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Four Health Care Organizations Pay \$68M to Settle Medicaid FCA Case

By Nina Youngstrom

In the third set of false claims settlements over California managed Medicaid payments for the adult expansion population, four health care organizations have agreed to pay \$68 million, the Department of Justice (DOJ) said June 29.^[1] Like the earlier settlements, they put to bed allegations that the organizations played games with an aspect of the Affordable Care Act (ACA).

This time around, the settlements are with CenCal Health, a county organized health system (COHS); Cottage Health System, a not-for-profit hospital network in Santa Barbara County; Sansum Clinic, a nonprofit outpatient clinic in Santa Barbara County; and Community Health Centers of the Central Coast (CHC), a nonprofit community health center in Santa Barbara and San Luis Obispo counties. CenCal will pay \$49.5 million, Cottage \$9 million, Sansum \$4.5 million and CHC \$3.15 million.

The False Claims Act (FCA) lawsuit was set in motion by a whistleblower, Julio Bordas, M.D., who's the former medical director of CenCal, which had a contract with the state to run Medicaid (known as Medi-Cal in California) in Santa Barbara and San Luis Obispo counties.

The allegations focus on additional Medicaid payments made available by the ACA for the adult expansion population. In California, starting in 2014, more than 1.4 million people in the state became newly eligible for Medicaid. To ensure the money was spent on their health care, the California Department of Health Care Services (DHCS) required managed care plans like CenCal to spend at least 85% of the capitation payments they received for the adult expansion population on covered medical services, according to the whistleblower's complaint.^[2] The ratio of the plan's medical expenses to its capitation payments is known as the medical loss ratio (MLR). If plans spend less, they're required to return the money to the state.

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