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Report on Medicare Compliance Volume 31, Number 31. August 29, 2022
Providers, Medicaid Managed Care Plan Settle FCA Case for $70M

By Nina Youngstrom

In a false claims settlement about California managed Medicaid payments, Ventura County's organized health system and several hospitals and clinics agreed to pay $70.7 million over payments that allegedly weren't for "allowed medical expenses," the U.S. Attorney's Office for the Central District of California said Aug. 18.[1] The case revolves around the medical loss ratio and payments to "favored providers" for services they allegedly "did not document and likely did not perform," according to a 2019 complaint filed by two whistleblowers who set the case in motion.[2]

It's a complicated case, with four parties to the settlement. Ventura County Medi-Cal Managed Care Commission, which does business as Gold Coast Health Plan, is a county-organized health system (COHS) that arranges for health care services under California Medicaid (known as Medi-Cal). The other three are Ventura County, which owns Ventura County Medical Center; Dignity Health, which operates two hospitals in Ventura County; and Clinicas del Camino Real Inc., a health care organization.

The allegations in the complaint, or a version of them, could conceivably come up in any state where the managed Medicaid plan is told "if you don't use all this money, you have to give it back," said an attorney who preferred not to be identified.

COHS are paid capitation for Medi-Cal patients, and in turn decide how to reimburse providers. Gold Coast's Medi-Cal contract with the state included an 85% medical loss ratio (MLR) requirement for the "adult expansion" population, which means 85% of the money must be spent on "allowed medical expenses," according to the complaint. Allowed medical expenses are actual expenses incurred and accounted for covered services, including utilization management and quality assurance, shared risk pools and incentives for providers but excluding administrative costs.