preparing for discussion sake - what the impact at an affilaite 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 thiss short notice for the call on Monday, I hope that each affilaite 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

SCHULER & BROWN ATTORNEYS AT LAW

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LOS ANGELES COUNTY
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VAN NUYS, CA 91406
TELEPHONE: (818) 756-0999
FAX (818) 756-0998
SchulerBrownLaw@aol.com

VENTURA/SANTA BARBARA COUNTIES
129 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. 20530-0001

Consuelo S. Woodhead, U.S. Attorney
United States Attorney's Office
Central District of California
Criminal Division
312 N. Spring Street
Los Angeles, CA 90012

Daniel R. Levinson, Inspector General
Health and Human Services Office
of Inspector General HHS-OIG
Department of HHS
330 Independence Avenue, SW
Washington, D.C. 20201

J. Stephen Tidwell, Assistant Director
FBI-Los Angeles
11000 Wilshire Blvd., Suite 1700
Los Angeles, CA 90024

Michael B. Enzi, United States Senator
Chairman, Senate Health, Education, Labor
and Pensions Committee
379 Russell Senate Office Building
Washington, D.C. 20510

Albert 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

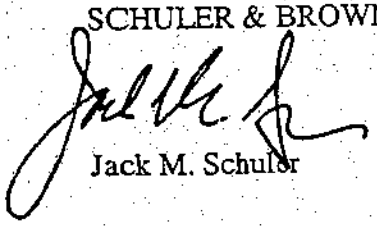
Planned Parenthood San Diego alone. The Department of Health Services chose to ignore these findings notwithstanding the serious violations implicated.

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	Revenue	Net Income
	CONTRACEPTIVE						
10000	Oral Contraceptive Veridate Com	Bx	$ -	0	$ -		
10128	Oral Contraceptive Modicon	Ea	$ 1.31	4,087	$ 5,353.97	49,044.00	43,690.03
10211	Preven (Emer Contra Kit)	Pk	$ 1.85	2,482	$ 4,591.70	47,009.08	42,417.38
10328	Oral Cont Ortho Novum 135	Ea	$ 0.61	6,481	$ 3,953.41	77,772.00	73,818.59
10528C	Oral Cont Ortho Novum 150	Ea	$ 3.66	217	$ 794.22	2,604.00	1,809.78
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20000	Depo-Provera 150MG	VL	$ 24.16	6,301	$ 152,232.16	294,697.77	142,465.61
20001	Depo-Provera 150MG W/SRNG	SY	$ 19.75	2,920	$ 57,670.00	136,568.40	78,898.40
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20004	Ortho Evra	Ea	$ 3.27	5,745	$ 18,768.92	63,941.85	45,172.94
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20028	Loestrin Fe 1/20 #913-45	Ea	$ 10.16	9,060	$ 92,049.60	108,720.00	16,670.40
20085	Diaphragms-All-Flex 85	Ea	$ 18.50	4	$ 74.00	52.00	(22.00)
20128	Tri-Levlen #43303	Ea	$ 1.89	7,908	$ 14,946.12	94,896.00	79,949.88
20160	Diaphragms-All-Flex 160	Ea	$ 15.25	2	$ 30.50	26.00	(4.50)
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20190	Diaphragms-All-Flex 190	Ea	$ 18.50	1	$ 18.50	13.00	(5.50)
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81.8%

$2,144,313.17

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Attorneys for P. Victor Gonzalez, Qui Tam Plaintiff, on Behalf of Himself, the United States of America, and the State of California

DRAFT

UNITED STATES DISTRICT COURT

FOR THE CENTRAL DISTRICT OF CALIFORNIA

P. VICTOR GONZALEZ, QUI TAM PLAINTIFF, ON BEHALF OF HIMSELF, THE UNITED STATES OF AMERICA, AND THE STATE OF CALIFORNIA, **Plaintiff,** vs. **PLANNED PARENTHOOD OF LOS ANGELES, a California Nonprofit Corporation, and DOES 1 through 10, inclusive.** **Defendants.**	**Case No.** **COMPLAINT FOR:** **1) DAMAGES; AND** **2) CIVIL PENALTY** **(FALSE CLAIMS ACTION)** **[DEMAND FOR JURY TRIAL]**

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

THE FALSE CLAIMS ACT

The False Claims Act ("FCA") provides, in pertinent part that:

(a) Any person who (1) knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for

payment or approval; (2) knowingly makes, uses or causes to be made or used a false record or statement to get a false of fraudulent claim paid or approved by the Government;... or (7) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,... is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000 plus 3 times the amount of damages which the Government sustains because the act of the person...

(b) For purposes of this section, the terms "knowing" and "knowingly" mean that a person, with respect to information (1) has actual knowledge of the information; (2) acts in deliberate ignorance of the truth or falsity of the information; or (3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required. False Claims Act, 31 U.S.C. Section 3729

JURISDICTION AND VENUE

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

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

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

PARTIES

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

5. Defendants Does 1 through 10 are PLANNED PARENTHOOD (PP) districts within the State of California, and individual PLANNED PARENTHOOD affiliates/clinics within the State of California; employees and agents of PLANNED PARENTHOOD districts and individual PLANNED PARENTHOOD affiliates/clinics in the State of California; and individuals, persons, associations and organizations, whose identity and capacity are presently unknown to Relator. Relator is informed and believes and thereon alleges that Defendants Does 1 through 10 are legally responsible and liable for the acts, omissions, injuries, damages and false claims hereinafter set forth and that each of said Defendants legally and proximately caused the injuries and damages herein alleged by reason of the conduct hereinafter set forth, or by reason of direct or imputed negligence or vicarious fault or breach of duty

arising out of the matters herein alleged. Relator will seek leave to amend this Complaint to set forth the true names, capacities and identities of Does 1 through 10, when same are ascertained.

6. Relator, P. Victor Gonzalez is an individual residing/domiciled in San Diego County, State of California. Relator was employed as the Vice President of Finance & Administration with Defendant PPLA between December 9, 2002 and March 9, 2004.

7. This action by relator is not based upon a "public disclosure" as defined by 31 U.S.C. § 3730(e)(4)(A), and even if there were a public disclosure in this case, relator would qualify as an "original source" as defined by 31 U.S.C. § 3730(e)(4)(A). P. Victor Gonzalez relayed the information contained herein to the DHS services auditor by e-mail corresopondence on ___,2004, and further relayed the information contained herein to the Department of Justice, the Health and Human Services Office of the Inspector General, the Federal Bureau of Investigations, and the Los Angeles County District Attorney as the "original source" of this information.

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

9. Relator is informed and believes and thereon alleges that at all times relevant, Defendants, and each of them, including each and every Doe

Defendant, authorized and ratified some or all of the acts and omissions alleged hereinafter.

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

GENERAL ALLEGATIONS

11. At all times relevant to this Complaint, the Defendants provided care and prescription medications including contraceptives to patients at one or more of the facilities referenced above. Defendants receive funding from state and federal governments, from private donors, certain insurance plans, and from fees received from patients.

12. At all times relevant to this Complaint, defendants were authorized providers of services to patients insured by Medicare, Medicaid, the Family Planning, Access, Care and Treatment (FPACT) program under the authority of section 1115(a)(2) of the Social Security Act, and other federally funded programs. All of these federally funded programs are collectively referred to hereinafter as "Federal Insurers." Defendants also received benefits pursuant to Section 340B of the Public Health Service Act.

13. 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 340B price is at least as low as the price that state Medicaid agencies currently pay.

14. Entities Covered under Section 340B must maintain accurate records documenting that the entities are not double dipping or reselling, or transferring drugs to persons who are not patients of the entity. An entity must present records in the case of an audit by the manufacturer or the federal government.

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

16. In the months preceding Relator's termination, 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 the Defendant were conveyed via writing, e-mails or orally. The written concerns related directly to the

qualifications of PPLA to remain qualified as a health care provider and to receive continued funding from governmental and other sources.

17. A review of these problems had been undertaken from time to time by PPLA, its affiliates, a number of consultants, and internal reviews conducted by PPLA employees and Board members. Relator had led the effort in identifying and enumerating these considerable problems and illicit acivities, locating consultants, looking for viable solutions, presenting these solutions to all necessary parties, and procuring the employees to formulate the solutions. Attached hereto is a true and correct copy of the draft report that mentions the various problems that truly existed at PPLA during Plaintiff's employment. (See Exhibit __).

18. From late 2003 through the actual date of his termination, Plaintiff 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: Many of these complaints are mentioned in Exhibit 3, a true and correct copy of a memorandum provided to upper management at Defendant PPLA.

19. 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 all the other California PP affiliates. As a result the overcharging exceeds $10,000,000.00 per year.

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

21. In early February 2004, The 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 Planned Parenthood San Diego alone. (See Exhibit ___)

22. The Department of Health Services chose to ignore these findings notwithstanding the serious violations implicated.

23. There are ten separate Planned Parenthood affiliates in California each of which also engaged in the same 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.

24. The actions of PPLA and other Defendants resulted in violations of the public policy set forth in or furthered by OMB Circular A-133, FPACT Written Regulations, 61 CFR 4359, Section 340B of Public Law 102-585 (Veterans Health Care Act of 1992), regulations of the Office of Pharmacy Affairs, and US Department of Health & Human Services

regulations, California Government Code §§ 12650-12655, 31 U.S.C. § 3729 et seq., and various other statutes.

25. While applicable regulations are designed to protect the most vulnerable of patient populations by reducing the costs of drugs, a fundamental public policy, PPLA and other Defendants have instead undercut this policy by overcharging, creating excess inventory, and other acts designed to generate revenue for themselves at the expense of the public. (Please see Exhibit __).

26. Relator additionally complained of filing, providing doctored and rosy financial projections, and suppression of Single Audit Report (OMB 133) findings to California Health Facilities Financing Authority (CHFFA) with the intention of inducing CHFFA to approve a loan of $400,000 to save the South Los Angeles PPLA clinic.

27. PPLA intentionally did not disclose the Single Audit findings and material weaknesses to CHFFA or other regulatory agencies, even though it pointed out failures in management and financial controls. This Single Audit report covered precisely the period under review and being questioned by CHFFA officials. In fact the Single Audit report's findings likely disqualified PPLA from many other government programs.

28. PPLA also sought to hide the losses and the funding freeze from the CHFC Title X grant which were over half a million dollars in the same 2002 period. The named CEO of PPLA, who personally terminated Plaintiff, sent an email advising to be deliberately vague in these disclosures, the chairman of the PPLA finance committee was copied in

this email. True and correct copies of emails seeking suppression are attached as Exhibits --- & --- hereto.

29. Rather than remedying the multiple serious problems identified by Relator, Defendants instead terminated his employment.

30. At and before the time of Relator's termination it was the intent of PPLA to suppress information from the government, potential auditors, and members of the public. (See Exhibit __). Moreover, Defendants knew that inaccurate information had been provided to the State of California, private funding sources, and the federal government, or that billing codes used by PPLA were creating problems that would affect funding. (See Exhibit __).

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

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

33. Defendants' conduct poured over into misrepresentation that was made to private donors and governmental agencies as well during and prior to 2004 in violation of California Business & Professions Code § 17500, et seq., and California Civil Code § 1760, et seq. (California Consumer Legal Remedies Act), which prohibit this type of deception. Moreover, Defendants had already agreed not to engage in certain violations of public policy designed to protect taxpayers from fraud and abuse.

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

35. At all times relevant to this Complaint, Defendants were authorized providers of services to patients insured by MediCal and other state funded All of these state funded programs are collectively referred to hereinafter as "State Insurers."

36. Relator is informed and believes and thereon alleges that, at all times relevant to this Complaint, Defendants submitted, or caused to be submitted, claims for reimbursement for services provided to individuals insured by MediCal to Electronic Data Systems, Inc., which then forwarded those claims to the Department of Health Services for ultimate payment by the Controller of the State of California. Relator is informed and believes and thereon alleges that, at all times relevant to this

Complaint, the State of California received at least 50% of its funding from HHS for payments made on behalf of MediCal patients.

37. Between at least 1999 and the present, Defendants have knowingly engaged in a series of fraudulent billing practices that have damaged State and Federal Insurers. Defendants have been enriched by these practices, directly or indirectly, in the form of excessive payments for the services provided.

38. At all times relevant to this Complaint, defendants billed, or caused to be billed, State and Fiscal Intermediaries who act on behalf of the State and the Federal Government, for Evaluation and Management ("E&M") services, drugs and medications provided to the patient and clientele population of Defendant, and other services as prescribed in the FPACT manual and guidelines controlling and emanating from the various Waiver programs and demonstration projects which funded these activities for Defendant and Does over the years as the law was interpreted and applied to all services performed by the health care providers on behalf of patients. The amount paid for such services depended variously on the Current Procedural Terminology ("CPT") code assigned by defendants for the services performed, as well as the "local and state codes" which FPACT enacted from time to time. The CPT coding system provides for the assignment of different codes by healthcare providers depending on the type of services provided as well as the drug and medications, the contraceptive pills, devices, and other drugs and materials being dispensed as a result of a physician visits or otherwise as "social" or community services visits as these were variously designated from time to time by Defendant and Does.

39. One of the practices of Defendants was the knowing and systematic assignment of codes allowing them to charge at other than cost for the services, drugs, and medications being dispensed and made available to patients and clientele. For example, the coding may have been designated as "supplies" from time to time and charged to the State, and by derivation to the Federal programs, at the marked up prices and not at the required cost of such services, drugs, and medications.

40. As a result of this mechanism of coding and perpetuating of historical flat fees charged for such medications, services, and drugs, in many instances, Defendants practices resulted in the equivalent of "upcoding" the acuity, economic, and time value of their services or prescriptions within the range applicable to the relevant type of service or prescription.

41. In many cases, the code assigned for a service or prescription was not even selected by a healthcare provider under whose name the service was billed or who provided the prescription medication; the charge was instead assigned by a non-healthcare provider staff member. The code was also often gang-assigned mechanically by a system, or "hidden from view" by use of "spoofing or cover coding" resulting in various tables, entries and devices inside the system being used to elevate miscoding and price-gouging and thereby creating an artifice of accepted and established methods of charging and coding. This artifice was comprised of billing entries corrolating to historically charged amounts for the corresaponding medications or services which were never checked by State DHS audits or otherwise validated. This was widely known to the Defendants and was the subject of emails with PPAC.

42. The alleged justification for this misconduct, as evident in the subject emails, was that the entire system was compensating for the shortfall in the basic visits charge that the State and by derivation the Federal government allowed. Complying with proper billing practices would have meant that Defendants' entire healthcare delivery system would have had to be significantly reshaped adopting more austere budgets and forestalling its expansion. It follows that complying with proper billing practices was not in Defendants' best interests and therefore was disregarded.

43. A report of PPLA's billing practices was performed on or about January 2004. (See Exhibit __) The report, which focused on the provision of contraceptives and subsequent reimbursements, showed that the extent of defendants' fraud was pervasive. The report indicates that defendants routinely engaged in numerous other improper billing practices and collected substantially higher reimbursement amounts for these contraceptives than if they had billed correctly. Defendants are in possession of the records necessary to further verify these allegations.

44. The internally prepared study, responsive to a call to action by PPAC, was based on PPLA records from 2002 through 2003. It represented a 12 month projection and it is representative of the the general billing practices and exhorbitant overbilling of Defendants. Based on his experience working at PPLA, relator is informed and believes that other defendants were at least equally aggressive, if not more so, when billing on behalf of patients insured by State and Federal Insurers.

45. Relator is further informed and believes that the defendants' aggressive billing practices with State and Federal Insurers were in place from as early as 1999 and persisted consistently thereafter. Previous auditing had revealed similar patterns of overbilling on the part of Defendants dating back to 1999 and earlier, yet the problems were not corrected by defendants.

46. Defendants were made aware of the various aforementioned improprieties. Nonetheless, relator is informed and believes that Defendants have not reimbursed State or Federal Insurers for the amounts that have been improperly billed. Relator is further informed and believes that defendants continued to engage in the unlawful practices described herein even after the problems were brought to their attention and the San Diego DHS audit was completed.

COUNT I

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

47. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

48. Between at least 1999 and the present, defendants have knowingly submitted, or caused to be submitted, claims for payment by Federal Insurers, FPACT, and MediCal for higher levels of E&M services than were actually provided to patients as well as reimbursements for medications/contraceptives in excess of allowable limits.

49. Relator is informed and believes that, between at least 1999 and the present, defendants have knowingly overbilled Federal Insurers, FPACT, and MediCal.

50. Defendants thus knowingly caused the submission of false claims to the United States in violation of the False Claims Act. The exact amount of the United States' harm has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT II

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

51. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

52. Between at least 1999 and the present, defendants knowingly prepared or caused to be prepared false records and/or statements in connection with the upcoding of the E&M services provided by defendants. Incorrect CPT codes and modifier codes were assigned to patients' records that were knowingly false.

53. Relator is informed and believes that, between at least 1999 and the present, defendants also knowingly prepared false records and/or statements in connection with billing for medications/contraceptives. Defendants frequently assigned incorrect CPT codes.

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

COUNT III

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

(All Defendants)

55. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

56. Between at least 1999 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.

57. 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 United States' harm has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT IV

(Reverse False Claims - 31 U.S.C. § 3729(a)(7)) (All Defendants)

58. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

59. By engaging in the conduct described above, defendants avoided or reduced obligations owed to reimburse funds to Federal Insurers.

60. When seeking additional payments from Federal Insurers following the improper receipt of funds described above, defendants knowingly concealed information concerning the offsetting reimbursements that were owed to the Government and thus reduced defendants' obligation to Federal Insurers. Further, relator is informed and believes that by knowingly concealing and/or failing to disclose the overpayments during federal government audits or reviews of their billing, defendants avoided making payments to Federal Insurers to refund monies overpaid to them.

61. Defendants thus knowingly used false records or statements to reduce or avoid an obligation to pay the United States in violation of the False Claims Act. The exact amount of the United States' harm has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT V

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

62. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

63. Between at least 1999 and the present, defendants have knowingly submitted, or caused to be submitted, claims for payment by State Insurers (including MediCal) for higher levels of E&M services and other

types of services, medications, and drugs, as variously coded from time to time, than were actually provided to patients.

64. Relator is informed and believes that, between at least 1999 and the present, defendants have knowingly over-billed State Insurers (including MediCal) for medications/contraceptives.

65. Defendants thus knowingly caused the submission of false claims to 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. Relator is informed and believes and thereon alleges that the State of California was damaged by defendants in an amount as yet unknown. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT VI

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

66. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

67. Between at least 1999 and the present, defendants knowingly prepared or caused to be prepared false records and/or statements in connection with incorrect CPT codes and modifiers which were assigned to patients' records that were knowingly false, misleading in their method of assignment, or deliberately concealed and billed as generalized supplies.

68. Relator is informed and believes that, between at least 1999 and the

present, defendants also knowingly prepared false records and/or statements in connection with billing for prescription medications/contraceptives. Defendants frequently assigned incorrect CPT codes and modifiers which were assigned to patients' records that were knowingly false, misleading in their method of assignment, or deliberately concealed and billed as generalized supplies. In an effort to conceal this pattern of coding and miscoding, Defendants' Chief Operations Officer, Steven Emmert, caused the OSHPD report to be inflated for the calendar year 2002.

69. 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. Relator is informed and believes and thereon alleges that the State of California was damaged by defendants in an amount as yet unknown. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT VII

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

70. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

71. By virtue of the acts and omission described above, defendants are the beneficiary of inadvertent submissions of false claims to the State of California and failed to disclose the false claims to the State of California

within a reasonable time after their subsequent discovery of the falsity of the claims.

72. The exact amount of the State of California's harm has not yet been determined. Relator is informed and believes and thereon alleges that the State of California was damaged by defendants in an amount as yet unknown. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT VIII

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

(All Defendants)

73. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

74. Between at least 1999 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.

75. Defendants thus knowingly conspired to defraud the State of California by getting false claims paid in violation of the State False Claims Act. The exact amount of the State's harm has not yet been determined. Relator is informed and believes and thereon alleges that the State of California was damaged by defendants in an amount as yet unknown. The precise amount of damage caused by defendants will be ascertained at trial.

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COUNT IX

(Submission of False Claims in Violation of Penal Code § 550(a)(6)/ Insurance Code § 1871.7) (All Defendants)

76. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

77. Between at least 1999 and the present, defendants have knowingly submitted, caused to be submitted, and conspired to submit, claims for payment the FPACT program for higher levels of reimbursement than Defendants were actually provided to for provision of prescription Medications/contraceptives to patients. Relator is informed and believes that, between at least 1999 and the present, defendants have knowingly submitted, caused to be submitted, and conspired to submit, inflated bills.

78. Defendants thus knowingly caused the submission of false claims to the State Compensation Fund in violation of Penal Code §§ 550(a)(6) and Insurance Code § 1871.7(b). The exact amount of harm to the State has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT X

(Use of False Statements or Records in Violation of California Penal Code §§ 550(a)(5), 550(b)(1)-(2)/Insurance Code § 1871.7(b)) (All Defendants)

79. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

80. Defendants knowingly prepared, caused to be prepared, and conspired to prepare, false records and/or statements in connection with their coding of services and provision of prescription medications/contraceptives. Specifically, CPT codes and modifiers which were assigned to patients' records that were knowingly false, misleading in their method of assignment, or deliberately concealed and billed as generalized supplies.

81. Defendants thus knowingly used false records or statements to get false or fraudulent claims paid or approved by the State in violation of Penal Code §§ 550(a)(5), 550(b)(1)-(2), and Insurance Code § 1871.7(b). The exact amount of harm to the State has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT XI

(Concealing Overbilling in Violation of Penal Code Section 550(b)(3)/ Insurance Code § 1871.7(b)) (All Defendants)

82. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

83. Defendants have concealed and knowingly failed to disclose the fact that they have overbilled the State for services rendered and provision of prescription medications/contraceptives, despite having had audits performed and other information that make the extent of the fraud manifest to defendants.

84. The exact amount of harm to the State Compensation Fund has not yet

been determined.). The exact amount of harm to the State has not yet been determined. The precise amount of damage caused by defendants will be ascertained at trial.

COUNT XII

(Unjust Enrichment) (All Defendants)

85. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

86. 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.

87. 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.

COUNT XII

Unfair Business Practices

(Business and Professions Code Section 17200 et seq.)

88. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

89. Beginning at an exact date that is unknown to plaintiffs, but within four years prior to the filing of this Complaint, defendants engaged in unfair competition as defined by Business and Professions Code section 17200, by engaging in the following unlawful, unfair or fraudulent acts or practices. Defendants violated the California False Claims Act, Government Code sections 12650 et seq., by the acts and practices set forth in paragraphs 1 through 47 of this First Amended Complaint;

COUNT XIII

Unfair Business Practices

(Business and Professions Code Section 17500 et seq.)

90. Relator realleges and incorporates paragraphs 1 through 47 and all preceding paragraphs of this Complaint as if fully set forth herein.

91. Defendants' conduct poured over into misrepresentation that was made to private donors and governmental agencies as well during and prior to 2004 in violation of California Business & Professions Code § 17500, et seq., and California Civil Code § 1760, et seq. (California Consumer Legal Remedies Act), which prohibit this type of deception. Moreover, Defendants had already agreed not to engage in certain violations of public policy designed to protect taxpayers from fraud and abuse.

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PRAYER FOR RELIEF

WHEREFORE, plaintiff/relator prays for judgment against defendants as follows:

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

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

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

D. On Count IV (Reverse False Claims), an order holding each of the defendants liable for treble the single damages they caused, the amount of which is to be established at trial, penalties of $10,000 for each false

statement or claim, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate.

E. On Count V (Submission of False Claims in Violation of California Government Code Section 12651(a)(1)), an order holding each of the defendants liable for treble the single damages they caused, the amount of which is to be established at trial, penalties of $10,000 for each false claim, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate;

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

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

H. On Count VIII (Conspiracy to Get False Claims Paid in Violation of California Government Code Section 12651(a)(3)), an order holding each of the defendants liable for treble the single damages they caused,

the amount of which is to be established at trial, penalties of $10,000 for each false statement or claim, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate.

I. On Count IX (Submission of False Claims in Violation of Penal Code § 550(a)(6)/Insurance Code § 1871.7), an order holding each of the defendants liable for treble the single damages they caused, the amount of which is to be established at trial, penalties of $10,000 for each false statement or record, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate;

J. On Count X (Use of False Statements or Records in Violation of California Penal Code §§ 550(a)(5), 550(b)(1)-(2)/Insurance Code § 1871.7(b)), an order holding each of the defendants liable for treble the single damages they caused, the amount of which is to be established at trial, penalties of $10,000 for each false statement or claim, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate;

K. On Count XI (Concealing Over-billing in Violation of Penal Code Section 550(b)(3)/Insurance Code § 1871.7(b)), an order holding each of the defendants liable for treble the single damages they caused, the amount of which is to be established at trial, penalties of $10,000 for each false statement or claim, the number of which is to be established at trial, plus such other relief as this Court deems just and appropriate;

L. On Count XI (Business and Professions Code Section 17200 et seq.)

1. Pursuant to Business and Professions Code section 17206, each defendant be assessed a civil penalty of $2,500 for each violation of Business and Professions Code section 17200, in an amount of not less than $1,000,000.00;

2. That pursuant to Business and Professions Code section 17203, defendants, their successors, agents, representatives, employees, and all other persons who act under, by, through, or on behalf of any of them, or any of them, be permanently restrained and enjoined from performing or proposing to perform any of the acts of unfair competition in the State of California;

3. That defendants be ordered to make full restitution for acts of unfair competition as determined by the court;

M. On Count XI (Business and Professions Code Section 17500 et seq.)

1. Plaintiff requests pursuant to Business and Professions Code §§ 17082 treble damages;

2. That pursuant to Business and Professions Code section 17203, defendants, their successors, agents, representatives, employees, and all other persons who act under, by, through, or on behalf of any of them, or any of them, be permanently restrained and enjoined from performing or proposing to perform any of the acts of unfair competition in the State of California;

N. That qui tam plaintiff/relator be awarded all costs of this action, including attorneys' fees; and costs;

O. That the United States and qui tam plaintiff/relator receive such other relief as the Court deems just and proper.

DATED: November 18, 2005

SCHULER & BROWN

DRAFT

By: _____
Jack M. Schuler
Sam D. Ekizian
Attorneys for Plaintiffs, Qui Tam Plaintiff, On Behalf of Himself and the United States

SCHULER & BROWN

ATTORNEYS AT LAW

RIVERSIDE/SAN BERNARDINO COUNTIES
4072 CHESTNUT STREET
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VAN NUYS, CA 91406
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SchulerBrownLaw@aol.com

VENTURA/SANTA BARBARA COUNTIES
129 SIMI AVENUE
OXNARD, CA 93035
(805) 985-8951

21
November ~~18~~, 2005

Alberto R. Gonzales, Attorney General
United States Department of Justice
950 Pennsylvania Avenue, N.W.
Washington, D.C. 20530-0001

Consuelo S. Woodhead, U.S. Attorney
United States Attorney's Office
Central District of California
Criminal Division
312 N. Spring Street
Los Angeles, CA 90012

Daniel R. Levinson, Inspector General
Health and Human Services Office
of Inspector General HHS-OIG
Department of HHS
330 Independence Avenue, SW
Washington, D.C. 20201

J. Stephen Tidwell, Assistant Director
FBI-Los Angeles
11000 Wilshire Blvd., Suite 1700
Los Angeles, CA 90024

Michael B. Enzi, United States Senator
Chairman, Senate Health, Education, Labor
and Pensions Committee
379 Russell Senate Office Building
Washington, D.C. 20510

Albert H. Mackenzie
Deputy District Attorney
Fraud Interdiction Program
Suite 1500
201 N. Figueroa Street
Los Angeles, CA 90012

Gentlepersons:

I have received some highly significant documents since my letter to you of November 18, 2005, and I have enclosed copies of those documents to supplement my earlier letter. These documents further evidence the significant illegal billing activity on the part of Planned Parenthood, which is readily confirmed by its own officials. Equally troubling is the fact that Planned Parenthood used its political influence to attempt to retroactively justify this activity with the collaboration of State officials.

The first document is the November 19, 2004 Audit Report of Jan Inglish, N.P., Chief Medical Review Branch Audits and Investigations, Department of Health Services, which documents $5,213,845.92 of illegal billing under the Family PACT program.

The second document is a copy of an e-mail correspondence from the Planned Parenthood Political Action Committee (PPAC) legal counsel, Lily Spitz. It indicates that PPAC

lobbyist, "Kathy Kneer has spoken with Kim Belshe [California Secretary of Health] about the audit currently being conducted at the San Diego affiliate and has asked that the cost portion of the audit be put on hold..."

The third document is an e-mail correspondence from PPAC lobbyist, Kathy Kneer, which indicates: "as Lily [Spitz] indicates below-I want to reiterate that Kim [Belshe] 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.

The fourth document is the November 19, 2004 letter of California Department of Health Services deputy director for medical care services, Stan Rosenstein. This letter confirms that "the audit report finds an estimated overpayment to the San Diego Planned Parenthood region for contraceptive drugs and supplies for the audit period of $5,213,645.92." This letter further confirms that the California Department of Health Services made a conscious decision to turn a blind eye toward the illegal billing practices of Planned Parenthood by defining the term "at cost" to mean at cost plus $5,213,645.92.

I hope this additional documentation is of assistance in your consideration of this matter.

Very truly yours,

SCHULER & BROWN

Jack M. Schuler

JMS:jpm
Enclosures

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

November 18, 2004

Mr. Bob Coles
Vice President & CFO
Planned Parenthood of San Diego & Riverside Counties
1075 Camino del Rio South, Suite 200
San Diego, CA 92108

PROVIDER NAME: PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTIES
PROVIDER NUMBERS: See Attached Listing (Schedule 5)
AUDIT PERIOD: July 1, 2002 To June 30, 2003 (Codes X1500 and X7706)
February 2, 2003 To May 30, 2004 (Code X7722)

Dear Mr. Coles:

We have completed the audit of Planned Parenthood of San Diego and Riverside Counties (PPH) claims under the Family Planning, Access, Care and Treatment Program (Family PACT) for the above noted audit periods. This audit was conducted in accordance with California Welfare and Institutions (W & I) Code, Sections 14124.2 and 14170. In conducting this audit, the auditors compared medical, financial, and management records relating to your Family PACT services with paid claims information supplied by the fiscal intermediary. The auditors also reviewed correspondence from Planned Parenthood Affiliates of California (PPAC) to determine statewide policies and business practices in place for Planned Parenthood Providers.

In accordance with California Code of Regulations (CCR), Title 22, Section 51021, an Exit Conference was held with you on October 25, 2004. Prior to the exit conference you received a report of the preliminary findings. During the exit conference the audit team discussed the findings with you, and gave you the opportunity to submit additional documentation and/or missing records identified during the audit. The current findings reflect the evaluation of all relevant information received prior and subsequent to the exit conference.

The auditors identified problems in your Medi-Cal billing procedures related to the following Family PACT Codes:

X1500 Contraceptive barrier products
X7706 Oral Contraceptives
X7722 Plan B products

Claims for services provided under the Family PACT program are governed by the Policies, Procedures and Billing manual (PPBI). This manual includes descriptions of the products and services covered by the program, billing codes and instructions. In accordance with Section *familypact22 page 2* of the PPBI Provider's are required to document the name of the medication or supply dispensed, the quantity and the provider's cost per unit. Section *familypact32* contains completed sample claims for the provider's reference. This requirement was in effect for the entire audit period. In December 2003, the Department issued a Medi-Cal Update, Medical Services Bulletin 353 which reminded providers of the existing policy that contraceptive supplies must be billed at cost.

During the audit review period, PPH did not comply with the published billing requirements. PPH submitted claims for program reimbursement based on their customary fee. For Oral Contraceptives, codes X7706 and X7722 PPAC has stated that the Planned Parenthood Organization has had a long standing relationship with manufacturers that allows the provider to receive deeply discounted prices, also known as "nominal prices". According to PPAC the nominal pricing arrangements exist outside of any legal mandate and as such are not subject to billing restrictions that would normally apply to federal discount programs such as the 340B program. According to PPAC, they bill Medi-Cal at their usual and customary fee which is higher than the amount they pay the drug companies, but lower than what would be considered the retail price of the product. PPAC believes this pricing methodology results in a sharing of the profits from the "nominal price" arrangements between the State and PPAC.

For barrier contraceptives and supplies, code X1500, PPH's claims were primarily for condoms. Based on our review of product invoices, "nominal pricing" was not an issue. The prices charged by the product distributors reflected normal wholesale pricing which would be available to any volume provider.

Failure to comply with Family PACT billing instructions has resulted in the Department reimbursing PPH for claims in excess of cost. Reimbursement in excess of cost for the

audit period totaled $5,213,845.92. The accompanying schedules detail the program reimbursement and product cost for each of the providers within the San Diego and Riverside region.

If you have any questions concerning these actions, please contact Stephen J. Edwards, Section Chief, at (619) 688-6485.

Sincerely,

Jan Inglish, N.P., Chief
Medical Review Branch
Audits and Investigations

Enclosures

Schedule 1 - Summary of Findings
Schedule 2 - Cost and Reimbursement Code X7708
Schedule 3 - Cost and Reimbursement Code X7722
Schedule 4 - Cost and Reimbursement Code X1500
Schedule 5 – Provider Numbers and Locations

Certified Mail #: 7004 1160 0003 2000 8469

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
SUMMARY OF FINDINGS
SCHEDULE 1

[redacted]

X7706	Oral Contraceptives (From schedule 2)	$3,030,347.00	$358,569.10	$4,170,777.90
X7722	Plan B Products (From schedule 3)	$1,119,351.53	$99,282.10	$1,020,069.43
X1500	Contraceptive Barrier Products (From schedule 4)	$35,117.30	$12,318.71	$22,798.59
	Totals	$6,184,815.83	$971,169.91	$5,213,645.92

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X7705
SCHEDULE 3

CM947[illegible]	Fleet Avenue Center	42,547	$2.05	$88,721.35	$390,488.00	$323,764.65
22711[illegible]	Escondido Center	30,[illegible]	$2.05	$62,418.80	$371,031.00	$307,612.20
CM947[illegible]	El Cajon Center	25,000	$2.05	$51,250.00	$299,931.00	$248,681.00
CM947[illegible]	Kearny Mesa Center	28,691	$2.05	$58,811.55	$343,061.00	$284,249.45
CM947[illegible]	College Avenue Center	36,580	$2.05	$74,949.00	$438,711.00	$363,762.00
CM947[illegible]	Mission Bay Center	20,931	$2.05	$42,908.55	$251,171.00	$208,262.45
CM947[illegible]	Riverside Center	37,410	$2.05	$76,690.50	$448,611.00	$371,920.50
CM947[illegible]	Downtown Center	39,490	$2.05	$80,911.00	$480,989.00	$332,478.00
CM947[illegible]	Euclid Avenue Center	15,579	$2.05	$31,936.95	$186,927.00	$154,990.05
CM947[illegible]	Mira Mesa Center	28,991	$2.05	$59,431.55	$347,699.00	$288,267.45
CM947[illegible]	Mission Valley Center	34,553	$2.05	$70,782.65	$414,087.00	$343,274.35
CM947[illegible]	Chula Vista Center	31,823	$2.05	$65,442.15	$383,037.00	$317,594.85
CM947[illegible]	Rancho Mirage Center	22,915	$2.05	$46,976.75	$274,941.00	$227,985.25
CM947[illegible]	Encinitas Center	8,807	$2.05	$18,054.35	$106,648.00	$87,593.65
22711[illegible]	Pacific Beach Express	23,897	$2.05	$48,373.85	$293,086.00	$224,712.15
CM947[illegible]	Moreno Valley Center	7,662	$2.05	$15,702.10	$90,741.00	$75,038.90
CM947[illegible]						
	Total	419,302		$859,669.10	$5,030,347.00	$4,170,677.90

[illegible] Schedule 3

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X7722
SCHEDULE 3

CMM70209F	First Avenue Center	3,776	$1.85	$6,986.60	$78,759.50	$71,772.90
ZZT12068F	Escondido Center	3,157	$1.85	$5,840.45	$55,849.81	$50,009.36
CMM70213F	El Cajon Center	2,909	$1.85	$4,826.65	$54,418.53	$49,591.88
CMM70210F	Kearny Mesa Center	2,920	$1.85	$5,217.00	$59,816.34	$54,599.34
CMM70200F	College Avenue Center	3,868	$1.85	$7,155.80	$80,988.48	$73,832.68
CMM70649F	Mission Bay Center	3,521	$1.85	$6,513.85	$79,432.43	$72,918.58
CM04702777F	Riverside Center	4,767	$1.85	$8,820.45	$98,214.74	$89,394.29
CMM70269FF	Oceanside Center	3,051	$1.85	$5,644.35	$63,645.68	$57,969.61
CMM70299F	Euclid Avenue Center	2,695	$1.85	$4,822.60	$78,228.47	$73,405.87
CMM70393F	Mira Mesa Center	3,978	$1.85	$7,359.30	$82,561.08	$75,201.78
CMM70420F	Mission Valley Center	5,094	$1.85	$9,423.90	$108,239.99	$98,816.09
CMM70510F	Chula Vista Center	4,734	$1.85	$8,757.90	$98,743.38	$89,985.48
CMM70532F	Rancho Mirage Center	3,818	$1.85	$6,138.30	$69,197.85	$63,059.55
ZZT11760G	Encinitas Center	778	$1.85	$1,439.30	$16,228.09	$14,788.79
CMM70245F	Pacific Beach Express	2,007	$1.85	$3,712.95	$41,850.39	$38,137.44
CMM70993F	Moreno Valley Center	2,510	$1.85	$4,643.50	$52,358.60	$47,715.10
	Total	69,666		[illegible]	$1,119,381.53	$1,020,058.32

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X1500
SCHEDULE 4

Provider Number: CA[illegible]NF

Provider Location: CHULA VISTA

Amount paid for Sample Population	$85,177.30
Percent of payments in excess of cost	64.81%
Payments in excess of cost	$22,798.59

Notes:

Review of Code X1500 claims were based on a statistical sample of paid claims. For the review period only one provider within the San Diego and Riverside County region submitted a material number of claims for Code X1500. The amounts above represent the statistical extrapolation of the difference between the Provider's average cost, $.07 per item and their claim amount of $.20 - .225 per item.

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
PROVIDER NUMBERS AND LOCATIONS
SCHEDULE 5

CS[illegible]209F	First Avenue Center	San Diego
ZZT12[illegible]	Escondido Center	San Diego
CS[illegible]213F	El Cajon Center	San Diego
CS[illegible]216F	Kearny Mesa Center	San Diego
CS[illegible]206F	College Avenue Center	San Diego
CS[illegible]249F	Mission Bay Center	San Diego
CS[illegible]277F	Riverside Center	Riverside
CS[illegible]264F	Oceanside Center	San Diego
CS[illegible]289F	Euclid Avenue Center	San Diego
CS[illegible]393F	Mira Mesa Center	San Diego
CS[illegible]420F	Mission Valley Center	San Diego
CS[illegible]510F	Chula Vista Center	San Diego
CS[illegible]532F	Rancho Mirage Center	Riverside
ZZT11[illegible]	Encinitas Center	San Diego
CS[illegible]245F	Pacific Beach Express	San Diego
CS[illegible]663F	Moreno Valley Center	Riverside

Gonzalez, Victor

From: Smith, Kathy
Sent: Friday, February 06, 2004 3:28 PM
To: Wagle, Mary-Jane; PPLA Senior Staff
Subject: RE: DHS Cost Audits - contraceptive drugs and supplies

My thoughts on this are if DHS pushes on this, we should begin to script out everything contraceptive and supply-wise. Patients will then need to get filled at regular pharmacies who are not acquiring at reduced rates and CAN charge at marked up pricing. Obviously, the cost to DHS will be greater than if they paid our measly marked up rates. There needs to be a consolidated push back on this

-----Original Message-----
From: Wagle, Mary-Jane
To: PPLA Senior Staff
Sent: 2/6/2004 12:55 PM
Subject: FW: DHS Cost Audits - contraceptive drugs and supplies

FYI - More info from Kathy Kneer with request for cost impact information (Victor to provide). MaryJane

-----Original Message-----
From: Kneer, Kathy
Sent: Thursday, February 05, 2004 6:48 PM
To: Spitz, Lilly; Reed, Angela; Berthelsen, Birgitta; Coles, Bob; Eckhardt, 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; Swiller, 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

As Lilly indictes below - 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 acquistion cost. She had this conversation with DHSafter 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 affilite to provide our office with information about your affilaites 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 accuarately reflecting the deepth 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 affilaite can estimate the Total $ impact - if not that's okay. You should also begin preparing for discussion sake - what the impact at an affilaite 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 thiss short notice for the call on Monday, I hope that each affilaite 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.

-----Original Message-----
From: Spitz, Lilly
To: Reed, Angela; Berthelsen, Birgitte; Coles, Bob; Eckhardt, Carla; Rollings, Cheryl; Barrera, Diahann; Harrison, Dian; Estes, Heather; Ewy, Jeanne; Giambruno, John; Dunn, Jon; Yarges, Judy; Pintarpe, Karen; Kneer, Kathy; Smith, Kathy; Spitz, Lilly; Williams, Linda; Schrepfer, Marcia; McKinney, Marie; Salo, Mark; Stanphill, Marsha; Swiller, 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
Sent: 2/5/04 4:23 PM
Subject: DHS Cost Audits - contraceptive drugs and supplies

TO: CEO's, CFO's and Pt. Services

RE: DHS cost audits, PP San Diego - Update

Kathy has spoken with Kim Belshe about the audit currently being conducted at the San Diego Affiliate, and has asked that the cost portion of the audit be put on hold pending final resolution on the policy issues raised specifically about our billing practices for oral contraceptives.

Kim has declined to halt the cost audit at this time. However, she has indicated that she is open to further discussion of the public policy concerns raised by Planned Parenthood.

[redacted]

PLEASE LET US KNOW IMMEDIATELY IF YOU ARE CONTACTED BY DHS TO SCHEDULE AN AUDIT, OR IF DHS AUDITS & INVESTIGATIONS CONTACTS YOU FOR ANY REASON.

We will be scheduling a meeting with DHS on the public policy implications of this issue as soon as possible. In preparation, PPAC needs some up-to-date information from you:

* Complete list of oral contraceptives and contraceptive supplies, the purchase price under nominal pricing, and the amount billed to Medi-Cal.

* A separate listing of all oral contraceptives and contraceptive supplies purchased under 340B, their purchase price and the amount billed to Medi-Cal.

Please contact Marsha Stanphill with any questions regarding this request for information: (916) 446-5247, ext. 108.

CONFERENCE CALL TO DISCUSS FURTHER
MONDAY, FEBRUARY 9th, 4:pm -

State of California—Health and Human Services Agency
Department of Health Services

SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

November 19, 2004

Bob Coles
Vice President & CFO
Planned Parenthood of San Diego & Riverside Counties
1075 Camino del Rio South, Suite 200
San Diego, CA 92108

Dear Mr. Coles:

The Department of Health Services (DHS) conducted an audit of the San Diego Planned Parenthood Region (SDPPR) comprised of sixteen clinics for the period July 1, 2002 to June 30, 2003. The audit report from that audit was completed in November of 2004, by the Department of Health Services (DHS) Audits and Investigations Branch (A & I).

(See Enclosed Audit Report dated November 19, 2004.)

The Audit Report finds an estimated overpayment to the San Diego Planned Parenthood Region for contraceptive drugs and supplies for the audit period of $5,213,846.92. The DHS, A & I auditors examined whether the San Diego Planned Parenthood Region were billing "at cost" as referenced in the Family Planning, Access, Care and Treatment (FPACT) program Policies, Procedures and Billing Instructions (PPBI) manual dealing with contraceptive drugs and supplies.

However, no specific definition of "at cost" is contained in that PPBI manual other than a general statement that "at cost" means "the cost to the provider." The DHS, A & I auditors viewed the term "at cost" to mean the acquisition cost of the product; i.e., invoice amount, plus tax and shipping. Where the DHS A & I auditors identified situations in which San Diego Planned Parenthood billed at amounts above their acquisition cost, the auditors would conclude that DHS was overbilled and thus the San Diego Planned Parenthood Region received reimbursement in excess of the amount they were owed, overpayments.

DHS became concerned that DHS had never clearly defined the term "at cost" to be a provider's acquisition cost. Providers have asserted that acquisition cost is too narrow a definition of "at cost", and DHS became concerned that DHS had never clearly defined the term "at cost" to be solely acquisition cost. Planned Parenthood Associates of California representatives met with DHS to express their concerns with the definition of "at cost" which

was used in the audit. In early 2004, DHS's new management team wanted to know if DHS had used the correct standard in the audit of San Diego Planned Parenthood, or if any true audit standard even existed.

DHS undertook a comprehensive review of all DHS relevant authority, statements, conduct and documentation for the period 1997 through 2003 in order to determine if a demand letter should issue in this unique case. That review also included interviews of DHS staff and other involved parties. The original Waiver, the PPSI manual and Medi-Cal billing regulations were reviewed. All aspects of this issue; regulatory, programatic, legal, financial and equitable were examined.

In researching this issue DHS has become concerned that, with regard to the definition of "at cost", conflicting, unclear, or ambiguous representations have been made to providers. During the period of time from 1997, forward through the implementation of the Section 1115 Waiver Demonstration Project (Waiver) in 1999 and continuing to the present, the FPACT programs for delivery of oral contraceptive drugs and supplies to Medi-Cal recipients have evolved, as have the billing mechanisms for those supplies during this period. Many DHS Office of Family Planning personnel, who administered the FPACT programs, have also changed during that period. One or all of these factors may have affected a clear and unambiguous definition of "at cost", from being presented to and enforced on providers. What the comprehensive review made clear is that providers were not given an unambiguous and consistent definition of "at cost" which could be used as an audit standard by DHS A & I auditors.

While it is certainly true that based on the definition of "at cost" used by A & I auditors, the audit results were correctly formulated, it has become clear that other considerations should factor into the decision concerning issuance of a demand letter pursuant to the audit. The responsibility of DHS is to regulate and audit, in an objective and fair manner, all providers in the performance of their duties. Where, as here, it can not be said that there was a clear and unambiguous understanding of the amounts providers may bill for oral contraceptive supplies, it would be unfair to demand repayment of disputed amounts based on strict adherence to an undefined standard.

Therefore it is the decision of DHS that no demand will issue pursuant to the audit of Planned Parenthood Associates for the cited period. There will be clear and unambiguous billing standards announced and enforced in the future applying to all oral contraceptive providers under Office of Family Planning programs.

Sincerely,

Stan Rosenstein
Deputy Director
Medical Care Services

Enclosure

Gonzalez, Victor

From:	Gonzalez, Victor
Sent:	Monday, February 16, 2004 8:41 AM
To:	Wagle, Mary-Jane
Cc:	Swiller, Martha
Subject:	Regulatory Issue and Compliance VERY IMPORTANT

The issue that has the largest impact for the Agency is the DHS audit started mid-January 2004. The audit focused on the markup for the Medications being sold and dispensed. Our supply contracts enable us deep discounts, and therefore the markups constitute not only a significant Revenue item, but virtually the only reason PPLA has been able to stay in business. This applies to all affiliates conducting business the same way PPLA does.

These argument points were recognized during a conference call February 9th, which I was asked to participate in by the CEO, the conference call was summarized for the management of PPLA. The statements were made that 1) the audit challenge came circa 3 years ago and at that time it was felt an interpretation was obtained, never in writing or formal communiqué from DHS, that DHS would stay out of this area, 2) that the information loop was never closed by confirming this in writing on our behalf by PPAC, 3)that by allowing the charging of our patients at, arguably, usual and customary charging similar to pharmacies in the private sector that PPLA would allow the State to participate in PPLA's own supplier discounts, and enable PPLA to make up for the the cutbacks across the spectrum of all the other procedures that we are experiencing now.

Kathy Kneer PPAC added two more points which are significant: 1) that we are the only group of clinics that we have knowledge of billing medications at usual and customary based on the interpretation outlined above and 2)that we need to quickly get other examples, and we were solicited to put feelers out to get examples where a comparison can be had of this billing practice. [redacted]

The State's argument is that pharmacies are billing at AWP (average wholesale price), and that the State has now negotiated a master supply contract that reportedly has OC's at $1 per cycle. The pharmacist bills the State, the State bills the manufacturer directly, the State cost is very low with huge volume discounts, and potential rebates.

My input to the conference was a review of the normal way in which community clinics handle this area, where the rule of "lower of cost or charges" is followed. The method is to compute a dispensing fee that bears the entire indirect cost as well as the direct costs of dispensing the medicine.

The communiqué from San Diego indicated that the State intended to audit each and every affiliate about this issue.

Action Item: As the VP of Finance of PPLA I am recommending the following course of action:

1-That the CEO and I engage an independent legal review using a competent healthcare attorney independent of the review at PPAC, encompassing all aspects of medications pricing. The dual dangers or being found out of compliance with normal billing practices, and potential recoupments from audits that are already being planned by DHS amply justify this course of action. This review should be submitted with Finance Committee as evidence of discharge of its legal obligation in this matter.

EXHIBIT 8

2-That an immediate and sustainable system to establish dispensing costs, and a Federal compliant

Indirect Cost rate be established for the Agency. I have already undertaken steps to start work in this area. Such a study and cost basis has never been undertaken at PPLA to my knowledge.

3-That a Charge Master review of all billable amounts be conducted by first hiring a Billing Manager with sufficient coding and analysis expertise who will have the time to complete a review of amounts chargeable under the various PPLA contracts. The
companion cost studies have already started where a consultant was retained and has achieved a monthly cost review of the clinics, and has started the study to arrive at costs per TAB, medication dispensing, and cost per all the other procedures that we provide. A period of three years at least has elapsed since this type of review.

I am also recommending that both Finance Committee and the Board be apprised of the danger the Agency faces with respect to an adverse DHS audit in this arena. I would also add that PPAC obviously did not handle this issue well and as a result left the entire system exposed.

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 he pills dispensed by a hefty markup over cost. This is proscribed by DHS regulations where the prevailing rule is that nedicines 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

letailed spreasheet.

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

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.

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, ve cannot continue to use the "we have experts who told us this or that..."

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.

Inventory Item#	Description	Base Unit of Measure	Base Unit Cost	YTD Utilization	YTD Expense	Revenue	Net Income
	CONTRACEPTIVE			0	$ -		
10000	Oral Contraceptive Veridate Com	Bx	$ -	4,087	$ 5,353.97	49,044.00	43,690.03
10128	Oral Contraceptive Modicon	Ea	$ 1.31	2,482	$ 4,591.70	47,009.08	42,417.38
10211	Preven (Emer Contra Kit)	Pk	$ 1.85	6,481	$ 3,953.41	77,772.00	73,818.59
10328	Oral Cont Ortho Novum 135	Ea	$ 0.61	217	$ 794.22	2,604.00	1,809.78
10528C	Oral Cont Ortho Novum 150	Ea	$ 3.66	15,500	$ 57,970.00	186,000.00	128,030.00
10628	Oral Cont Orhto-Cyclen 28	Ea	$ 3.74	21,128	$ 33,170.96	253,536.00	220,365.04
10728	Oral Cont Ortho Novum 777	Ea	$ 1.57	2,652	$ 7,505.16	31,824.00	24,318.84
10828	Oral Cont Micronor	Ea	$ 2.83	6,301	$ 152,232.16	294,697.77	142,465.61
20000	Depo-Provera 150MG	VL	$ 24.16	2,920	$ 57,670.00	136,568.40	78,898.40
20001	Depo-Provera 150MG W/SRNG	SY	$ 19.75	15,747	$ 70,861.50	328,482.42	257,620.92
20002	Plan B	Ea	$ 4.50	0	$ -	-	-
20003	Lunelle	VL	$ 14.93	5,745	$ 18,768.92	63,941.85	45,172.94
20004	Ortho Evra	Ea	$ 3.27	1,296	$ 3,888.00	47,964.96	44,076.96
20005	Nuva-Ring	Ea	$ 3.00	2,088	$ 12,565.58	25,056.00	12,490.42
20008	Demulen 1/35	Ea	$ 6.02	25,563	$ 92,384.68	306,756.00	214,371.32
20018	Alesse-28	Ea	$ 3.61	9,060	$ 92,049.60	108,720.00	16,670.40
20028	Loestrin Fe 1/20 #913-45	Ea	$ 10.16	4	$ 74.00	52.00	(22.00)
20085	Diaphragms-All-Flex 85	Ea	$ 18.50	7,908	$ 14,946.12	94,896.00	79,949.88
20128	Tri-Levlen #43303	Ea	$ 1.89	2	$ 30.50	26.00	(4.50)
20160	Diaphragms-All-Flex 160	Ea	$ 15.25	24	$ 444.00	312.00	(132.00)
20165	Diaphragms-All-Flex 165	Ea	$ 18.50	29	$ 536.50	377.00	(159.50)
20170	Diaphragms-All-Flex 170	Ea	$ 18.50	36	$ 666.00	468.00	(198.00)
20175	Diaphragms-All-Flex 175	Ea	$ 18.50	8	$ 148.00	104.00	(44.00)
20180	Diaphragms-All-Flex 180	Ea	$ 6.50	1	$ 6.50	13.00	6.50
20185	Diaphragms-All-Flex 185	Ea	$ 18.50	1	$ 18.50	13.00	(5.50)
20190	Diaphragms-All-Flex 190	Ea	$ 18.50	2	$ 37.00	26.00	(11.00)
20195	Diaphragms-All-Flex 195	Ea	$ 1.07	17,901	$ 19,154.07	214,812.00	195,657.93
20228	Levlen #41128	Ea	$ 15.25	2	$ 30.50	26.00	(4.50)
20255	Diaphragms-Koromex 255	Ea	$ 15.25	5	$ 76.25	65.00	(11.25)
20260	Diaphragms-Koromex 260	Ea	$ 15.25	7	$ 106.75	91.00	(15.75)
20265	Diaphragms-Koromex 265	Ea	$ 15.25	5	$ 76.25	65.00	(11.25)
20270	Diaphragms-Koromex 270	Ea	$ 15.25	10	$ 152.50	130.00	(22.50)
20275	Diaphragms-Koromex 275	Ea	$ 15.25	3	$ 45.75	39.00	(6.75)
20280	Diaphragms-Koromex 280	Ea	$ 18.50	1	$ 18.50	13.00	(5.50)
20285	Diaphragms-Koromex 285	Ea	$ 15.25	1	$ 15.25	13.00	(2.25)
20290	Diaphragms-Koromex 290	Ea	$ 18.50	3	$ 55.50	39.00	(16.50)
20295	Diaphragms-Koromex 295	Ea	$ 2.25	23,664	$ 53,244.00	283,968.00	230,724.00
20428	Ortho Tri-Cyclen Lo	Ea	$ 50.00	10	$ 500.00	130.00	(370.00)
25000	Cervical Cap-Fitting Set	Ea	$ 46.00	1	$ 46.00	13.00	(33.00)
25022	Cervical Cap 22MM						

25025	Cervical Cap 25MM	Ea	$ 26.00	3	$ 78.00	39.00		(66.00)
25028	Cervical Cap 28MM	Ea	$ 46.00	2	$ 92.00	26.00		(208.00)
25031	Cervical Cap 31MM	Ea	$ 26.00	16	$ 416.00	208.00		692,388.35
30028	Ortho Tri-Cyclen	Ea	$ 2.95	76,507	$ 225,695.65	918,084.00		27,440.00
30300	IUD-Paragard	Ea	$ 149.80	245	$ 36,701.00	64,141.00		2,935.20
30400	IUD-Mirena	Ea	$ 301.82	40	$ 12,072.80	15,008.00		
40100	Condoms (Lubricated)	Ea	$ 0.06	611,000	$ 34,827.00			2,108.07
40102	Reality (Female Condom)	Ea	$ 1.09	177	$ 192.93	2,301.00		
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	$ 0.48	1,745	$ 157.05			
40110	Latex Barriers (Vanilla)	Ea	$ 0.48	45	$ 21.60			
40111	Latex Barriers (Strawberry)	Ea	$ 0.20	79	$ 37.92			
40114	Slippery Stuff	Ea	$ 0.05	2,408	$ 481.60			
40117	Condoms, Non-Lubricated	Ea	$ 2.70	5,000	$ 265.00			2,904.60
40200	Jelly Contra Kormx #115C	Ea	$ 0.60	282	$ 761.40	3,666.00		1,835.20
40300	Applicator (Jelly #K52B)	Ea	$ 4.81	148	$ 88.80	1,924.00		3,816.54
40401	Contra. Foam Koromex 635C	Ea	$ 0.60	466	$ 2,241.46	6,058.00		36,815.60
40500	Vaginal Contraceptive Fil			2,969	$ 1,781.40	38,597.00		

						3,605,719.48
	FPACT & Medi-Cal			894,464	$ 1,022,119	

81.8%

$2,144,313.17

MY ORIGINAL REPORT

PLANNED PARENTHOOD LOS ANGELES
REPORT TO THE FINANCE COMMITTEE
FROM VP OF FINANCE
MONTH OF December 2003 commentary

SUMMARY

Budget was met. The transition from the MAPICS system to GREAT PLAINS was completed successfully, and January closed in the GREAT PLAINS systems. All audit adjustments were recorded in the MAPICS system and system was archived for future audits.

A number of significant accomplishments have taken place in the areas of systems demo and implementation costs have been budget projected through 2008-09, budget for 2004-05 was started and distributed, support for both the Technology grant and the CHFFA loan, contracting outreach resulting in appointments with large healthcare delivery systems (ALTAMED), as well significant reductions by facilitating negotiations with the largest pharmaceutical vendor carrier (McKesson) have taken place during both months. The systems clean up and readiness for implementation of a new system continues. All financially related filings with regulatory Agencies namely CHFC, OSHPD, and OFC were made on time for year 2003. All of these are very good developments.

On a more sobering note, a couple of developments which affect the future financial conduct and operation of the Agency need to be brought to the attention of the Board. One affects a long-standing compliance issue resulting from an audit of the San Diego affiliate brought to our attention January 26, 2004. The second affects materially erroneous filings of the OSHPD report for the year 2002 under the rubric of Mr. Steven Emmert as both preparer and person approving the report.

This report will address these summary points in order of importance and will also address financial reports, presently prepared and used throughout the Agency, in a summary intended for Executive review and not in the detail of previous reports. Henceforth, we will attempt to use this same system of Executive Summary in our reporting.

REGULATORY ISSUES

Medications Audit

The issue that has the largest impact for the Agency is the DHS audit started mid-January 2004. The audit focused on the markup for the Medications being sold and dispensed. Our supply contracts enable us deep discounts, and therefore the markups constitute not only a significant Revenue item, but also virtually the only reason PPLA has been able to stay in business. This applies to all affiliates conducting business the same way PPLA does.

The communiqué from San Diego indicated that the State intended to audit each and every affiliate about this issue.

EXHIBIT 9

MY ORIGINAL REPORT

These argument points were recognized during a conference call February 9th, which I was asked to participate in by the CEO, the conference call was summarized for the management of PPLA.

My input to the conference was a review of the normal way in which community clinics handle this area, where the rule of "lower of cost or charges" is followed. The method is to compute a dispensing fee that bears the entire indirect cost as well as the direct costs of dispensing the medicine.

Action Item: As the VP of Finance of PPLA I am recommending the following course of action:

1-That the CEO and I engage an independent legal review using a competent healthcare attorney independent of the review at PPAC, encompassing all aspects of medications pricing. The dual dangers or being found out of compliance with normal billing practices, and potential recoupments from audits that are already being planned by DHS amply justify this course of action. This review should be submitted at completion to Finance Committee as evidence of discharge of its legal obligation in this matter.

2-That an immediate and sustainable system to establish dispensing costs, and a Federal compliant Indirect Cost rate be established for the Agency. I have already undertaken steps to start work in this area. Such a study and cost basis has never been undertaken at PPLA to my knowledge.

3-That a Charge Master review of all billable amounts be conducted by first hiring a Billing Manager with sufficient coding and analysis expertise who will have the time to complete a review of amounts chargeable under the various PPLA contracts. The companion cost studies have already started where a consultant was retained and has achieved a monthly cost review of the clinics, and has started the study to arrive at costs per TAB, medication dispensing, and cost per all the other procedures that we provide. A period of three years at least has elapsed since this type of review.

OSHPD (Office of Strategic Health Planning and Development) Annual Utilization Report of Primary Care Clinic.

Client Services entered the reports submitted for each clinic in the PPLA clinic through the ALIRT system on line last year for the calendar year 2002. The reports that were filed then indicate Steven Emmert as the preparer and the Administrator, and list him as COO.

This year, calendar 2003, the report preparer is the VP of Finance and the CEO is Administrator. The reports contain a level of accuracy heretofore unattainable, this was accomplished, under my direction, by joining the Data Mart project in November 2003 and along with the Interim IT Director, facilitating the loading of all clinical data and the financial results of the clinics. The results obtained allowed Administrative Staff to quickly load a correct report online.

The reports for 2002 contain significantly erroneous data, with clinic dollar billing volumes virtually two to three times the normal rates. We arrived at this conclusion by review of our own reports, and going back a number of years for those prepared by an Accounting Manager. Not only were the dollars inflated, but also the number of encounters and visits

in order to make the ratios come out. We do not know of the number of personnel and professionals loaded is accurate or not, presumably this data is also not accurate.

Upon contacting the OSHPD designated inquiry desk, we were informed Friday 2/13/04 that the 2002 report is frozen and cannot be modified.

These actions may have significant consequences for the Agency, given that the data set submitted is the basis for the Title X Grant as well as MediCal contracting. My recommended course of action, which we are pursuing, is to ascertain the use of the data by CHFC at a meeting the third week of February 2004 and independent inquiry. The consequences are likely to arise once the newly finished 2003 report is activated only, the comparability and the ratios may need to be explained. Hopefully, it will not trigger an audit of PPLA.

REVENUES

- Title X billing for the year was completed and the FSR form sent on time.
- Contributions are under $136k year to date, the month of October added another $10k to the gap. We are encouraged by some of the amounts received in November and hope to meet the December budgeted year end donations planned
- Contract income continues to as has been the case all year, however, we have recently completed loading the Molina contract, and are pursuing a number of contracting initiatives which will add volume to the Agency. The Talbert contract has produced significant utilization, this was a contract sent to us by our Orange County affiliate.
- Goodman pledge was reversed.

EXPENSES

The Malpractice premium payable to ARMS, the Federation pooled insurance program offered several options for payment for the risk year 2004. On the strength of the improving cash position of PPLA we made this payment early February. This is a return of 8% cannot get that at USTRUST at the prevailing interest rates.

BALANCE SHEET—MAPICS transition

A number of important steps were taken to assure that the MAPICS transition to Great Plains occurred uneventfully. One was the hiring of a Controller who is familiar with operating Great Plains and is also oriented to reconciling accounting activity.

Due to the dearth of accurate Balance Sheet reporting from July through November, reconciliations satisfactory to the VP of Finance did not occur until the recording of audit adjustments and final closing of the 6/30/2003 fiscal year. Since MAPICS could not be balanced at the Balance Sheet level throughout this period, spreadsheet tracking for all Balance Sheet accounts was attempted. It appears that these efforts resulted in adjustments that are reflected in two stages 1- audit adjustments are reflected in the December closing, and complete accounting for Prepaids and final adjustment of Payable Accruals will occur in January.

As we indicated in prior reports, it appears that we have been over relieving inventory, and this has resulted in adjustments that will increase the fiscal year to date net income at the Operating Line.

The net result of these adjustments, still projected at the end of December, will be recognition of additional surplus and not an adverse adjustment

CLINICS

A separate table is provided with all the Cash Balances by Account as of December 31, 2003 per previous request of Finance Committee.

CLINICS

A separate summary report is attached reflecting clinic visits and costs. This report is now routine and reviewed by VP of Client Services, to whom we are forever grateful for her contribution to this effort. It could not have happened without her dedication and support as simple there was no historical base to draw from.

Purchasing and Inventory

As we reported last month we hired Leif Eric Williams as Purchasing, Materials, and Inventory Control Director starting November 19th. His introductory program was presented as a separate exhibit in last month's report.

A negotiation with McKesson, just completed yields a 5% reduction in important elements of our purchasing cycle.

BUDGET for the Agency 2004

The anticipated budget cuts by the new Governor requires a new budget revision for both the short term and for the 2004 fiscal year budget commencing 6/30/2004.

The following are the major questions for consideration:

1-Impact of the $750,000 anticipated 15% cut in MediCal and FPACT within the Operations Budget of the Agency.
2-Projection of 4 types of budgets to control the operations and Advancement Campaign: an Operation Budget, a Capital Equipment Replacement Budget which includes an IT systems budget, a Headquarters building, and a South Los Angeles Clinic and Clinics Expansion Program budget.
3-Impact of potential cost reductions in the way of Labs, Inventory Improvements, and Internal Process Improvements.
4-Impact of the Medications reduction of margins due to adoption of dispensing fee approach.

This process is now under way and we hope will be completed in presentable format by the new Controller by the March Board meeting.

CONTRACT ADMINISTRATION

Two new efforts in the contract area are:

Molina Medical—The contract with this group was reviewed for the incorrect and misapplied coding. The coding discrepancies were reconciled with the Molina personnel in order to recover reimbursement in the surgical procedures, and fine tuning the coding for the pills and medications to standard Medi-Cal codes.

A letter of intent to contract was forwarded to AltaMed Medical resulted in an invitation to meet mid February.

Information Technology—new Systems review

Tom Dawson the Santa Barbara consultant who facilitated their implementation of Millbrook (now called Centricity), a system that has sufficiently impressed us, completed the three vendor contacts and demos as follows:

1-Centricity/ old Millbrook system—Santa Barbara
2-Medical Manager/Web Md —Golden Gate San Francisco
3-Mysis/Vision product—San Jose Marmonte

Of these three, the most promising, and most responsive has been Mysis, we already have a complete proposal from them, costing and a tentative implementation. This cost proposal is for $491,000 inclusive of consulting implementation time.

Mr. Dawson has presented a proposal to complete an RFP document and we are presently reviewing this proposal. It encompasses 454 hours of consulting support and these are being reviewed to see what can be done by the new IT Director and those where we need to rely on the consultants.

Please be aware that this process has been completed in record time, in a month and a half. A similar process in the San Diego affiliate is still under way.

The next logical step is a thorough systems analysis phase, which hopefully will be completed in record time, given the existing talent pool at the Agency, which hopefully will shortly be supplemented with a new Billing Manager. Systems implementation consume time voraciously, and this is the reason for the slight increase in staffing. We are planning a smooth systems transition without operations and billing deteriorating during the implementation.

Planned Parenthood LA

Balance Sheet

At December 31, 2003

	December 31, 2003	June 30, 2003
ASSETS		
Current Assets		
Cash and cash equivalents	$3,755,399.96	$ 1,268,570.00
Investments	4,655,312.31	4,514,842.00
Accounts receivable, net	840,566.90	1,315,000.00
Pledges and contributions receivable	645,569.00	2,143,500.00
Inventories	335,616.29	723,539.00
Prepaid expenses and other current assets	(4,953.44)	62,128.00
	10,827,511.02	10,027,579.00
Pledges and Contributions Receivable, net	619,846.00	241,182.00
Property and Equipment, net	2,302,092.51	2,528,527.00
	$13,349,449.53	$12,797,288.00
ES AND NET ASSETS		
Current Liabilities		
Current portion of note payable	22,411.00	$22,411.00
Capital lease obligations	11,146.01	33,030.00
Accounts payable	227,989.40	1,032,198.00
Accrued payroll and other liabilities	946,667.70	801,746.00
Preopening expenses reserve	66,433.06	117,204.00
	1,274,647.17	2,006,589.00
Long-term Liabilities		
Note payable, net of current portion	283,538.98	294,494.00
Total Liabilities	1,558,186.15	2,301,083.00
Net Assets		
Unrestricted		
General	4,860,031.00	4,860,031.00
Board-designated	1,923,597.00	1,923,597.00
	6,783,628.00	6,783,628.00
Temporarily restricted	1,705,577.00	1,705,577.00
Permanently restricted	2,007,000.00	2,007,000.00
Changes in net assets - current year	1,295,058.38	-
Total Net Assets	11,791,263.38	10,496,205.00
	$13,349,449.53	$12,797,288.00

Planned Parenthood LA

Cash Flows

For The Six Months Ended December 31, 2003

Cash Flows From Operating Activities:	
Changes in Net Assets	$ 1,295,058.38
Adjustments to reconcile changes in net assets to net cash provided by operating activities:	
Depreciation and Amortization	290,124.18
Realized gains on sales of investments	(248,986.66)
Unrealized losses on investments	156,425.56
Decrease (increase) in operating assets:	
Accounts receivable	262,767.86
Pledges and contributions receivable	(1,546,500.00)
Inventories	399,587.95
Prepaids and other current assets	67,081.44
Increase (decrease) in operating liabilities:	
Accounts payable	(804,208.60)
Accrued payroll and other current liabilities	144,921.70
Accrued vacancy	(50,770.94)
Net cash provided by operating activities	*$ (34,499.13)*
Cash Flows From Investing Activities:	
Purchases of property and equipment	$ (25,354)
Purchases of investments, net of proceeds from sales of investments, transfers and donations	(47,909.21)
Payments on pledges receivable	2,627,431.00
Net cash provided by investing activities	*$ 2,554,168*
Cash Flows From Financing Activities:	
Principal payments on note payable	(10,955.02)
Principal payments on capital lease obligations	(21,883.99)
Net cash provided in financing activities	*$ (32,839)*
Net Increase in Cash and Cash Equivalents	*2,486,829.96*
Cash and Cash Equivalents, beginning of year	*1,268,570.00*
Cash and Cash Equivalents, at December 31, 2003	*$ 3,755,399.96*

CURRENT YEAR ACTUALS VS. BUDGET THROUGH : 12/31/03 ACCRUAL BASIS

	MONTHLY ACTUALS	MONTHLY BUDGET	VARIANCE	2003-04 YTD ACTUALS	YTD BUDGET	VARIANCE	YTD % ACTUAL	2002-03 Prev. YTD ACTUALS	VARIANCE	2001-02 Prev. YTD ACTUALS
REVENUES										
Family PACT	680,672	618,723	61,949	4,260,127	3,891,848	368,279	109%	3,184,394	1,105,733	3,845,729
Patient Fees, Donations, Copay	167,317	147,890	19,427	1,042,896	965,254	77,642	108%	787,697	255,199	1,064,041
Contract Income	39,636	81,894	(42,258)	333,207	518,363	(185,156)	64%	398,229	(65,022)	556,272
Medi-Cal	121,194	108,318	12,876	745,535	722,634	22,901	103%	620,130	125,405	758,772
Insurance - other	4,414	5,297	(883)	27,621	32,757	(5,136)	84%	34,562	(6,940)	43,514
Government Grants	68,569	48,723	19,846	435,743	292,338	143,405	149%	257,177	178,566	463,092
Fundraising:	-	-	-	-	-	-	-	-	-	-
Contributions	638,422	627,334	11,088	1,046,151	1,230,745	(184,594)	85%	554,490	491,661	1,675,802
Events	80,334	26,333	54,001	185,111	74,998	110,113	247%	413,569	(228,458)	246,630
All other	9,781	5,873	3,906	63,913	39,250	24,663	163%	50,792	13,121	44,010
TOTAL REVENUES	1,830,339	1,670,387	159,952	8,140,304	7,768,187	372,117	105%	6,271,039	1,869,264	8,697,863
EXPENSES										
Salaries/Fringes, Clinicians, Casual Labor	823,217	841,929	18,712	4,725,012	4,863,576	140,564	97%	4,050,058	(674,955)	4,529,520
Special Events	12,956	13,871	1,815	37,173	34,026	(3,147)	109%	12,348	(24,826)	81,151
Advertising/Marketing	640	14,348	13,708	43,796	86,088	42,292	51%	88,145	(5,652)	122,365
Administrative	116,713	103,047	(13,666)	909,161	650,882	(258,279)	140%	591,790	(317,371)	486,220
Clinical Supplies	189,799	146,904	(42,895)	1,284,003	881,424	(402,579)	146%	1,012,338	(271,665)	937,253
Rent, Telephone, Utilities, Maintenance	137,305	142,880	5,575	919,336	857,582	(61,774)	107%	917,460	(1,906)	858,319
Printing, Postage, Office supplies	16,170	44,800	28,630	256,997	290,126	33,129	82%	411,306	174,309	344,340
Mileage, Conferences and Training	11,129	23,372	12,243	71,624	145,372	73,748	49%	226,532	154,908	159,966
Depreciation	38,744	56,693	17,949	251,787	340,158	88,371	74%	295,239	43,452	345,252
TOTAL EXPENSES [1]	1,345,774	1,387,844	42,070	8,478,909	8,151,234	(327,675)	104%	7,555,204	(923,706)	7,814,386
OPERATING GAIN/(LOSS)	484,565	282,543	202,022	(338,606)	(383,047)	44,441	88%	(1,284,165)	945,559	883,478
Investment Income	96,286	17,232	79,054	106,362	103,388	2,974	103%	35,417	70,945	75,412
Realized Gain/(Loss)		-	-	-	-	-	-	-	-	-
Unrealized Gain/(Loss)	-	-	-	-	-	-	-	-	-	-
Pledges discounted	37,964	-	37,964	(38,336)	-	(38,336)		-	(38,336)	-
Bequests, Capital Contributions, Endowment	277,781	55,000	222,781	1,607,781	380,000	1,227,781	-	807,788	799,993	330,830
Advancement Campaign Expenses	(7,556)	(18,078)	10,522	(28,342)	(108,468)	80,126		-	(28,342)	
Investment Expense	(6,546)	-	(6,546)	(13,801)	-	(13,801)	-	-	(13,801)	(15,214)
GAIN/(LOSS) including Endowment	882,494	336,697	545,797	1,295,059	(8,127)	1,303,186	-16035%	(440,959)	1,736,018	1,214,505
Visits	9,194	9,418	(224)	57,556	56,508	1,048				
Equivalent visits	12,368	not available		77,646	not available					

This presentation reflects the Monthly Budget and YTD Budget adopted by the Board in May 2003 for the new fiscal year.

[1] Dues, Subscription, Licenses, Insurance, Interest, Investment, Legal & Acctg, Misc, Taxes, Professional fees, Auto lease

Gonzalez, Victor

From: Wagle, Mary-Jane
Sent: Wednesday, February 18, 2004 7:07 PM
To: Peralez, Nadine; Gonzalez, Victor
Subject: Finance Report to Budget and Finance Committee

VP Finance Report.doc

[redacted] have also removed the discussion of the discrepancies in the OSHPD results since at this point we do not believe there is any risk and therefore no need to raise this at the board level.

Ready to go out with attachments.....

Victor - what's your practice? Do you email this with the financials to Richard and mail out packages to the members of the B & F Report? Does Nadine mail them out?

Go for it!. MJ

EXHIBIT 10

Planned Parenthood
Los Angeles

Vice President of Finance Report
February 2004

Key report areas:

- Financial results
- Financial Systems
- Regulatory Issues
- Cost Containment Initiatives
- Budget Planning
- Clinic Management System Status
- Third Party Contract Administration

Attached Exhibits: December and YTD Financial Statements
Clinic Visits and Costs
Cash Balances by Account

December Financial Results
Operating Statement
December YTD financial results are modestly ahead of budget, although net of depreciation, operating results are modestly behind budget.

Revenues from Family PACT, Medi-Cal, patient fees and Government Grants continue to run ahead of budget, while contract income continues behind budget reflecting primarily lower Kaiser referrals. Fundraising for the Annual Campaign recovered substantial ground in December, with current results $74,000 below budget; the key shortfall continues to be in foundations.

Expenses are 4% over budget, primarily because of higher consulting fees than originally budgeted for new initiatives, higher clinical supplies, and higher utilities. Clinical supplies continue to run well over budgeted amounts; Finance and Inventory are exploring the reasons for this and suspect that this may quirks in the present MAPICS system, or how different employees interpreted some of features of the current inventory/billing interface. We are currently combining manual inventory counts with an analysis of the system to pin down what is going on. This is not inflating our billing, just (we believe) over-depleting inventory. We hope to have an answer regarding this in March. Assuming this is the case, our costs are actually running lower than shown and our operating margin is better than shown, and of course, we will recognize this in future financials for your review.

Balance Sheet
The agency's balance sheet is healthy. Note that Pledges and Contributions Receivable under current assets reflect pledges against which payment is expected within 12 months; Pledges and Contributions Receivable, net shown below Current assets reflect pledges against which payment is expected over a longer-term period. Both categories are entirely Advancement Campaign pledges. The Goodman pledge is no longer included.

Accounts payable are being maintained current to 30 days.

"Temporarily Restricted" Net Assets include the Ann L. Nickoll Endowment Fund in addition to cash and pledges received for restricted purposes as of 6/30/03. "Permanently Restricted" Net Assets include the Anna Bing Arnold Endowment Fund and the Betty and Charles Wilson Endowment Fund. "Changes in net assets – current year" also includes some temporarily restricted pledges/cash received since 6/30/03.

The December balance sheet reflects FY 02-03 audit adjustments. Complete accounting for Prepaids and final adjustment of Payable Accruals will be completed with the January statements.

FINANCIAL SYSTEMS

The transition from the MAPICS system to GREAT PLAINS systems was completed successfully, and January closed in the GREAT PLAINS systems. All audit adjustments were recorded in the MAPICS system and the system was archived for future audits.

REGULATORY ISSUE

DHS Medications Audit

In the course of a DHS audit of the San Diego affiliate in mid-January 2004, DHS staff requested information about PP's medications costs and indicated that they believed that PP should be charging for medications at cost.

California Planned Parenthood affiliates have been charging for meds (chiefly oral contraceptives) based on a Usual and Customary fixed rate per medication which is required to be no greater than the fee charged to the public; this rate passes on some of the reduced cost for medications that PP receives through its negotiated contracts with medications suppliers, but not all and it clearly marks up the medicines to the FPACT defaulted bill rate. This has been the practice of all PP affiliates since the FPACT program was inaugurated in 1997, with verbal but not written approval by the Department of Health Services (at the time of the Wilson administration). The regulations as currently written and Federal law do provide a defensible basis for the Planned Parenthood affiliates' Usual and Customary rate practice. Planned Parenthood affiliates' contracts are on a fee for service basis. Other community clinics, which receive cost-based reimbursement for all of their services and supplies, bill for medications at cost plus a dispensing fee or provide prescriptions to patients which are filled at pharmacies. The State is likely viewing this as a way to save money in the context of the tight budget. The State indicates that it has now negotiated prices with the drug companies that are comparable to Planned Parenthood's negotiated prices for oral contraceptives. The State could simply alter the regulations under the program to eliminate the language that provides justification for PP's current fee practice.

The contribution to Net Income provided by our reimbursement for oral contraceptives is substantial (over $2 million annualized). A decision by DHS would have severe financial consequences for us – as for all other Planned Parenthood affiliates.

PPAC, through Kathy Kneer and PPAC's in-house attorney Lilly Spitz, is taking the lead on negotiating with DHS on this issue and coordinating a combined effort on behalf of all affiliates. PPAC discussed this issue with DHS when FPACT was first instituted in the late 1990's and, at that time, DHS did not elect to change the language in the regulations and allowed Planned Parenthood affiliates to continue their billing practice. PPAC is already in discussions with DHS and is preparing a case to leave current practices as they are, based on negative policy impact of any change by DHS in the regulations. It is not in DHS' interest to lose Planned Parenthoods as

service providers for the Family PACT program or to cripple them financially. Ultimately, PPAC is considering introducing legislation to codify the language that is currently in the regulations that permits our fee practice, so that the issue does not arise again at a later date. We will continue to collaborate with PPAC on this matter and will keep the Board posted.

Other Reports

The following reports for Calendar Year 2003 were submitted on time:

- California Family Health Council (CFHC)
- OSHPD (Office of Strategic Health Planning and Development) Annual Utilization Report of Primary Care Clinic
- Federal Audit Clearinghouse (FAC)
- Title X Financial Status Report

Cost Containment Initiatives

The Malpractice premium payable to ARMS, the Federation pooled insurance program, offered several options for payment for the risk year 2004. On the strength of the improving cash position of PPLA, we made this payment early February, achieving a savings of 8% by electing not to phase payments.

A negotiation with McKesson, just complete will yield 5% reduction in a key area of our purchasing. Leif Williams is exploring similar discount with other key suppliers.

Budget Planning

The Agency has begun the budget cycle for 2004-2005, starting with the preparation of operational plans by each department and clinic. In preparation for this, our new Controller has been working with each department to assure that current costs are correctly allocated by department and program to provide a solid basis for forward budgeting and for management against budget.

A copy of the cover memo provided to staff with guidelines for planning is attached for reference and discussion.

We will also be working on 04-05 capital budgets in the following areas: Infrastructure, including IT and clinic refurbishment; South LA Health Center; Headquarters planning.

Finally, we are anticipating a contingency plan to address the potential 15% cut in MediCal and FPACT.

Clinic Management System Status

We are working with Tom Dawson, the consultant who facilitated the Santa Barbara Planned Parenthood implementation of Millbrook (now called Centricity). Mr. Dawson has presented a proposal to complete an RFP document and we are presently reviewing this proposal. It encompasses 454 hours of consulting support and these are being reviewed to see what can be done by the new IT Director and those where we need to rely on the consultants. Dawson has already completed three vendor contacts and demos as follows:

1. Centricity/ old Millbrook system –Santa Barbara

2. Medical manager/Web MD – Golden Gate San Francisco
3. Mysis/Vision product – San Jose Mar Monte

Of these three, the most promising, and most responsive has been Mysis, we already have a complete proposal from them, including costing and a tentative implementation plan. This cost proposal is for $491,000 inclusive of consulting implementation time. We are in the process of evaluating all three proposals.

Please be aware that this process has been completed in record time, in a month and a half. A similar process in the San Diego affiliate is still under way.

The next logical step is a thorough systems analysis phase, which hopefully will be completed in record time, given the existing talent pool at the Agency, which hopefully will shortly be supplemented with a new Billing Manager. Systems implementation consumes time voraciously, and this is the reason for the slight increase in staffing. Our goal is a smooth systems transition without operations and billing deteriorating during the implementation.

We have been working with Development on structuring targeting proposals to donors and Foundations for this to help pay for needed systems.

Third Party Contract Administration

An agreement with Talbert Medical, based on a contact initiated by Orange County PP, to provide abortions services has been signed.

Molina Medical – The contract with this group was reviewed for the incorrect and misapplied coding. The coding discrepancies were reconciled with the Molina personnel in order to recover reimbursement in the surgical procedures, and fine tuning the coding for the pills and medications to standard Medi-Cal codes.

A letter of intent to contract to AltaMed Medical resulted in an invitation to meet mid February.

PLANNED PARENTHOOD LOS ANGELES
REPORT TO THE FINANCE COMMITTEE
FROM VP OF FINANCE
MONTHS OF December 2003 & January 2004 commentary

SUMMARY

Budget was met. The transition from the MAPICS system to GREAT PLAINS was completed successfully, and January closed in the GREAT PLAINS systems. All audit adjustments were recorded in the MAPICS system and system was archived for future audits.

A number of significant accomplishments have taken place in the areas of systems demo and implementation costs have been budget projected through 2008-09, budget for 2004-05 was started and distributed, support for both the Technology grant and the CHFFA loan, contracting outreach resulting in appointments with large healthcare delivery systems (ALTAMED), as well significant reductions by facilitating negotiations with the largest pharmaceutical vendor carrier (McKesson) have taken place during both months. The systems clean up and readiness for implementation of a new system continues. All financially related filings with regulatory Agencies namely CHFC, OSHPD, and OFC were made on time for year 2003. All of these are very good developments.

On a more sobering note, a couple of developments which affect the future financial conduct and operation of the Agency need to be brought to the attention of the Board. One affects a long standing compliance issue resulting from an audit of the San Diego affiliate brought to our attention January 26. The second affects materially erroneous filings of the OSHPD report for the year 2002 under the rubric of Mr. Steven Emmert as both preparer and person approving the report.

2004

EXHIBIT 11

Note:
We have flagged values which deviate significantly from the previous year's value or the historical average.
However, our standard for "significant" deviation is arbitrary - please review ALL of the values on the sheet.

This report will address these summary points in order of importance and will also address financial reports, presently prepared and used throughout the Agency, in a summary intended for Executive review and not in the detail of previous reports. Henceforth, we will attempt to use this same system of Executive Summary in our reporting.

REGULATORY ISSUES

Medications Audit

The issue that has the largest impact for the Agency is the DHS audit started mid-January 2004. The audit focused on the markup for the Medications being sold and dispensed. Our supply contracts enable us deep discounts, and therefore the markups constitute not only a significant Revenue item, but virtually the only reason PPLA has been able to stay in business. This applies to all affiliates conducting business the same way PPLA does.

These argument points were recognized during a conference call February 9th, which I was asked to participate in by the CEO, the conference call was summarized for the management of PPLA. The statements were made that 1) the audit challenge came circa 3 years ago and at that time it was felt an interpretation was obtained, never in writing or formal communiqué from DHS, that DHS would stay out of this area, 2) that the information loop was never closed by confirming this in writing on our behalf by PPAC, 3)that by allowing the charging of our patients at, arguably, usual and customary charging similar to pharmacies in the private sector that PPLA would allow the State to participate in PPLA's own supplier discounts, and enable PPLA to make up for the the cutbacks across the spectrum of all the other procedures that we are experiencing now.

Kathy Kneer PPAC added two more points which are significant: 1) that we are the only group of clinics that we have knowledge of billing medications at usual and customary based on the interpretation outlined above and 2)that we need to quickly get other examples, and we were solicited to put feelers out to get examples where a comparison can be had of this billing practice. [redacted]

The State's argument is that pharmacies are billing at AWP (average wholesale price), and that the State has now negotiated a master supply contract that reportedly has OC's at $1 per cycle. The pharmacist bills the State, the State bills the manufacturer directly, the State cost is very low with huge volume discounts, and potential rebates.

My input to the conference was a review of the normal way in which community clinics handle this area, where the rule of "lower of cost or charges" is followed. The method is to compute a dispensing fee that bears the entire indirect cost as well as the direct costs of dispensing the medicine.

The communiqué from San Diego indicated that the State intended to audit each and every affiliate about this issue.

Action Item: As the VP of Finance of PPLA I am recommending the following course of action:

1-That the CEO and I conduct an independent legal review, from a competent healthcare attorney of this entire matter. The dual dangers or being found out of compliance with normal billing practices, and potential recoupments amply justify this course of action. This review should be reviewed with Finance Committee.

2-That an immediate and sustainable system to establish dispensing costs, and a Federal compliant Indirect Cost rate be established for the Agency. I have already undertaken steps to start work in this area. Such a study and cost basis has never been undertaken at PPLA to my knowledge.

3-That a Charge Master review of all billable amounts be conducted by first hiring a Billing Manager with sufficient coding and analysis expertise who will have the time to complete a review of amounts chargeable under the various PPLA contracts. The companion cost studies have already started where a consultant was retained and has achieved a monthly cost review of the clinics, and has started the study to arrive at costs per TAR, medication dispensing, and cost per all the other procedures that we provide. A period of three years at least has elapsed since this type of review.

OSHPD (Office of Strategic Health Planning and Development) Annual Utilization Report of Primary Care Clinic.

The reports submitted for each clinic in the PPLA clinic were entered through the ALIRT system on line by Client Services last year for the calendar year 2002. The reports that were filed then indicate Steven Emmert as the prepared and the Administrator and list him as COO.

This year, calendar 2003, the report preparer is the VP of Finance and the CEO is Administrator. The reports contain a level of accuracy heretofore unattainable, this was accomplished, under my direction, by joining the Data Mart project in November 2003 and along with the Interim IT Director, facilitating the loading of all clinical data and the financial results of the clinics. The results obtained allowed Administrative Staff to quicky load a correct report online.

The reports for 2002 contain significantly erroneous data, with clinic dollar billing volumes virtually two to three times the normal rates. We arrived at this conclusion by review of our own reports, and going back a number of years for those prepared by an Accounting Manager. Not only were the dollars inflated, but also the number of encounters and visits in order to make the ratios come out. We do not know of the number of personnel and professionals loaded is accurate or not, presumably this data is also not accurate.

Upon contacting the OSHPD designated inquiry desk, we were informed Friday 2/13/04 that the 2002 report is frozen and cannot be modified.

These actions may have significant consequences for the Agency, given that the data set submitted is the basis for the Title X Grant as well as MediCal contracting. My recommended course of action, which we are pursuing, is to ascertain the use of the data by CHFC at a meeting the third week of February 2004 and independent inquiry. The consequences are likely to arise once the newly finished 2003 report is activated only, the comparability and the ratios may need to be explained. Hopefully, it will not trigger an audit of PPLA.

REVENUES

- Title X billing for the year was completed and the FSR form sent on time.
- Contributions are under $136k year to date, the month of October added another $10k to the gap. We are encouraged by some of the amounts received in November and hope to meet the December budgeted year end donations planned
- Contract income continues to as has been the case all year, however, we have recently completed loading the Molina contract, and are pursuing a number of contracting initiatives which will add volume to the Agency. The Talbert contract has produced significant utilization, this was a contract seat to us by our Orange County affiliate.

EXPENSES

The Malpractice premium payable to ARMS, the Federation pooled insurance program offered several options for payment for the risk year 2004. On the strength of the improving cash position of PPLA we made this payment early February. This is a return of 8% cannot get that at USTRUST at the prevailing interest rates.

BALANCE SHEET—MAPICS transition

A number of important steps were taken to assure that the MAPICS transition to Great Plains occurred uneventfully. One was the hiring of a Controller who is familiar with operating Great Plains and is also oriented to reconciling accounting activity.

Due to the dearth of accurate Balance Sheet reporting from July through November, reconciliations satisfactory to the VP of Finance did not occur until the recording of audit adjustments and final closing of the 6/30/2003 fiscal year. Since MAPICS could not be balanced at the Balance Sheet level, spreadsheet accounting for all Balance Sheet accounts were undertaken. It appears that these efforts resulted in adjustments which are reflected in two stages 1- audit adjustments are reflected in the December closing, and complete accounting for Prepaids and final adjustment of Payable Accruals will occur in January.

In addition to this, after 4 back to back physical inventories, with mixed results and limited success at isolating reasons for differences, and discrepancies with CVR reliefs for many material categories, both the December and January inventories are being reconciled and adjusted to Balance Sheet. As we indicated in prior

reports, it appears that we have been overrelieving inventory, and this has resulted in adjustments which will increase the fiscal year to date net income at the Operating Line.

CLINICS

A separate summary report is attached reflecting clinic visits and costs. This report is now routine and reviewed by VP of Client Services, to whom we are forever grateful for her contribution to this effort. It could not have happened without her dedication and support as simple there was no historical base to draw from.

Purchasing and Inventory

As we reported last month we hired Leif Eric Williams as Purchasing, Materials, and Inventory Control Director starting November 19th. His introductory program was presented as a separate exhibit in last month's report.

A negotiation with McKesson, just completed yields a 5% reduction in important elements of our purchasing cycle.

BUDGET for the Agency 2004

The anticipated budget cuts by the new Governor requires a new budget revision for both the short term and for the 2004 fiscal year budget commencing 6/30/2004.

The following are the major questions for consideration:

1-Impact of the $750,000 anticipated 15% cut in MediCal and FPACT within the Operations Budget of the Agency.
2-Projection of 4 types of budgets to control the operations and Advancement Campaign: an Operation Budget, a Capital Equipment Replacement Budget which includes an IT systems budget, a Headquarters building, and a South Los Angeles Clinic and Clinics Expansion Program budget.
3-Impact of potential cost reductions in the way of Labs, Inventory Improvements, and Internal Process Improvements.
4-Impact of the Medications reduction to dispensing fee only marginizing.

This process is now under way and we hope will be completed in presentable format by the new Controller by the March Board meeting.

CONTRACT ADMINISTRATION

Two new efforts in the contract area are:

Molina Medical—The contract with this group was reviewed for the incorrect and misapplied coding. The coding discrepancies were reconciled with the Molina personnel

in order to recover reimbursement in the surgical procedures, and fine tuning the coding for the pills and medications to standard Medi-Cal codes.

A letter of intent to contract was forwarded to AltaMed Medical resulted in an invitation to meet mid February.

Information Technology—new Systems review

Tom Dawson the Santa Barbara consultant who facilitated their implementation of Millbrook (now called Centricity), a system that has sufficiently impressed us, completed the three vendor contacts and demos as follows:

1-Centricity/ old Millbrook system—Santa Barbara
2-Medical Manager/Web Md —Golden Gate San Francisco
3-Mysis/Vision product—San Jose Marmonte

Of these three, the most promising, and most responsive has been Mysis, we already have a complete proposal from them, costing and a tentative implementation. This cost proposal is for $491,000 inclusive of consulting implementation time.

Mr. Dawson has presented a proposal to complete an RFP document and we are presently reviewing this proposal. It encompasses 454 hours of consulting support and these are being reviewed to see what can be done by the new IT Director and those where we need to rely on the consultants.

Please be aware that this process has been completed in record time, in a month and a half. A similar process in the San Diego affiliate is still under way.

The next logical step is a thorough systems analysis phase, which hopefully will be completed in record time, given the existing talent pool at the Agency, which hopefully will shortly be supplemented with a new Billing Manager. Systems implementation consume time voraciously, and this is the reason for the slight increase in staffing, in abeyance of preventing operations and billing from deteriorating while a better solution is obtained.

Provider Name:
PLANNED PARENTHOOD OF
SAN DIEGO & RIVERSIDE COUNTIES

Medi-Cal Provider Numbers:
CMM70209F, ZZT12066F, CMM70213F,
CMM70210F, CMM70200F, CMM70949F,
CMM70277F, CMM70264F, CMM70299F,
CMM70393F, CMM70420F, CMM70510F,
CMM70632F, ZZT11780G, CMM70245F,
CMM70963F

Audit Period:
July 1, 2002 To June 30, 2003 (Codes X1500 and X7706)
February 2, 2003 To May 30, 2004 (Code X7722)

Medical Review Section – South III
Medical Review Branch
Audits and Investigations

Stephan J. Edwards, Chief
Donna Gray-Bowersox, Staff Services Manager I
Lenard Lynch, Health Program Auditor III

Report Issue Date: November 19, 2004

EXHIBIT 12

State of California—Health and Human Services Agency
Department of Health Services

California Department of Health Services
SANDRA SHEWRY
Director

ARNOLD SCHWARZENEGGER
Governor

November 19, 2004

Mr. Bob Coles
Vice President & CFO
Planned Parenthood of San Diego & Riverside Counties
1075 Camino del Rio South, Suite 200
San Diego, CA 92108

PROVIDER NAME:	**PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTIES**
PROVIDER NUMBERS:	**See Attached Listing (Schedule 5)**
AUDIT PERIOD:	**July 1, 2002 To June 30, 2003 (Codes X1500 and X7706)** **February 2, 2003 To May 30, 2004 (Code X7722)**

Dear Mr. Coles:

We have completed the audit of Planned Parenthood of San Diego and Riverside Counties (PPH) claims under the Family Planning, Access, Care and Treatment Program (Family PACT) for the above noted audit periods. This audit was conducted in accordance with California Welfare and Institutions (W & I) Code, Sections 14124.2 and 14170. In conducting this audit, the auditors compared medical, financial, and management records relating to your Family PACT services with paid claims information supplied by the fiscal intermediary. The auditors also reviewed correspondence from Planned Parenthood Affiliates of California (PPAC) to determine statewide policies and business practices in place for Planned Parenthood Providers.

In accordance with California Code of Regulations (CCR), Title 22, Section 51021, an Exit Conference was held with you on October 25, 2004. Prior to the exit conference you received a report of the preliminary findings. During the exit conference the audit team discussed the findings with you, and gave you the opportunity to submit additional documentation and/or missing records identified during the audit. The current findings reflect the evaluation of all relevant information received prior and subsequent to the exit conference.

The auditors identified problems in your Medi-Cal billing procedures related to the following Family PACT Codes:

X1500 Contraceptive barrier products
X7706 Oral Contraceptives
X7722 Plan B products

Claims for services provided under the Family PACT program are governed by the Policies, Procedures and Billing manual (PPBI). This manual includes descriptions of the products and services covered by the program, billing codes and instructions. In accordance with Section ***familypact22 page 2*** of the PPBI Provider's are required to document the name of the medication or supply dispensed, the quantity and the provider's cost per unit. Section ***familypact32*** contains completed sample claims for the provider's reference. This requirement was in effect for the entire audit period. In December 2003, the Department issued a Medi-Cal Update, Medical Services Bulletin 353 which reminded providers of the existing policy that contraceptive supplies must be billed at cost.

During the audit review period, PPH did not comply with the published billing requirements. PPH submitted claims for program reimbursement based on their customary fee. For Oral Contraceptives, codes X7706 and X7722 PPAC has stated that the Planned Parenthood Organization has had a long standing relationship with manufacturers that allows the provider to receive deeply discounted prices, also known as "nominal prices". According to PPAC the nominal pricing arrangements exist outside of any legal mandate and as such are not subject to billing restrictions that would normally apply to federal discount programs such as the 340B program. According to PPAC, they bill Medi-Cal at their usual and customary fee which is higher than the amount they pay the drug companies, but lower than what would be considered the retail price of the product. PPAC believes this pricing methodology results in a sharing of the profits from the "nominal price" arrangements between the State and PPAC.

For barrier contraceptives and supplies, code X1500, PPH's claims were primarily for condoms. Based on our review of product invoices, "nominal pricing" was not an issue. The prices charged by the product distributors reflected normal wholesale pricing which would be available to any volume provider.

Failure to comply with Family PACT billing instructions has resulted in the Department reimbursing PPH for claims in excess of cost. Reimbursement in excess of cost for the

audit period totaled $5,213,645.92. The accompanying schedules detail the program reimbursement and product cost for each of the providers within the San Diego and Riverside region.

If you have any questions concerning these actions, please contact Stephan J. Edwards, Section Chief, at (619) 688-6465.

Sincerely,

for H. Gray Barker

Jan Inglish, N.P., Chief
Medical Review Branch
Audits and Investigations

Enclosures

Schedule 1 - Summary of Findings
Schedule 2 - Cost and Reimbursement Code X7706
Schedule 3 - Cost and Reimbursement Code X7722
Schedule 4 - Cost and Reimbursement Code X1500
Schedule 5 – Provider Numbers and Locations

Certified Mail #: 7004 1160 0005 9900 9449

bcc:

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PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
SUMMARY OF FINDINGS
SCHEDULE 1

Billing Code	Code Description	Amount Paid	Provider's Cost	Payments in Excess of Cost
X7706	Oral Contraceptives (From schedule 2)	$5,030,347.00	$859,569.10	$4,170,777.90
X7722	Plan B Products (From schedule 3)	$1,119,351.53	$99,282.10	$1,020,069.43
X1500	Contraceptive Barrier Products (From schedule 4)	$35,117.30	$12,318.71	$22,798.59
	Totals	**$6,184,815.83**	**$971,169.91**	**$5,213,645.92**

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X7706
SCHEDULE 2

PROVIDER #	NAME	Number of Cycles Paid	Average Cost Per Cycle	Providers Cost (Cycles paid x avg cost)	Amount Paid	Program Payments in excess of cost
CMM70209F	First Avenue Center	32,547	$2.05	$66,721.35	$390,486.00	$323,764.65
ZZT12066F	Escondido Center	30,936	$2.05	$63,418.80	$371,031.00	$307,612.20
CMM70213F	El Cajon Center	25,000	$2.05	$51,250.00	$299,931.00	$248,681.00
CMM70210F	Kearny Mesa Center	28,591	$2.05	$58,611.55	$343,081.00	$284,469.45
CMM70200F	College Avenue Center	36,560	$2.05	$74,948.00	$438,711.00	$363,763.00
CMM70949F	Mission Bay Center	20,931	$2.05	$42,908.55	$251,171.00	$208,262.45
CMM70277F	Riverside Center	37,410	$2.05	$76,690.50	$448,611.00	$371,920.50
CMM70264F	Oceanside Center	33,420	$2.05	$68,511.00	$400,989.00	$332,478.00
CMM70299F	Euclid Avenue Center	15,579	$2.05	$31,936.95	$186,927.00	$154,990.05
CMM70393F	Mira Mesa Center	28,991	$2.05	$59,431.55	$347,889.00	$288,457.45
CMM70420F	Mission Valley Center	34,533	$2.05	$70,792.65	$414,067.00	$343,274.35
CMM70510F	Chula Vista Center	31,923	$2.05	$65,442.15	$383,037.00	$317,594.85
CMM70632F	Rancho Mirage Center	22,915	$2.05	$46,975.75	$274,941.00	$227,965.25
ZZT11780G	Encinitas Center	8,807	$2.05	$18,054.35	$105,648.00	$87,593.65
CMM70245F	Pacific Beach Express	23,597	$2.05	$48,373.85	$283,086.00	$234,712.15
CMM70963F	Moreno Valley Center	7,562	$2.05	$15,502.10	$90,741.00	$75,238.90
	Total	419,302		$859,569.10	$5,030,347.00	$4,170,777.90

(To Schedule 1)

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X7722
SCHEDULE 3

PROVIDER #	NAME	Number of Pills Paid	Average Cost Per Pill	Providers Cost (Pills paid x avg cost)	Amount Paid	Program payments in excess of cost
CMM70209F	First Avenue Center	3,776	$1.85	$6,985.60	$78,759.50	$71,773.90
ZZT12066F	Escondido Center	3,157	$1.85	$5,840.45	$65,849.81	$60,009.36
CMM70213F	El Cajon Center	2,609	$1.85	$4,826.65	$54,418.53	$49,591.88
CMM70210F	Kearny Mesa Center	2,820	$1.85	$5,217.00	$58,819.34	$53,602.34
CMM70200F	College Avenue Center	3,868	$1.85	$7,155.80	$80,686.48	$73,530.68
CMM70949F	Mission Bay Center	3,521	$1.85	$6,513.85	$73,432.43	$66,918.58
CMM70277F	Riverside Center	4,757	$1.85	$8,800.45	$99,214.74	$90,414.29
CMM70264F	Oceanside Center	3,051	$1.85	$5,644.35	$63,643.86	$57,999.51
CMM70299F	Euclid Avenue Center	3,688	$1.85	$6,822.80	$76,926.47	$70,103.67
CMM70393F	Mira Mesa Center	3,978	$1.85	$7,359.30	$82,981.08	$75,621.78
CMM70420F	Mission Valley Center	5,094	$1.85	$9,423.90	$106,239.99	$96,816.09
CMM70510F	Chula Vista Center	4,734	$1.85	$8,757.90	$98,743.38	$89,985.48
CMM70632F	Rancho Mirage Center	3,318	$1.85	$6,138.30	$69,197.85	$63,059.55
ZZT11780G	Encinitas Center	778	$1.85	$1,439.30	$16,229.08	$14,789.78
CMM70245F	Pacific Beach Express	2,007	$1.85	$3,712.95	$41,850.39	$38,137.44
CMM70963F	Moreno Valley Center	2,510	$1.85	$4,643.50	$52,358.60	$47,715.10
	Total	53,666		$99,282.10	$1,119,351.53	$1,020,069.43

(To Schedule 1)

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
COST AND REIMBURSEMENT CODE X1500
SCHEDULE 4

Provider Number	CMM70510F
Provider Location	CHULA VISTA

Amount paid for Sample Population	$35,177.30
Percent of payments in excess of cost	64.81%
Payments in excess of cost	$22,798.59

(To Schedule 1)

Notes:

Review of Code X1500 claims were based on a statistical sample of paid claims. For the review period only one provider within the San Diego and Riverside County region submitted a material number of claims for Code X1500. The amounts above represent the statistical extrapolation of the difference between the Provider's average cost, $.07 per item and their claim amount of $.20 - .$25 per item.

PLANNED PARENTHOOD OF SAN DIEGO & RIVERSIDE COUNTY
PROVIDER NUMBERS AND LOCATIONS
SCHEDULE 5

Provider Number	Location	County
CMM70209F	First Avenue Center	San Diego
ZZT12066F	Escondido Center	San Diego
CMM70213F	El Cajon Center	San Diego
CMM70210F	Kearny Mesa Center	San Diego
CMM70200F	College Avenue Center	San Diego
CMM70949F	Mission Bay Center	San Diego
CMM70277F	Riverside Center	Riverside
CMM70264F	Oceanside Center	San Diego
CMM70299F	Euclid Avenue Center	San Diego
CMM70393F	Mira Mesa Center	San Diego
CMM70420F	Mission Valley Center	San Diego
CMM70510F	Chula Vista Center	San Diego
CMM70632F	Rancho Mirage Center	Riverside
ZZT11780G	Encinitas Center	San Diego
CMM70245F	Pacific Beach Express	San Diego
CMM70963F	Moreno Valley Center	Riverside

Gonzalez, Victor

To: Mary-Jane Wagle
Cc: Cain, Richard; Swiller, Martha
Subject: RE: Reminder about RBZ Language

Mary Jane, thank you for composing the paragraph. I discussed this with RBZ and they are indicating that this language is much stronger than they would feel comfortable with.
Strength in financial systems and control has been fully recovered and we are confident that the audits we are providing and the interim financial statements represent in materially significant respects the financial condition
They are comfortable in saying only that significant progress has occurred towards recovery of financial systems and that additional steps need to be taken along with continuance of recently instituted controls.

Also I would like to suggest, which I am sure is the case, that we need a level of complete candor and full disclosure to any source that we obtain financing from. Hopefully, this loan is a building block for future financing and long term relationships, and trust built on compete disclosure is the usual norm.

From: Mary-Jane Wagle [mailto:maryjane@onecompany.org]
Sent: Wednesday, October 22, 2003 6:49 PM
To: Gonzalez, Victor
Cc: Cain, Richard; Swiller, Martha
Subject: RE: Reminder about RBZ Language

Hi Victor - Perhaps you could show RBZ the "Management Discussion" that I drafted for purposes of the CHFFA application and ask them if they believe we should make a statement in that discussion that says something like:

"We have provided audited financial statements for FY 1999-2000 and for FY 2000-2001 prepared by Miller, Kaplan, Arase; and for FY 2001-2002 prepared by RBZ. There was a temporary breakdown in financial reporting mechanisms owing to personnel changes and attempted system overhaul during the last few months of Fiscal Year 2001-2002 and the first few months of Fiscal Year 2002-2003; and the agency changed auditors in the beginning of our FY 2002-2003 year to complete the FY 2001-2002 audit. Strength in financial systems and control has been fully recovered and we are confident that the audits we are providing and the interim financial statements represent in materially significant respects the financial condition of the agency. RBZ is in the process of completing the audit for FY 2002-2003, which is anticipated by December 2003."

We are providing the standard audits, not the HUD audit with the negative notations. Maybe they don't think we need to say anything or we can say something less definitive that the above. We want to be as vague as possible while still providing whatever disclosure is appropriate - vague because these applications become a matter of public record should any persistent anti-choicer be on the lookout; but providing appropriate disclosure because we know that CHFFA will rely in part on these documents to underwrite our creditworthiness for a loan. We can bear in mind as will they that the loan is only $400,000.

Thanks. MaryJane

Richard - would also appreciate your thoughts on this. MJ

-----Original Message-----
From: Gonzalez, Victor [mailto:Victor.Gonzalez@pp-la.org]
Sent: Wednesday, October 22, 2003 5:00 PM
To: 'Mary-Jane Wagle'; Swiller, Martha
Subject: RE: Reminder about RBZ Language

EXHIBIT 13

I discussed this with RBZ and, if you will recall, there was a 'comfort letter' that Tom Schulte sent in to us to support the earlier Title X audit, it indicated the significant strength in system and control, RBZ has not difficulty with including this letter, provided I can locate a copy in the files. They will add language to the effect that significant systems improvements have in fact occurred, and were tested as part of their audit. Please be aware that this latter letter format will not be ready for a few more weeks.....so I am back to the comfort letter

-----Original Message-----
From: Mary-Jane Wagle [mailto:maryjane@onecompany.org]
Sent: Wednesday, October 22, 2003 1:49 PM
To: Gonzalez, Victor; Swiller, Martha
Subject: Reminder about RBZ Language

Please remember to talk to RBZ about whether there is any language they recommend that we include in our management discussion about the past three years' audited financials when we submit them to the State of California as part of the loan request package. As a refresher, we are applying to the California Health Facilities Financing Authority for a $400,000 loan at 3% interest repayable monthly over 5 years to help build and equip the new South LA clinic; while they are aware that we are doing a capital campaign, they are underwriting us as an organization to determine their comfort with our ability to repay.

Thanks. MJ

Mary-Jane Wagle
CFO
O.N.E. Company
1139 West Sixth Street
Los Angeles, CA 90017
213/202-3930 Fax: 213/202-3934

Gonzalez, Victor

From: Gonzalez, Victor
Sent: Thursday, January 29, 2004 1:44 PM
To: Wagle, Mary-Jane
Cc: PPLA Senior Staff
Subject: FW: Audit Status

The latest on the audit at San Diego, section of the audit on hold

-----Original Message-----
From: Coles, Bob
Sent: Thursday, January 29, 2004 9:57 AM
To: Gonzalez, Victor
Subject: FW: Audit Status

Below is the latest correspondence from the DHS auditor

Bob Coles
Vice President/CFO
Planned Parenthood of San Diego and Riverside Counties
1075 Camino Del Rio South
San Diego, Ca. 92108
Tel: (619)-881-4500
E-mail: Bob.Coles@PPFA.Org
www.planned.org

-----Original Message-----
From: Edwards, Stephan (DHS-A&I) [mailto:SEdwards@dhs.ca.gov]
Sent: Tuesday, January 27, 2004 2:05 PM
To: Coles, Bob
Cc: Gray-Bowersox, Donna (DHS)
Subject: Audit Status

Bob, This is to follow up on our phone conversation today regarding the status of the DHS audit of your Planned Parenthood sites. There are two primary components to the audit process. The first involves the verification that services billed to the Medi-Cal program were delivered. As we discussed at the entrance conference, we will be visiting your clinic sites to examine 5-10 patient records. We will provide the clinic managers a list of patient names at the time of the visit, if the requested records have been transferred to storage, we will provide alternate names. We will follow this process for each of the sites except Chula Vista. For the Chula Vista site we have provided you with a statistical sample of claims that we would like to review. As soon as your staff have pulled the Medi-Cal claim, super bill, and patient record we will review these at your San Diego headquarters.

The second component of the audit is the comparison of product acquisition costs to amount billed to the program. You have advised us that PPH is exempt from this requirement and that products are billed at your usual and customary charge. This position was elaborated on by your legal counsel Lilly Spitz from California Planned Parenthood in Sacramento. We agreed that while this matter is being resolved we would pend this part of the audit.

To assist your staff in planning, the following is our tentative audit

EXHIBIT 14

schedule for the next two weeks.

January 28 - 29: Riverside county locations.

Feb 2 - 6 : San Diego / Escondido Sites

Please call or e-mail me if you have any questions.

Stephan J Edwards, Chief
Medical Review Section - South III
7575 Metropolitan Dr, Suite 200
San Diego CA 92108
619-688-6469 fax 619-688-6480
sedwards@dhs.ca.gov <mailto:sedwards@dhs.ca.gov>

Gonzalez, Victor

From: Kneer, Kathy
Sent: Thursday, February 05, 2004 6:48 PM
To: Spitz, Lilly; Reed, Angela; Berthelsen, Birgitte; Coles, Bob; Eckhardt, 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; Swiller, 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 acquistion cost. She had this conversation with DHSafter 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 affilite to provide our office with information about your affilaites 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 accuarately reflecting the deepth 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 affilaite can estimate the Total $ impact - if not that's okay. You should also begin preparing for discussion sake - what the impact at an affilaite 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 thiss short notice for the call on Monday, I hope that each affilaite 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.

-----Original Message-----
From: Spitz, Lilly
To: Reed, Angela; Berthelsen, Birgitte; Coles, Bob; Eckhardt, Carla; Rollings, Cheryl; Barrera, Diahann; Harrison, Dian; Estes, Heather; Ewy, Jeanne; Giambruno, John; Dunn, Jon; Yarges, Judy; Pinterpe, Karen; Kneer, Kathy; Smith, Kathy; Spitz, Lilly; Williams, Linda; Schrepfer, Marcia; McKinney, Marie; Salo, Mark; Stanphill, Marsha; Swiller, 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
Sent: 2/5/04 4:23 PM
Subject: DHS Cost Audits - contraceptive drugs and supplies

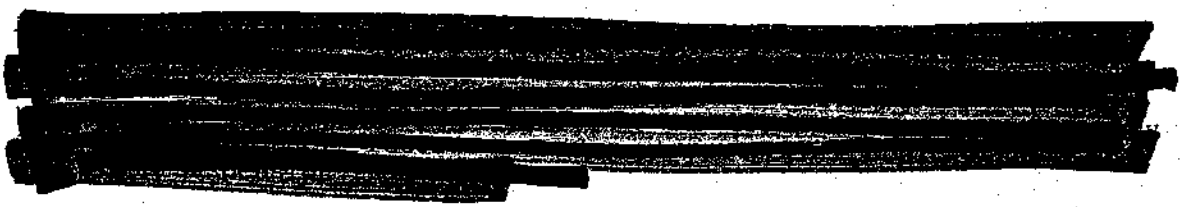
TO: CEO's, CFO's and Pt. Services

RE: DHS cost audits, PP San Diego - Update

Kathy has spoken with Kim Belshe about the audit currently being conducted at the San Diego Affiliate, and has asked that the cost portion of the audit be put on hold pending final resolution on the policy issues raised specifically about our billing practices for oral

:raceptives.

Kim has declined to halt the cost audit at this time. However, she has indicated that she is open to further discussion of the public policy concerns raised by Planned Parenthood.



PLEASE LET US KNOW IMMEDIATELY IF YOU ARE CONTACTED BY DHS TO SCHEDULE AN AUDIT, OR IF DHS AUDITS & INVESTIGATIONS CONTACTS YOU FOR ANY REASON.

We will be scheduling a meeting with DHS on the public policy implications of this issue as soon as possible. In preparation, PPAC needs some up-to-date information from you:

* Complete list of oral contraceptives and contraceptive supplies, the purchase price under nominal pricing, and the amount billed to Medi-Cal.

* A separate listing of all oral contraceptives and contraceptive supplies purchased under 340B, their purchase price and the amount billed to Medi-Cal.

Please contact Marsha Stanphill with any questions regarding this request for information: (916) 446-5247, ext. 108.

CONFERENCE CALL TO DISCUSS FURTHER
MONDAY, FEBRUARY 9th, 4:pm -
1-888-872-1176 code 9713#

Lilly Spitz
Chief Legal Counsel
California Planned Parenthood Education Fund
555 Capital Mall, Suite 510
Sacramento, CA 95814
(916) 446-5247 ext. 102
Lilly.spitz@ppfa.org
Fax: (916) 441-0632

March for Choice - Be a part of history! The time is right for a public demonstration of historic size in support of reproductive freedom. March with over a million others in Washington, DC on Sunday, April 25, 2004. www.MarchForChoice.org <http://www.marchforchoice.org/>

[redacted]

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Staff Legal Counsel
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www.MarchForChoice.org <http://www.marchforchoice.org/>

[Emmert, Steven]

Earlier you heard from Mark Salo about his impending audit by Medi-Cal and the affiliate's response. [redacted]

As you recall, when this issue was addressed seven years ago, PPAC participated in endless meetings to educate DHS on the rationale for PP clinics to legitimately bill "usual and customary" rates for OCs. Our final communication with DHS included a lengthy legal opinion that explained the legal and public policy reasons for allowing flexibility to PP clinics who purchase OCs at nominal rates. DHS never responded in writing to this final letter, and also did not sanction or issue warnings to any of our clinics regarding billing practices. Based on this lack of action on the part of DHS, we assume that our practices meet the DHS requirements.

The problem is that we don't have any documentation of an exception for Planned Parenthood or clinics that have nominal purchase prices. Our goal, now, is to finalize the negotiations that were begun in 1997 by getting a written agreement from DHS authorizing our current billing practices for OCs.

NOTE: The San Diego DHS district office **will be going forward with a chart audit**, and has indicated that DHS intends to conduct chart audits at all Planned Parenthood in the state. Chart audit are routine and seek to document that billing records are supported by medical chart notes. Based on our experience over the years, all of you have taken steps to ensure proper chart documentation. It would be helpful to PPAC if you could **notify Marsha Stanphil or Lilly Spitz if your affiliate experiences a chart audit.** It is important that we keep everyone on the same page and message.

Kathy Kneer, President
Planned Parenthood Affiliates of California
555 Capitol Mall, Suite 510
Sacramento, CA 95814
(916) 446-5247 (Office)
(916) 441-0632 (FAX)
(916) 275-7946 (Cell)
kathy.kneer@ppfa.org <mailto:kathy.kneer@ppfa.org>
www.ppacca.org <http://www.ppacca.org>