

DHCS AUDITS AND INVESTIGATIONS
CONTRACT AND ENROLLMENT REVIEW DIVISION
SAN DIEGO SECTION

**REPORT ON THE SUBSTANCE USE DISORDER
(SUD) AUDIT OF EL DORADO COUNTY
FISCAL YEAR 2025-26**

Contract Number: 21-10027

Contract Type: Drug Medi-Cal Organized Delivery System (DMC-ODS)

Audit Period: July 1, 2024 — June 30, 2025

Dates of Audit: October 6, 2025 — October 17, 2025

Report Issued: March 18, 2026

TABLE OF CONTENTS

I.	INTRODUCTION	3
II.	EXECUTIVE SUMMARY	4
III.	SCOPE/AUDIT PROCEDURES	6
IV.	COMPLIANCE AUDIT FINDINGS	
	Category 1 –Availability of Drug Medi-Cal Organized Delivery System Services.....	7
	Category 7 – Program Integrity.....	9

I. INTRODUCTION

El Dorado County Behavioral Health (Plan) is governed by a Board of Supervisors and contracts with the Department of Health Care Services (DHCS) for the purpose of providing substance use disorder services to county residents.

El Dorado County is located in northern California. The Plan provides services within the unincorporated county and in two cities: Placerville and South Lake Tahoe.

As of August 2025, the Plan had a total of 1,799 members receiving services.

II. EXECUTIVE SUMMARY

This report presents the audit findings of the DHCS audit for the period of July 1, 2024, through June 30, 2025. The audit was conducted from October 6, 2025, through October 17, 2025. The audit consisted of documentation review and interviews with the Plan's representatives.

An Exit Conference with the Plan was held on March 11, 2026. The Plan was allowed 15 calendar days from the date of the Exit Conference to provide supplemental information addressing the draft audit findings. On March 11, 2026, the Plan submitted a response after the Exit Conference. The evaluation results of the Plan's response are reflected in this report.

The audit evaluated five categories of performance: Availability of Drug Medi-Cal Organized Delivery System (DMC-ODS) Services, Quality Assurance and Performance Improvement, Coverage and Authorization of Services, Beneficiary Rights and Protection, and Program Integrity.

The prior DHCS compliance report, covering the review period from July 1, 2023, through June 30, 2024, identified deficiencies incorporated in the Corrective Action Plan (CAP). The prior year CAP was closed on November 26, 2025. Therefore, this audit included a review of documents to determine the implementation and effectiveness of the Plan's corrective actions.

The summary of the findings by category follows:

Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

The Plan and its subcontractors are required to establish a written Code of Conduct with specific elements that encourage ethical behavior, safeguard members' rights, and ensure all interactions between staff and members are safe and confidential. The Code of Conduct sets clear expectations to prevent misconduct and conflicts of interest.

Finding 1.4.1: The Plan and its subcontractors did not maintain a written Code of Conduct that included all minimum required elements.

Category 3 – Quality Assurance and Performance Improvement

There were no findings noted for this category during the audit period.

Category 5 – Coverage and Authorization of Services

There were no findings noted for this category during the audit period.

Category 6 – Beneficiary Rights and Protection

There were no findings noted for this category during the audit period.

Category 7 – Program Integrity

The Plan and its subcontractors are required to disclose detailed information regarding ownership and control to ensure transparency and prevent conflicts of interest. The disclosures allow DHCS to monitor accountability and safeguard program integrity.

Finding 7.4.1: The Plan did not ensure that its disclosure forms included all the detailed information required regarding ownership and control.

The Plan and its subcontractors are required to submit ownership and control disclosures at specific times to maintain compliance with regulatory requirements. The timely submission of disclosures allows DHCS to monitor changes that could affect program integrity. Finding 7.4.2: The Plan did not ensure that all required disclosure timing and notification requirements were addressed.

III. SCOPE/AUDIT PROCEDURES

SCOPE

The DHCS, Contract and Enrollment Review Division conducted the audit to ascertain that medically necessary services provided to Plan members comply with federal and state laws, Medi-Cal regulations and guidelines, and the State's DMC-ODS Contract.

PROCEDURE

DHCS conducted an audit of the Plan from October 6, 2025, through October 17, 2025, for the audit period of July 1, 2024, through June 30, 2025. The audit included a review of the Plan's policies for providing services, procedures to implement these policies, and the process to determine whether these policies were effective. Documents were reviewed and interviews were conducted with the Plan's representatives.

The following verification studies were conducted:

Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

There were no verification studies conducted for the audit review.

Category 3 – Quality Assurance and Performance Improvement

There were no verification studies conducted for the audit review.

Category 5 – Coverage and Authorization of Services

There were no verification studies conducted for the audit review.

Category 6 – Beneficiary Rights and Protection

There were no verification studies conducted for the audit review.

Category 7 – Program Integrity

There were no verification studies conducted for the audit review.

COMPLIANCE AUDIT FINDINGS

Category 1 – Availability of Drug Medi-Cal Organized Delivery System Services

1.4 Provider Selection and Monitoring

1.4.1 Codes of Conduct

The Plan and its subcontractor's written Code of Conduct for employees and volunteers/interns shall be established, which addresses at least the following: use of drugs and/or alcohol; prohibition of social/business relationship with beneficiaries or their family members for personal gain; prohibition of sexual contact with beneficiaries; conflict of interest; providing services beyond scope; discrimination against beneficiaries or staff; verbally, physically, or sexually harassing, threatening, or abusing beneficiaries, family members, or other staff; protection of beneficiary confidentiality; and cooperate with complaint investigations. (*Exhibit A Attachment I, Section III Program Specifications, XX, 4, iii, a-i*)

Finding: The Plan and its subcontractors did not maintain written Codes of Conduct that included all minimum required elements.

A review of written Codes of Conduct found that the Plan and two of six subcontractors did not address all minimum required elements. The audit found noncompliance with the following:

- The Plan's Code of Conduct did not address conflict of interest.
- The first subcontracted provider's Code of Conduct did not address the use of drugs and alcohol, prohibition of social and business relationships with beneficiaries or their family members for personal gain, prohibition of sexual contact with beneficiaries, providing services beyond scope, and verbally, physically, or sexually harassing, threatening, or abusing beneficiaries, family members, or other staff.
- The second subcontracted provider's Code of Conduct did not address discrimination against beneficiaries and verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members, or other staff.

In an interview, the Plan stated that it addresses conflict of interest through a separate form for its staff. A review of the Plan's Conflict of Interest Form found it is used to

identify potential conflicts between a staff member's County employment and any outside or secondary employment, business ventures, or professional and advisory roles. However, the form does not address potential conflicts of interest between Plan staff and members.

The Plan did not have a formal policy for Code of Conduct. The Plan confirmed it ensures subcontractors maintain a Code of Conduct by communicating this requirement in provider contracts and verifying compliance through its annual monitoring process. A review of the Plan's audit tool, the On-Site Personnel Review Form, confirmed that the tool assesses whether subcontracted providers have a policy and procedure in place to support a Code of Conduct that includes required elements. However, the tool does not verify if the Codes of Conduct are inclusive of all minimum required elements.

Without a Code of Conduct that addresses all the minimum required elements, it can potentially increase the risk of ethical violations and lead to inadequate protection of beneficiaries and staff. Subsequently, it may weaken the integrity of the Medi-Cal program.

Recommendation: Develop and implement policies and procedures to ensure the Plan and its subcontractors maintain a complete written Codes of Conduct.

COMPLIANCE AUDIT FINDINGS

Category 7 – Program Integrity

7.4 Disclosure Requirements

7.4.1 Disclosure Information

As part of the Drug Medi-Cal certification process outlined in Article III.K of the Agreement, the Plan and its subcontractors are required to disclose detailed information regarding ownership and control. This includes the name and address of any individual or corporation with an ownership or control interest, along with additional identifying details such as date of birth, Social Security Number (for individuals), and tax identification numbers (for corporations). Furthermore, the disclosure must indicate any familial relationships—such as spouse, parent, child, or sibling—between individuals with ownership or control interests. It must also identify any other entities in which these individuals hold ownership or control interests, as well as provide the name, address, date of birth, and Social Security Number of any managing employees associated with the disclosing entity. (*Plan Contract, Exhibit A Attachment I, Section II Federal Requirements, H, 7, i, a-f*)

Plan policy, *M-176 Ownership Interest Disclosure of Managing Staff and Contract Providers; Conflicts of Interest* (effective 06/17/2022), stated that the Plan collects the following information on ownership interest: full name, address, address for corporate entities, date of birth, and Social Security Number (for individuals), other tax identification numbers (for corporations), whether an individual or entity with ownership or control interest is related by family (spouse, parent, child, or sibling) to another such person in the same or another network provider, subcontractor, or the managed care entity, name of any other disclosing entity in which the contractor or subcontract network provider has an ownership or control interest, and the name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

Finding: The Plan did not ensure that the ownership and control disclosure form included all the required elements.

The Plan collects disclosure information with its Provider Integrity Disclosure Statement Template, which omits several required elements, specifically:

- Social Security Number (for individuals)
- Address, date of birth, and Social Security Number of managing employees

A review of completed disclosure forms for six subcontractors found that these elements were also omitted. The Plan acknowledged the omissions and stated that their disclosure forms request either a Social Security Number, a tax identification number, or an National Provider Identifier number, and the subcontractors may have submitted only one of the three elements.

The Plan uses a tracking spreadsheet to monitor the timely submission of disclosures for subcontracted providers. However, the Plan did not ensure that the requested disclosure documentation included all required elements.

In an interview, the Plan confirmed that they only verify the presence of a disclosure form, not its completeness. The Plan further noted that CAPs were issued to subcontractors in Fiscal Year 2023–24 for the late submission of disclosure forms. Because no disclosure events occurred during the audit period, the Plan was not prompted to review for the completeness of the disclosure forms.

Incomplete disclosure information may hinder the Plan’s ability to identify potential conflicts of interest or fraud, waste, and abuse, and may weaken the integrity of the Medi-Cal program.

Recommendation: Implement policies and procedures to ensure disclosure forms include all required elements.

7.4.2 Implementation of Disclosure Timing and Notification Requirements

The Plan and its subcontractors must submit ownership and control disclosures at the following times:

- Upon submitting a proposal to DHCS
- Upon executing the agreement with DHCS
- Upon renewal or extension of the agreement
- Within 35 days of any change in ownership
- Upon submitting a provider application
- Upon executing a provider agreement
- Upon request during re-validation under Code of Federal Regulations, Title 42, section 455.414

All disclosures must be submitted to DHCS. Failure to provide required disclosures may result in the loss of Federal Financial Participation (FFP). (*Exhibit A Attachment I, Section II Federal Requirements, H, 7, ii-iii and Exhibit A Attachment I, Section III Program Specifications, J, 2, i-iii*)

The Plan's policy, *M-176 Ownership Interest Disclosure of Managing Staff and Contract Providers: Conflicts of Interest* (effective 06/17/2022), stated that disclosure information is collected and required to be reported at the time of hire (for Plan staff), at the time of contract execution between the subcontractor and the Plan, upon renewal of each contract, annually, and when there is a change in ownership interest. If any ownership, control interest, or partnership interest changes occur, they must be disclosed within 35 days of the change.

Finding: The Plan did not ensure that all required disclosure timing and notification requirements were addressed in its policies, procedures, or subcontractor forms.

A review of the Plan's Provider Integrity Disclosure Statement Template and completed forms from all six subcontractors revealed missing required elements, including:

- Disclosure due upon agreement execution
- Disclosure due upon re-validation request
- Notification to the Medicaid agency
- A statement of FFP consequences for noncompliance

On a monthly basis, the Plan requires subcontractors to complete an attestation, the Monthly Compliance Reporting Form, indicating whether they have experienced triggering events. However, the attestation responses do not address the missing required elements, and the Plan did not provide evidence of monitoring for all required disclosure triggers. Plan policy M-176 outlines disclosure requirements at contract execution, renewal, and upon changes in ownership. However, the policy does not address several required disclosure triggers, including:

- Provider application or agreement execution
- Upon extension of each contract
- Re-validation requests under Code of Federal Regulations, Title 42, section 455.414
- Requirement to submit disclosures to the Medicaid agency
- Consequences for noncompliance (e.g., loss of FFP)

Additionally, the Plan maintains a disclosure-tracking spreadsheet for each subcontractor. However, the Plan acknowledged that disclosures were not submitted at all required times and was unaware of the missing elements in its policy and forms.

The Plan did not implement adequate oversight to ensure that all federally required disclosure triggers and notification requirements were incorporated into its policies and monitoring.

When the Plan's monitoring is inadequate to ensure timely disclosures, it may result in noncompliance with federal requirements and jeopardize the availability of FFP, and limit the Plan's ability to detect potential fraud, waste, or abuse.

Recommendation: Revise its policies, procedures, and forms to include all required disclosure timing and notification requirements.