



February 6, 2012

TO: The Honorable Cliff Stearns, Chairman  
Energy and Commerce Committee,  
Subcommittee on Oversight and Investigations  
United States House of Representatives

FROM: Steven H. Aden, Senior Counsel  
Michael J. Norton, Senior Counsel  
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Alliance Defense Fund

RE: Summary of State Audits of Planned Parenthood Affiliated Providers  
Showing Waste, Abuse, and Potential Fraud

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Mr. Chairman:

This memorandum supplements and updates the memorandum we provided to you on October 26, 2011.

Please let us know if you have questions or require additional information.

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#### **EXECUTIVE SUMMARY**

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

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

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

**These ten state audits found numerous improper practices resulting in significant Title XIX-Medicaid overpayments of nearly \$8 million<sup>1</sup> to Planned Parenthood affiliates for family planning and reproductive health services claims.**

**Furthermore, thirty-eight federal audits of state family planning programs by HHS-OIG found between \$88 million and \$99 million in overbilling.** The federal audits detailed "unbundling" billing schemes related to pre-abortion examinations, counseling visits, and other services performed in conjunction with an abortion; and improper billing for the abortions themselves.<sup>2</sup> In New York alone during one four-year

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<sup>1</sup> The total is between \$7,867,547.15 and \$7,987,580.02, depending on the true amount of the outstanding billings in Texas.

<sup>2</sup> One federal audit (Review of Clinic and Practitioner Claims Billed as Family Planning Services Under the New York State Medicaid Program, A-02-07-01037, Nov. 2008) noted that 27 of the 119 claims in the sample were abortion procedures, and one provider was responsible for 25 of them. Based on the procedure codes used, the auditors believed that this provider billed for at least 3,900 abortions during the audit claim, but only reviewed the 25 claims in the sample. Some were associated with no order at all; some orders had expired or had been signed only by a Registered Nurse (RN), without countersignature by a clinician. This practice is often associated with HOPE (Hormones with Optional Pelvic Exam) visits.

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

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

Seven of the federal HHS-OIG audits were of New York State and found federal overpayments in excess of \$32 million<sup>3</sup> to the New York State Medicaid family planning program. These audits likely led to the seven state audits of New York Planned Parenthood affiliates; thirteen months after the federal audit of New York State that

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

FFP is the federal portion of the shared federal-state contributions to the Medicaid program; the precise share is determined by the federal medical assistance percentage (FMAP). *See generally* Title XIX of the Social Security Act. In New York, the FMAP was 50% from January 1, 2000 through March 31, 2003, and 52.95% from April 1, 2003 through December 31, 2003. However, Social Security Act § 1903(a)(5) and 42 C.F.R. §§ 433.10, 433.15 provide for an enhanced 90% FFP for family planning services, which are defined in the Centers for Medicare & Medicaid Services (CMS) State Medicaid Manual. While a state may determine the specific services and supplies to be covered as Medicaid family planning services, such procedures and items must adhere to certain CMS guidelines. CMS State Medicaid Manual § 4270 also provides that an abortion may not be claimed as a family planning service. Further, based on the Supplemental Appropriations and Recession Act of 1981, P.L. No. 97-12 and 42 C.F.R. § 441.203, federal funds may only be used for an abortion in cases where the life of the mother is endangered. Therefore, many laboratory services related to an abortion are ineligible for federal funding. However, FFP is available at the applicable FMAP for the costs of certain services associated with the provision of a non-federally funded abortion if the same services would have been provided to a pregnant woman not seeking an abortion, CMS State Medicaid Manual § 4432, but these services will not be reimbursable at the enhanced ninety-percent rate, CMS Financial Management Review Guide Number 20, Family Planning Services, Medicaid State Operations Letter 91-9.

<sup>3</sup> The true amount may be \$35,381,352 or even higher, as HHS-OIG set aside certain amounts in question for further review, and as the scope of the audits was limited.

identified “especially Planned Parenthoods” as incorrectly claiming services as family planning,<sup>4</sup> New York State released its first known audit report of a Planned Parenthood affiliate.<sup>5</sup>

Additionally, we understand that the Internal Revenue Service’s criminal division is in the process of auditing the former PPFA affiliate Planned Parenthood Golden Gate (herein “PPGG”). This audit was reportedly instigated by a former employee who lodged a complaint about an improper relationship between that PPGG and its related political organization, and also about PPGG’s financial dealings.

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

#### **TYPES OF FRAUD IDENTIFIED**

1. In a process known as “unbundling,” billing and being reimbursed by Title XIX agencies for medications and/or services provided in connection with an abortion procedure;

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<sup>4</sup> Other audits may single out Planned Parenthood affiliates, as well, without referring to them by name. For example, in the November 2008 New York State audit A-02-07-01037, HHS-OIG found that New York improperly received enhanced ninety-percent federal reimbursement for 102 out of 119 sample claims. Of these, 96 were for services unrelated to family planning, and 33 were for services for which no reimbursement was available - including twenty-seven abortion procedures, and four services performed in conjunction with an abortion. HHS-OIG found that one provider was responsible for twenty-five of the twenty-seven abortion claims; this provider billed at least 3,900 abortion claims during the audit period.

<sup>5</sup> It is logical to presume that New York State, after being audited and charged over \$32 million, would attempt to recover this loss from the Planned Parenthood family planning clinics that would have been a primary source of the overpayments. One of the 2008 federal audits of New York State (Review of Federal Medicaid Claims Made for Beneficiaries in the Family Planning Benefit Program in New York State, A-02-07-01001, May 2008) specifically noted Planned Parenthood (and only Planned Parenthood) as a major offender in incorrectly claiming services as family planning: “[M]any provider officials (especially Planned Parenthoods) stated that they billed most of their claims to Medicaid as related to ‘family planning.’”

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

#### **CALIFORNIA AUDIT**

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

The California Health and Human Services Agency, Department of Health Services conducted the audit of paid claims from July 1, 2002 to June 30, 2003 for Codes

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<sup>6</sup> In some cases, oral contraceptives were dispensed to patients with no order at all; some orders had expired or had been signed only by a Registered Nurse (RN), without countersignature by a licensed clinician or medical doctor. This practice is often associated with HOPE (Hormonal Option without Pelvic Examination) visits. Typically, in a HOPE examination, a non-licensed staff person takes a patient's blood pressure and obtains a brief medical history and, in lieu of a physical examination by a licensed clinician or medical doctor, thereupon provides the patient with contraceptives.

X1500 (contraceptive barrier products) and X7706 (oral contraceptives), and February 2, 2003 to May 30, 2004 for Code X7722 (Plan B products).

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

<b>Billing Code</b>	<b>Code Description</b>	<b>Amount Paid</b>	<b>Provider's Cost</b>	<b>Payments in Excess of Cost</b>
X1500	contraceptive barrier products	\$35,117.30	\$12,318.71	\$22,798.59
X7706	oral contraceptives	\$5,030,347.00	\$859,569.10	\$4,170,777.90
X7722	Plan B products	\$1,119,351.53	\$99,282.10	\$1,020,069.43
<b>Total</b>		<b>\$6,184,815.83</b>	<b>\$971,169.91</b>	<b>\$5,213,645.92</b>

In the case of oral contraceptives and Plan B products, Planned Parenthood Affiliates of California (PPAC) claimed that it had a longstanding relationship with manufacturers that allowed them to purchase these products at deeply discounted rates, i.e., “nominal prices.” By then billing Medi-Cal at a “usual and customary rate,” which is higher than what PPAC had paid for the Plan B product, but somewhat lower than the normal retail price for the product, PPAC defended its improper practices by deeming that PPAC was “sharing the profits” of the “nominal price” arrangements with the State of California. No such “nominal pricing” arrangement existed with respect to condoms. The health department rejected this justification and required repayment of amounts billed over acquisition cost.

#### **NEW YORK AUDITS**

The seven New York State audits of New York Planned Parenthood affiliates were likely conducted due to seven federal audits of New York Medicaid family planning

program claims. The first known New York State audit of New York Planned Parenthood affiliates was released thirteen months after a federal audit identified “especially Planned Parenthoods” as incorrectly claiming services as family planning, as detailed in the Federal Audits of State Family Planning Programs section below.

State Audit I - Hudson Peconic, June 2009

A June 2009 audit<sup>7</sup> of Medicaid payments for family planning and reproductive health services paid to Planned Parenthood Hudson Peconic, Inc. (PPHP) on behalf of Medicaid beneficiaries while they were enrolled in Community Choice Health Plan and Health Insurance Plan of New York found significant overpayments for family planning and reproductive health services claims, resulting in an overpayment of \$15,723.91, inclusive of interest.

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

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

In PPHP’s April 23, 2009 response to OMIG’s March 23, 2009 draft report, it indicated (1) that PPHP considered it unfair to request repayment or documentation “four

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<sup>7</sup> The audit (Family Planning Chargeback to Managed Care Network Providers, 09-1415, June 10, 2009) was conducted of the period Jan. 1, 2004 through Dec. 31, 2004.

to five years after the fact”; (2) that it considered the Electronic Medicaid Eligibility Verification System (EMEVS) to be inaccurate for verifying that clients are enrolled in a managed care plan; and (3) an expression of doubt as to why Medicaid would pay the fee for service claim if the client was a managed care member. OMIG responded to each of these concerns.

State Audit II - Hudson Peconic, May 2010

A May 2010 audit<sup>8</sup> of PPHP found six categories of overbilling, resulting in an overpayment of \$112,490.31, inclusive of interest.

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

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

The audit uncovered six improper practices:

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<sup>8</sup> The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

1. Multiple initial prenatal care visits: Initial visits receive the highest PCAP clinic reimbursement, and only one initial visit may be billed per patient per pregnancy, PCAP Billing Guidelines Booklet, May 2005. The audit found multiple PCAP recipients for whom more than one initial visit was billed, resulting in no overpayment.
2. Initial, follow-up, and postpartum services billed incorrectly after delivery: Only one postpartum visit may be billed; if additional visits are needed, claims should be submitted with the clinic's general medicine rate codes, PCAP Billing Guidelines Booklet, May 2005. The audit found PCAP initial and follow-up visits reduced to the lower postpartum visit rate or, in some instances with multiple postpartum visits, reduced to the general medicine clinic rate, resulting in an overpayment of \$162.96.
3. Laboratory services billed fee for service that are included in the PCAP rate: The PCAP services are comprehensive and cover services provided both at the clinic and at other locations, 10 NYCRR 85.40(i)(1)(ii)(iii); Medicaid Provider Manual for Physicians, Policy Guidelines, Section II, Physician Services, PCAP Billing Guidelines Booklet, May 2005. PPHP billed laboratory services ordered during PCAP visits in addition to the PCAP clinic rates, resulting in duplicate payments totaling \$3,117.75.
4. Ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed: Ultrasounds, whether performed at a PCAP facility or not, should not be billed fee for service by facilities due to the comprehensive nature of PCAP, PCAP Billing Guidelines

Booklet, May 2005; PCAP Medicaid Policy Guidelines Manual, January 2007; DOH Medicaid Update, September 2008, Vol. 24, No. 10. The audit identified obstetrical ultrasounds and diagnostic procedures performed within 30 days of a PCAP visit, excluding any procedures associated with visits to other facilities or non-obstetrical providers, resulting in duplicate billing and an overpayment of \$25,802.60.

5. Ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed: Similarly, ultrasounds, whether performed at a PCAP facility or not, should not be billed fee for service by physicians due to the comprehensive nature of PCAP, DOH Medicaid Update, September 2008, Vol. 24, No. 10; 18 NYCRR 518.3(a). Using the same procedures as with claims improperly filed by facilities, the audit identified obstetrical ultrasounds and diagnostic procedures that were billed in duplicate, resulting in an overpayment of \$68,105.40.
6. Vitamin and iron supplement services billed fee for service that are included in the PCAP rate: Similarly, vitamin and iron supplements as defined by drug therapeutic codes are included in the PCAP reimbursement and should not be billed fee for service, New York State Department of Health, PCAP Services Description, March 2003; the PCAP provider is responsible for providing these services. PPHP, however, billed for these supplements separately from the comprehensive PCAP rate, resulting in an overpayment of \$3,995.86.

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

State Audit III - Nassau, February 2010

A February 2010 audit<sup>9</sup> of Planned Parenthood of Nassau County, Inc. (PPNC) found six improper practices, resulting in an overpayment of \$12,031.29, inclusive of interest.

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

The audit uncovered the same six improper practices as were discovered in the May 2010 audit<sup>10</sup> of PPHP. In PPNC, (1) the multiple initial prenatal care visits resulted in an overpayment of \$0; (2) the initial, follow-up, and postpartum services billed incorrectly after delivery resulted in an overpayment of \$0; (3) the laboratory services billed fee for service that are included in the PCAP rate resulted in an overpayment of \$169.55; (4) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed resulted in an overpayment of \$0; (5) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed resulted in an overpayment of

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<sup>9</sup> The audit (Prenatal Care Assistance Program, 2009Z33-083W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

<sup>10</sup> The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

\$9,045.00; and (6) the vitamin and iron supplement services billed fee for service that are included in the PCAP rate resulted in an overpayment of \$1,315.62.

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

State Audit IV - NYC, January 2009

A January 2009 audit<sup>11</sup> of Planned Parenthood of New York City, Inc. (PPNYC) / Margaret Sanger Center resulted in PPNYC electing to repay the amount of \$207,809.00.

State Audit V - NYC, June 2009

A June 2009 audit<sup>12</sup> of payments to PPNYC / Margaret Sanger Center for diagnostic and treatment center services paid by Medicaid found five improper practices, with sample overpayments of \$7,960.01 and total overpayments of at least \$1,254,603.00.

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

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

OMIG found five improper practices:

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<sup>11</sup> Audit # 08-3045. No further information on this audit is readily available.

<sup>12</sup> The audit (06-6696) was conducted of the period Jan. 1, 2004 through Dec. 31, 2005.

1. Missing documentation: In thirty-four instances pertaining to twenty patients, the services were not documented as required by 18 NYCRR §§ 504.3, 517.3, 540.7(a)(8), resulting in a sample overpayment of \$3,629.63.
2. Inadequate documentation of HIV pre-test counseling visit: In thirty-three instances pertaining to twenty-seven patients, the justification for the service billed was incomplete in the record, and the case record form was not completed as required by 18 NYCRR § 504.3(a), 517.3, 540.7(a)(8); Department of Health Memorandum 93-26 – HIV Primary Care Provider Agreement – Attachment I, resulting in an overpayment of \$2,973.96.
3. Visit billed for managed care client within network: In nine instances pertaining to four patients, PPNYC billed Medicaid for services provided to patients enrolled in PPNYC's HMO network, contrary to 18 NYCRR § 360-7.2; MMIS Provider Manual for Clinics § 2.1.9, resulting in an overpayment of \$1,109.38. (MMIS is a computerized payment and information reporting system that is used to process and pay Medicaid claims.)
4. Medical entry not signed: In one instance, the practitioner did not sign the entry in the medical record as required by 10 NYCRR § 751.7(f), resulting in an overpayment of \$164.02.
5. Incorrect rate code billed: In six instances pertaining to five patients, the incorrect rate code was billed, contrary to 18 NYCRR §§ 504.3(e), 504.3(h); MMIS Provider Manual for Clinics § 2.1.14, resulting in a higher reimbursement than indicated in the fee schedule for the proper rate code and an overpayment of \$83.02.

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

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

State Audit VI - NYC, December 2009

A December 2009 audit<sup>13</sup> of Medicaid payments for family planning and reproductive health services paid to PPNYC/Margaret Sanger Center on behalf of Medicaid beneficiaries while they were enrolled in VidaCare Inc. SNP found overpayments, inclusive of interest, of \$886.26.

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

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

State Audit VII - South Central, February 2010

A February 2010 audit<sup>14</sup> of Planned Parenthood of South Central New York, Inc. (PPSCNY) found six improper practices, resulting in an overpayment of \$11,539.48, inclusive of interest.

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<sup>13</sup> The audit (Family Planning Chargeback to Managed Care Network Providers, 09-4845, Dec. 16, 2009) was conducted of the period Jan. 1, 2005 through Dec. 31, 2005.

<sup>14</sup> The audit (Prenatal Care Assistance Program, 2009Z33-0480, Feb. 24, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

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

The audit uncovered the same six improper practices as were discovered in the May 2010 audit<sup>15</sup> of PPHP. In PPNC, (1) the multiple initial prenatal care visits resulted in an overpayment of \$0; (2) the initial, follow-up, and postpartum services billed incorrectly after delivery resulted in an overpayment of \$24.30; (3) the laboratory services billed fee for service that are included in the PCAP rate resulted in an overpayment of \$291.77; (4) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – facility billed resulted in an overpayment of \$4,272.09; (5) the ultrasound services and diagnostic procedure services billed fee for services that are included in the PCAP rate – physician billed resulted in an overpayment of \$3,804.56; and (6) the vitamin and iron supplement services billed fee for service that are included in the PCAP rate resulted in an overpayment of \$1,895.16.

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

#### **TEXAS AUDIT**

A 2009 audit<sup>16</sup> of the 501(c)(3) and Texas Department of State Health Services (DSHS) contractor Planned Parenthood Center of El Paso (PPCEP) revealed numerous instances of subcontractors remaining unpaid for services rendered, despite the fact that

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<sup>15</sup> The audit (Prenatal Care Assistance Program, 2009Z33-136W, May 27, 2010) was conducted of the period Jan. 1, 2006 through Dec. 31, 2008.

<sup>16</sup> The audit (Attestation – Agreed-Upon Procedures Report on Planned Parenthood Center of El Paso, 09-56-00001-SP-19 Aug. 31, 2009) was conducted July 20-24, 2009.

the amounts had been included in PPCEP's requests for DSHS reimbursement. The total amount of the outstanding billings was likely between \$409,675.10 and \$529,707.97.

Founded in 1937,<sup>17</sup> PPCEP closed its seven centers<sup>18</sup> on June 30, 2009 for financial reasons.<sup>19</sup> Due to published reports of this closure, DSHS became concerned about the availability of PPCEP resources and records, and DSHS General Counsel requested that the Texas Health and Human Services Commission (HHSC), OIG conduct an audit of PPCEP.

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

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

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<sup>17</sup> The center was founded in 1937 as Mothers Health Center, *see* <http://www.prochoicetexas.org/news/headlines/200906271.shtml>.

<sup>18</sup> PPCEP had six locations in El Paso and one in Sierra Blanca, *see* <http://www.prochoicetexas.org/news/headlines/200906271.shtml>.

<sup>19</sup> *See* <http://www.plannedparenthood.org/about-us/newsroom/politics-policy-issues/el-paso-closing-information-30208.htm>.

allowable and in compliance with federal and state regulations and contract requirements.

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

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

#### **WASHINGTON STATE AUDIT**

A 2007-2009 audit<sup>20</sup> of the Planned Parenthood of the Inland Northwest (PPINW) affiliate<sup>21</sup> found numerous instances of overbilling or other irregularities, resulting in an overpayment of \$629,142.88, inclusive of interest.

The audit began after Washington Department of Social and Health Services grew suspicious of the frequency of clinic visits by Medicaid patients.<sup>22</sup> It was conducted by the Medical Audit Unit, Office of Payment Review and Audit, within the Department of Social and Health Services (DSHS) to determine provider compliance with applicable

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<sup>20</sup> The audit (MA 07-13, July 20, 2009) was conducted May 8-10, 2007.

<sup>21</sup> Doing business as Planned Parenthood of Spokane – Take Charge.

<sup>22</sup> See <http://www.spokesman.com/stories/2009/aug/12/audit-clinic-overbilled-medicaid/>.

federal, state, and departmental regulations<sup>23</sup> relative to claims paid from Mar. 15, 2004 to Feb. 26, 2007 for services provided under the Health & Recovery Services Administration (HRSA) programs.<sup>24</sup> A total of 267,840 procedures, totaling \$7,697,613.86, met these criteria.

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

The audit found:

1. In seventeen instances, prescription drugs were dispensed without an authorizing order. In ten audited instances, the dispenser did not have a current, valid authorizing order (prescription) to dispense and bill for the prescription drug on the date of service, for example, where the prescription was outdated. In seven audited instances, there was no valid authorizing order at all to dispense the prescription drug billed; for instance, in one case there was no documentation from the office visit of the medication being prescribed, and additionally, a licensed clinician had not signed the exam form.
2. In sixteen instances, documentation was missing or did not support the level of evaluation and management (E/M) service billed and paid by HRSA. There

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<sup>23</sup> Specifically, compliance with regulations stated in the Revised Code of Washington (RCW), Washington Administrative Code (WAC), the provider's Core Provider Agreement with DSHS, the Schedule of Maximum Allowances, Billing Instructions, and Numbered Memoranda.

<sup>24</sup> Procedures paid at \$0 and Medicare crossover claims were excluded.

was one instance of incorrect coding, fourteen instances in which the visit was to pick up medication and there were no chart notes to substantiate that a face-to-face office visit with a licensed clinical staff member occurred, and one instance in which there was no chart note or other signed documentation to substantiate a billed pregnancy test visit.

3. In thirteen instances, PPINW billed HRSA for more than the acquisition cost of the contraceptive supply, i.e., condom, contrary to the fee schedule.
4. In one instance, PPINW billed for a pregnancy test that was not medically necessary. The patient had been receiving contraceptive “shot[s]” and was not due for another, and on her HOPE (Hormones with Optional Pelvic Exam) form had indicated that there was no need for a test; no other chart note or documentation supported the test.
5. In one instance, PPINW billed separately for a medication included in a bundled service for an abortion that was covered under a different contract with the provider and a different provider number, thus engaging in “unbundling” and billing for medication not covered by the Family Planning or Take Charge programs.
6. In two instances, the Registered Nurse (RN) wrote an oral contraceptive order for a new patient without countersignature by a clinician, contrary to the Department of Health Nursing Commission’s Telehealth/Telenursing guidelines for Registered Nurses that require a prior patient-practitioner relationship for such an order.

7. In those same two cases, the RN did not identify the order as following the standing order protocol, so it was unclear where the order originated. The order could have originated over the telephone or by fax.

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

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

#### **FEDERAL AUDITS OF STATE FAMILY PLANNING PROGRAMS**

Thirty-eight federal audits of state family planning programs by HHS-OIG found between \$88 million and \$99 million in overbilling.

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

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

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

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

In the July 2007 New York State audit A-02-05-01009, HHS-OIG noted that one “laboratory provider [which specialized in examining abortion-related specimens] submitted 95 of the 98 improper sample claims” out of the 100 claims sampled. Forty-two of the improper claims involved abortion-related laboratory tests for which no federal funding is available, e.g., tests performed on the aborted fetus and tests performed before the abortion to assess the risk to the patient, such as complete blood counts, electrolytes, and blood typing.

In the September 2009 New York State audit A-02-09-01015, the 105 sample claims had been submitted by a total of fourteen providers. Six of them coded

approximately ninety-nine percent of their claims as family planning during the audit period, improperly claiming, inter alia, treatment for sexually transmitted diseases and pre-abortion counseling visits unrelated to family planning services.

	<b>HHS-OIG Audit #</b>	<b>Audited Period</b>	<b>Total Overbilling</b>
<b>Arizona</b>	A-09-04-00027	10/1/1999 – 9/30/2002	undetermined <sup>25</sup>
<b>Colorado</b>	A-07-04-01005	10/1999 – 12/2003	\$1,587,305
<b>Colorado</b>	A-07-04-01008	7/1/1998 – 6/30/1999	\$454,786
<b>Colorado</b>	A-07-11-01095	10/1/2005 – 9/30/2009	\$617,999
<b>Colorado</b>	A-07-11-01096	10/1/2005 – 9/30/2009	\$1,975,800
<b>Colorado</b>	A-07-11-01097	10/1/2005 – 9/30/2009	\$2,295
<b>Delaware</b>	A-03-03-00220	10/2000 – 06/2004	\$2,916,288 <sup>26</sup>
<b>Illinois</b>	A-05-10-00053	10/1/2007 – 9/30/2009	\$869,273
<b>Kansas</b>	A-07-09-04146	7/1/2005 – 6/30/2009	\$589,355
<b>Kansas</b>	A-07-10-04156	7/1/2005 – 6/30/2009	\$2,447,414
<b>Kansas</b>	A-07-10-04157	7/1/2005 – 6/30/2009	\$151,526
<b>Kansas</b>	A-07-10-04162	7/1/2005 – 6/30/2009	\$485,982
<b>Louisiana</b>	A-06-10-00076	10/1/2007 – 9/30/2009	\$0
<b>Maryland</b>	A-03-03-00218	7/2000 – 3/2004	\$228,643
<b>Michigan</b>	A-05-08-00064	10/1/2005 – 9/30/2007	\$1,000,519
<b>Michigan</b>	A-05-09-00050	10/1/2005 – 9/30/2007	\$838
<b>Missouri</b>	A-07-04-01004	10/1/2000 – 9/30/2003	\$0
<b>Missouri</b>	A-07-04-01012	10/1/1995 – 9/30/2001 <sup>27</sup>	\$6,467,583
<b>New Jersey</b>	A-02-05-01016	7/1/1997 – 3/31/2002	\$314,446 <sup>28</sup>
<b>New Jersey</b>	A-02-05-01019	2/1/2001 – 1/31/2005	\$2,219,746
<b>New Jersey</b>	A-02-06-01010	1/1/2001 – 1/31/2005	\$597,496
<b>New Jersey</b>	A-02-06-01020	2/1/2001 – 1/31/2005	\$162,548
<b>New York</b>	A-02-05-01001	1/1/2000 – 12/31/2003	\$1,566,740
<b>New York</b>	A-02-05-01009	1/1/2000 – 12/31/2003	undetermined <sup>29</sup>
<b>New York</b>	A-02-05-01018	1/1/2000 – 12/31/2003	\$6,132,366 <sup>30</sup>

<sup>25</sup> HHS-OIG recommended that the Medicaid agency work with Centers for Medicare and Medicaid Services (CMS) to determine the eligibility of \$558,093 in payments. However, another HHS-OIG audit, A-03-06-00200 included this figure in its entirety in its total amount of claimed unallowable family planning costs.

<sup>26</sup> Alternatively, Delaware could provide support for the family planning service costs claimed.

<sup>27</sup> These were retroactive claims that were submitted in the quarter ending March 31, 2001.

<sup>28</sup> Additionally, HHS-OIG set aside \$4,346,987 in unsupported claims for resolution with CMS.

<sup>29</sup> HHS-OIG set aside \$3,235,640 for consideration by CMS and the State because qualified practitioners had not performed a medical review of the sample claims.

<sup>30</sup> This audit did not question the medical necessity of the services or their eligibility for Medicaid reimbursement. Thus, the audit questioned and calculated only the difference between the applicable FMAP and the enhanced ninety-percent federal funding rate, which is either 40% (for the 50% FMAP, 90%

<b>New York</b>	A-02-06-01007	1/1/2000 – 6/30/2005	\$2,603,128
<b>New York</b>	A-02-07-01001	10/1/2002 – 6/30/2006	\$918,816
<b>New York</b>	A-02-07-01037	4/1/2003 – 3/31/2007	\$17,151,156
<b>New York</b>	A-02-09-01015	4/1/2007 – 9/30/2008	\$3,773,506
<b>North Carolina</b>	A-04-10-01092	10/1/2004 – 9/30/2007	\$541,513
<b>Ohio</b>	A-05-10-00035	10/1/2007 – 9/30/2009	\$320,774
<b>Oklahoma</b>	A-06-10-00047	1/1/2005 – 12/31/2009	\$3,356,074
<b>Oregon</b>	A-09-10-02043	10/1/2006 – 9/30/2009	\$1,487,974
<b>Oregon</b>	A-09-11-02010	10/1/2006 – 9/30/2009	\$1,692,956 <sup>31</sup>
<b>Pennsylvania</b>	A-03-03-00214	10/2000 – 2/2004	\$15,070,548
<b>Vermont</b>	A-01-05-00002	10/1/2003 – 9/30/2004	\$323,367
<b>Virginia</b>	A-03-04-00209	04/2001 – 03/2004	\$1,388,506
<b>Washington</b>	A-09-09-00049	10/1/2005 – 9/30/2008	\$8,458,169
<b>TOTAL</b>			<b>\$87,875,435<sup>32</sup></b>

- 50%) or 37.05% (for the 52.95% FMAP, 90% - 52.95%). Thus, the actual amount of overbilling may have been even higher.

<sup>31</sup> Additionally, HHS-OIG set aside 27,405 claims totaling \$3,310,404 (\$2,979,364 federal share) for resolution for clients for whom the State agency did not verify client incomes and/or social security numbers.

<sup>32</sup> Including the amounts set aside, which HHS-OIG elected to include in additional audits as part of the total amount of overbilling, the total amount of overbilling would be \$98,995,919.

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