DHCS Chart Review FY 15/16 Plan of Correction

INTRODUCTION

Based on the Department of Health Care Services (DHCS) Chart Review for Fiscal Year 15/16, the Los Angeles County Department of Mental Health (LACDMH) will take the below three (3) over-arching system-wide actions as part of its plan of correction. The LACDMH system will also take specific actions related to each finding as noted throughout this plan of correction.

In addition to the steps mentioned throughout this plan of correction, the QA Division required each individual provider who had findings and/or disallowances in the chart review to submit an individualized plan of correction (Attachment 1). The QA Division reviewed all submitted plans of corrections to ensure appropriateness and will follow up with providers to monitor completion.

[1]QA Bulletin:

The QA Division issues "QA Bulletins" for distribution to all Directly Operated (DO) and Legal Entity (LE) providers to highlight changes in documentation, claiming and other Local Mental Health Plan requirements. The QA Bulletins are reviewed in a monthly QA Liaison's Meeting and then reviewed with providers at the nine (9) QIC meetings throughout LA County.

A QA Bulletin will be developed and distributed to all staff highlighting keys areas found to be out of compliance in the Chart Review. The QA Bulletin will serve as a reminder and/or clarification of existing policies and procedures as well as notification of new policies based on the Chart Review findings.

[2]Training:

The QA Division offers monthly "Understanding Documentation and Claiming" trainings to all DO and LE providers. The QA Division also offers bimonthly "Understanding Documentation, Claiming & How to Assist Practitioners" supervisor trainings for DO clinical supervisors. QA Division staff from the Training and Operations Unit and the Policy and Technical Development Unit meet on a weekly basis during the "Policy and Training Updates" meeting to review any needed updates to the training PowerPoints as well as discuss issues to be highlighted during the trainings and answers to questions that arise during the trainings.

Findings from the Chart Review will be discussed during the Policy and Training Updates meeting for incorporation into the existing trainings.

[3]Chart Reviews:

The Quality Assurance Division currently requires all DO providers to review a minimum of 5% of their records on a quarterly basis (20% annually) using the Chart Review Tool (Attachment 2). Redacted tools are then sent to the QA Division to ensure providers are completing chart reviews. The QA Division

also requires all LE providers to have their own chart review process in place and attest annually that the LE provider is completing the required chart reviews.

For DO providers, the Chart Review Tool will be incorporated into the electronic health record (EHR) in order for the QA Division to monitor that programs are completing chart reviews as required and to monitor trends related to chart review findings. In addition, the QA Division will review a sample of chart reviews that programs have completed to ensure accuracy of chart reviews. The QA Division will provide feedback to programs regarding chart review findings via the monthly QA/Error Correction Call-In which is a monthly conference call where the QA Division provides specific information related to errors found in the EHR as well as documentation and claiming to DO providers.

The QA Division will begin conducting chart reviews of LE providers using an LE Chart Review Tool. The QA Division will review an estimated ten (10) LE providers per quarter. The chart reviews will include a minimum of five (5) charts per provider. LE providers will provide redacted charts to allow the QA Division to remain in a technical assistance role. The QA Division will meet with the LE provider upon completion of the chart review to provide feedback regarding findings and will also provide a summary report. If there are any egregious documentation or claiming issues found during the review, a focused review of the provider will be coordinated by the QA Division.

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Finding	Plan of Correction		
1c-1	**Indicate how the MHP will ensure that interventions are focused on a significant functional impairment that is directly related to the mental health condition** .		
Description of correction actions, including milestones:		**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]		March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]		March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]		1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
1c-2	**Indicate how the MHP will ensure that the interventions provided meet the intervention criteria**.		
Description of correction actions, including milestones:		**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]		March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]		March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]		1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
2a	**Indicate how the MHP will ensure that assessments are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards**.		
Description of correction actions, including milestones:		**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]		March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]		March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]		1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool

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2b	**Indicate how the MHP will ensure that every assessment contains all of the required elements specified in the MHP Contract with the Department (specific elements missing: presenting problems, relevant psychosocial factors, mental health history, medical history, medications, substance exposure/use, strengths, risks, MSE)**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
The Annual Assessment form has been discontinued from use due to not containing all assessment requirements.	June 12, 2014	Clinical Records Bulletin (Attachment 3)
QA Bulletin Distributed[1]	March 31st , 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]	March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool

3a	**Indicate how the MHP will ensure that:** **1. A written medication consent form is obtained and retained for each medication prescribed and administered under the direction of the MHP** **2. Written medication consent forms are completed in accordance with the MHP's written documentation standards**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting

3b	**Indicate how the MHP will ensure that every medication consent includes documentation of all the required elements in the MHP Contract with the Department**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
The Outpatient Medication Review form, which is the required medication consent form in LA County, was revised to include all required data elements	September 26, 2016	1. Clinical Forms Bulletin (Attachment 4) 2. Revised "Outpatient Medication Review" form (Attachment 5)

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4a-2	**Indicate how the MHP will:** **1. Ensure that client plans are completed at least on an annual basis as required in the MHP Contract with the Department and within the timelines and frequency specified in the MHP's written documentation standards** **2. Ensure that all types of interventions/service modalities provided and claimed are recorded as proposed intervention on a current client plan** **3. Ensure that non-emergency services are not claimed when:** **a. A client plan has not been completed** **b. The service provided is not included in the current client plan** **4. Provide evidence that all services claimed outside of the audit review period for which no client plan was in effect are disallowed**

Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]	March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
Development of a Management Report for DO that flags clients who do not show in the EHR as having a Client Treatment Plan and conduct self-audit of random sample of clients showing as not having a Client Treatment Plan	May 31st, 2016	1. Sample Management Report (Attachment 6) 2. Directly-Operated Memo re: self-audit (Attachment 7)
Void all services claimed outside of the audit review period for which no Client Plan was in effect.	March 1st, 2017	1. Copy of Void Requests for LE providers 2. Memo to DHCS regarding repayment due to Client Treatment Plan self-audit (Attachment 8)
Specialized Treatment Plan Trainings for DO	January 12, 2016 January 19, 2016 January 20, 2016 March 7, 2016 March 8, 2016 March 10, 2016 March 11, 2016 March 21, 2016 March 22, 2016 March 23, 2016 March 24, 2016 March 25, 2016 June 16, 2016	Treatment Plan Training PowerPoint (Attachment 9)

	September 9, 2016 Ongoing quarterly trainings	
4b	**Indicate how the MHP will ensure that:** **1. All client plan goals/treatment objectives are specific, observable and/or quantifiable and relate to the client's documented mental health needs and functional impairments as a result of the mental health diagnosis** **2. All mental health interventions/modalities proposed on client plans include a detailed description of the interventions to be provided and do not just identify a type or modality of service (e.g. therapy, medication, case management, etc.)** **3. All mental health interventions proposed on client plans indicate both an expected frequency and duration for each intervention** **4. All mental health interventions/modalities proposed on client plans address the mental health needs and identified functional impairments of the client as a result of the mental disorder** **5. All mental health interventions proposed on client plans are consistent with client plan goals/treatment objectives** **6. All client plans are consistent with the qualifying diagnosis**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]	March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
Specialized Treatment Plan Training for DO	January 12, 2016 January 19, 2016 January 20, 2016 March 7, 2016 March 8, 2016 March 10, 2016 March 11, 2016 March 21, 2016 March 22, 2016 March 23, 2016 March 24, 2016 March 25, 2016 June 16, 2016 September 9, 2016 Ongoing quarterly trainings	Treatment Plan Training PowerPoint (Attachment 9)
Form modification in the EHR to make frequency a required field for DO	April 4, 2016	Screenshot from EHR (Attachment 10)

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4d	**Indicate how the MHP will:** **1. Ensure that each client's participation and agreement is obtained and documented in a timely manner** **2. Ensure that the client's signature is obtained in a timely manner on the client plan** **3. Ensure that services are not claimed when the client's:** **a. Participation and agreement with the client plan is not obtained or not obtained in a timely manner and the reason for refusal is not documented** **b. Signature is not obtained when required and not obtained in a timely manner and the reason for refusal is not documented**		
Description of correction actions, including milestones:		**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]		March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]		March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]		1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
Specialized Treatment Plan Training for DO		January 12, 2016 January 19, 2016 January 20, 2016 March 7, 2016 March 8, 2016 March 10, 2016 March 11, 2016 March 21, 2016 March 22, 2016 March 23, 2016 March 24, 2016 March 25, 2016 June 16, 2016 September 9, 2016 Ongoing quarterly trainings	Treatment Plan Training PowerPoint (Attachment 9)
4e	**Indicate how the MHP will:** **1. Ensure that there is documentation substantiating that the client was offered a copy of the client plan** **2. Submit evidence that the MHP has an established process to ensure that the client is offered a copy of the client plan and whether or not he/she received a copy of the client plan**		
Description of correction actions, including milestones:		**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]		March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]		March 15th, 2017	Minutes from QA Training Meeting

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Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
Specialized Treatment Plan Training for DO	January 12, 2016 January 19, 2016 January 20, 2016 March 7, 2016 March 8, 2016 March 10, 2016 March 11, 2016 March 21, 2016 March 22, 2016 March 23, 2016 March 24, 2016 March 25, 2016 June 16, 2016 September 9, 2016 Ongoing quarterly trainings	Treatment Plan Training PowerPoint (Attachment 9)
Implementation of EHR for DO made the following field required: 'Client/Legal Representative was offered a copy of the plan'	May 31st, 2015	Screenshot from EHR (Attachment 11)
4f	**Indicate how the MHP will ensure that all documentation includes the signature or electronic equivalent with the professional degree, licensure or title of the person providing the service.**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Training[2]	March 15th, 2017	Minutes from QA Training Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool

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5a	**Indicate how the MHP will:** 1. **Describe how the MHP will ensure that progress notes are completed in accordance with the timeliness and frequency requirements specified in the MHP's written documentation standards** 2. **Ensure that progress notes document:** **a. Timely completion by the person providing the service and relevant aspects of client care, as specified in the MHP Contract with the Department and the MHP's written documentation standards** **b. Relevant clinical decisions, when decisions are made, and alternative approaches for future interventions, as specified in the MHP Contract with the Department** **c. Interventions applied, the client's response to the interventions and the location of the interventions, as specified in the MHP Contract with the Department** **d. The provider's professional degree, licensure, or job title** 3. **Each progress note describes how services provided reduced impairment, restored functioning, or prevented significant deterioration in an important area of life functioning** 4. **All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary**

Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
For DO, conduct monthly Call-In for clinical supervisors going over QA items, specifically, examples of notes that are & are not billable	April 21, 2016 May 19, 2016 June 16, 2016 July 21, 2016 September 15, 2016 October 20, 2016 November 17, 2016 December 15, 2016 Ongoing on a monthly basis	Sample Agenda (Attachment 12)
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
Modification of Policy 401.02 Clinical Records Maintenance, Organization, and Contents to include a standardized timeliness requirement for both LE and DO	April 1st, 2017	Revised Policy
STATS (Strategies for Total Accountability and Total Success), which is LACDMH's formal performance-base management process, incorporated a new progress note timeliness matrix. This	August 25, 2016	Progress Note Timeliness PowerPoint (Attachment 13)

new tool tracks how quickly DO practitioners finalize their notes with their signature and any co-signatures		
5a-3	**Indicate how the MHP will ensure that:** **1. All services claimed are appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary** **2. Services provided and claimed are not solely vocational services that consists of generalized group activities that do not provide systematic, individualized feedback to the specific targeted behaviors** **3. Services provided and claimed are not solely clerical** **4. Services claimed were provided in a setting where the client was eligible for FFP or not subject to lockouts**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
For DO, conduct monthly Call-In for clinical supervisors going over QA items, specifically, examples of notes that are & are not billable	April 21, 2016 May 19, 2016 June 16, 2016 July 21, 2016 September 15, 2016 October 20, 2016 November 17, 2016 December 15, 2016 Ongoing on a monthly basis	Sample Agenda (Attachment 12)
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
5b	**Indicate how the MHP will ensure that:** **1. Group progress notes clearly document the contribution, involvement or participation of each staff member as it relates to the identified functional impairment and mental health needs of the client** **2. There is medical necessity for the use of multiple staff in the group setting** **3. The type of service, units of time and dates of service claimed are accurate and consistent with the documentation in the medical record and that services are not claimed when billing criteria are not met**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Chart Reviews[3]	1. April 1st, 2017	1. DO Chart Review Tool in Electronic Health Record

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	2. May 1st, 2017 3. March 1st, 2017	2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
For DO, conduct monthly Call-In for clinical supervisors going over QA items, specifically, examples of notes that are & are not billable	April 21, 2016 May 19, 2016 June 16, 2016 July 21, 2016 September 15, 2016 October 20, 2016 November 17, 2016 December 15, 2016 Ongoing on a monthly basis	Sample Agenda (Attachment 12)
5c	**Indicate how the MHP will:** **1. Ensure that all SMHS claimed are:** **a. Documented in the medical record** **b. Actually provided to the client** **c. Appropriate, relate to the qualifying diagnosis and identified functional impairments and are medically necessary** **d. Claimed for the correct service modality and billing code** **2. Ensure that all progress notes are accurate and meet the documentation requirements described in the MHP Contract with the Department**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
For DO, conduct monthly Call-In for clinical supervisors going over QA items, specifically, examples of notes that are & are not billable	April 21, 2016 May 19, 2016 June 16, 2016 July 21, 2016 September 15, 2016 October 20, 2016 November 17, 2016 December 15, 2016 Ongoing on a monthly basis	Sample Agenda (Attachment 12)

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5d	**Indicate how the MHP will:** **1. Ensure that all documentation includes the signature or electronic equivalent with the professional degree, licensure or title of the person providing the service** **2. Ensure that all documentation includes the date the signature was completed and the document was entered in the medical record**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Chart Reviews for LEs[3]	March 1st, 2017	LE Chart Review Tool
The EHR was implemented for DO which automatically logs the date the signature was completed and the document was entered in the clinical record	May 31st, 2015	Screenshot from EHR (Attachment 14)
6a	**Indicate how the MHP will ensure that there is documentation substantiating that clients and their parents/legal guardians are offered mental health interpreter services when applicable**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Chart Reviews[3]	1. April 1st, 2017 2. May 1st, 2017 3. March 1st, 2017	1. DO Chart Review Tool in Electronic Health Record 2. Chart Review Trends Monitoring Report for DO 3. LE Chart Review Tool
7b	**Indicate how the MHP will ensure that the total number of minutes/hours each client actually attends a Day Rehabilitation are documented for each day attended**	
Description of correction actions, including milestones:	**Timeline for implementation and/or completion of correction actions:**	**Proposed (or actual) evidence of correction that will be submitted to DHCS:**
QA Bulletin Distributed[1]	March 31st, 2017	1. QA Bulletin 2. Minutes from QA Liaisons Meeting
Chart Reviews for LEs[3]	March 1st, 2017	LE Chart Review Tool
Finalize and issue standardized Day Rehabilitation form	March 1st, 2017	1. Clinical Forms Bulletin 2. Day Rehabilitation form

County of Los Angeles – Department of Mental Health
Mental Health Plan
Medi-Cal Consolidated Specialty Mental Health Services Audit: February 8-February 12, 2016
Plan Of Correction

ITEM 1	**Section A**	**ACCESS**
Question No.9a:		
Regarding the statewide, 24 hours a day, 7 days a week (24/7) toll-free telephone number: (2) Does the toll-free telephone number provide information to beneficiaries about how to access specialty mental health services, including specialty mental health services required to assess whether medical necessity criteria are met? (3) Does the toll-free telephone number provide information to beneficiaries about services needed to treat a beneficiary's urgent condition? (4) Does the toll-free telephone number provide information to the beneficiaries about how to use the beneficiary problem resolution and fair hearing processes?		
Findings		
9a(2) Test Call #5 was deemed out of compliance, the caller was placed on hold for ten minutes and decided to terminate the call. The caller was not provided information about how to access SMHS. **9a(3)** Test Call #5 was deemed out of compliance, the caller was placed on hold for ten minutes and decided to terminate the call. The caller was not provided information about services needed to treat a beneficiary's urgent condition. **9a(4)** Test Call #2 was deemed out of compliance, the caller was not provided with appropriate information about how to use the beneficiary problem resolution and State Fair Hearing processes. Test Call #7 was deemed out of compliance, the caller requested information about how to file a complaint. The caller was provided with the telephone number for which the caller could call to file a complaint. No additional information was provided to the caller about how to use the beneficiary problem resolution and Fair Hearing processes.		
Corrective Action		
9a(2) Test Call #5 - The MHP consulted with the Los Angeles County Department of Mental Health, telephone vendor Verizon about the possibility of an automated announcement system that would inform callers of the anticipated wait time. Instead, Verizon recommended notification of the caller's position in the line which is more accurate. While the details are being resolved, it is likely that the position in line will be linked by the call type that is selected, (for example if the call is related to urgent or crisis services or patients' rights information) and the caller's position will be updated as the caller progresses to the front of the line. The tentative implementation date is March 31, 2017. Also, the MHP tracks the number of calls that are answered in under a minute. The current annual goal is 65% of calls should be answered in under a minute during business hours, and 75% of calls should be answered in under a minute for after hours (including weekend) calls. Following the System Review, the ACCESS Center increased the number of agents for responding to calls during all transitional work shifts. This has resulted in a performance improvement whereby the current year-to-date average of calls answered in under a minute increased to 78% during the daytime hours and 77% during business hours. Response time data reports are reviewed monthly in the ACCESS Center supervisors meetings. **9a(3)** Test Call #5 – The caller selected the incorrect option on the telephone tree. The caller chose the "general information" option and not the "crisis" option that is the appropriate option for an urgent condition. The "crisis" option for urgent conditions is connected to priority telephone response whereby the caller would not have been placed on hold for ten minutes. The corrective action has been already addressed in		

aforementioned **9a(2).**

9a(4) Test Call #7 - The MHP provided training to the ACCESS Center supervisors on 9/6/2016 and 11/1/2016. The training focused on the MHP's expectations of telephone agents in handling complaints, appeals and request for State Fair Hearings. The Director of Patients' Rights completed re-training of all ACCESS Center telephone agents by 11/30/2016. The re-training was mandatory for telephone agents of all shifts of the ACCESS Center. With the assistance of Patients' Rights staff, the ACCESS Center Protocols were revised by 11/1/2016 and distributed on 11/3/2016 to all of the ACCESS Center staff. The revision incorporated the expectations and guidance from Patients' Rights in how staff are to respond to complaints, appeals and requests for State Fair Hearings. The MHP's State Performance Improvement Plan provides for a monthly review of all randomly selected telephone calls to the main ACCESS Center toll free line. The results of the telephone calls, including recommendations for individual and group agent trainings are reviewed by Service Area Quality Improvement Committee chairs, members of the Quality Improvement Division and others. The reviews include telephone calls that could be grievances and requests for appeals. The monthly reviews will continue until at least June, 2017.

Attachment I	ACCESS Center Calls Answered Within I Minute Calendar Year 2016 Table
Attachment II	Quality Improvement Division Non-Clinical PIP Committee Minutes dated 9/27/2016
Attachment III	ACCESS Center Protocols for State Compliance, Revised 2016, pages 20-21
Attachment IV	ACCESS Center Supervisors' Meeting Minutes dated 9/6/2016
Attachment V	Grievance & Appeal Procedures

ITEM 2	**SECTION A**	**ACCESS**
Question No. 13a & 13b		
Regarding the MHP's plan for annual cultural competence training necessary to ensure the provision of culturally competent services: Is there a plan for cultural competency training for persons providing SMHS employed by or contracting with the MHP? Does the MHP have evidence of the implementation of training programs to improve the cultural competence skills of staff and contract providers?		
Findings		
The MHP did not furnish evidence it has a plan for annual cultural competence training necessary to ensure the provision of culturally competence services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P #614.02 In-Service Training; Cultural Competence Plan; and Cultural Competence Training Plan. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and /or contractual requirements. Specifically, the MHP did not have a plan for or evidence of implementation of cultural competency training for persons contracting with the MHP. In addition, the MHP did not have a tracking mechanism to ensure all staff and contractors receive annual cultural competence training.		
Corrective Action		
13a - The MHP did not have evidence or a mechanism in the contract to ensure, implementation of cultural competency training for persons contracting with the MHP. The MHP will implement proposed changes to the contract boilerplate as specified in Attachment VI that incorporates the following		

language.

The Contractor's Quality Management Program shall be consistent with the Department's Cultural Competence Plan. In accordance with the Cultural Competence Plan Requirements (CCPR), ***Contractor shall ensure that 100% of Contractor's staff, including clerical, administrative/management, and clinical; and subcontractors receive annual cultural competence training. Contractor shall monitor, track, document (e.g., training bulletins/flyers, sign-in sheets specifying name and function of staff, and/or individual certificates of completion, etc.) and make available upon request by the Federal, State and/or County reviewers the annual cultural competence training provided to Contractor's staff, including clerical, administrative/ management, and clinical; and subcontractors.***

Timelines for the Proposed Changes to the Boilerplate

The Quality Improvement Division (QID) of the MHP submitted proposed changes for the boilerplate to the Contracts Development and Administration Division (CDAD) of the MHP on November 9, 2016.

The Quality Improvement Division (QID) of the MHP notified the (CDAD) of the MHP regarding proposed changes to the boilerplate in December 2016.

The MHP's CDAD will incorporate feedback from County Counsel and implement changes to the boilerplate effective 07/01/2017 or incorporate the changes sooner if there is a plan to amend the contracts prior to 07/01/2017.

The Quality Improvement Division-Cultural Competence Unit (QID-CCU) developed a two (2) hour basic cultural competence training, titled "Cultural Competency 101", Attachment X. This training meets the Cultural Competence Plan Requirements (CCPR) for cultural competence training. In September 2016, this training was provided to all Service Area Quality Improvement Committees.

For Calendar Year (CY) 2017, an online version of this "Cultural Competency 101" training was made available to all Directly Operated and Contracted Providers via a hyperlink accessible on the Los Angeles County Department of Mental Health (LACDMH) Internet site on December 20, 2016. In CY 2017, all programs – DO and LE will be required to have 100% of their staff complete the Online Cultural Competency 101 training, or an annual cultural competence training that meets the CCPR and is also pertinent and adds to the cultural competence skills of the staff to fulfill their job duties in a culturally competent manner. Any questions pertinent to annual CC trainings that would meet the CCPR may be directed to the LACDMH Ethnic Services Manager. From CY 2018 and thereafter, 100% of staff will be required to complete an annual cultural competence training that meets the CCPR and is also pertinent and adds to the cultural competence skills of the staff to fulfill their job duties in a culturally competent manner.

1**3b** – To demonstrate evidence of implementation of training programs to improve the cultural competence skills of staff and contact providers the MHP is implementing the following actions and tracking mechanism. The MHP will include two new questions on the Quality Assurance (QA) Monitoring Report, Attachment VII, for both Directly Operated (DO) and Legal Entity (LE)/Contract programs to ensure there is a mechanism to track that all staff and contractors actually received the required cultural competence training. Listed below are the proposed two new questions that will appear (Please see Attachments titled, "QA_Report_ for_LE_Contract Providers" and QA_Monitoring_Report_DO Programs – Fourth Quarter") in the revised QA monitoring reports for DO Programs and LEs.

Timelines for Implementation of the Revised QA Monitoring Reports: • Completed Drafts of updated Annual QA Report and Quarterly Monitoring Report forms on November 18, 2016, Attachment VIII. • Notified providers of upcoming changes at December 12, 2016, Departmental QIC meeting. • The MHP Implemented an online Cultural Competence 101 training available to all DO and LE programs via a hyperlink on the MHP internet site on December 20, 2016. Note this training meets the CCPR for cultural competence trainings. • The Quarterly Monitoring Report for Fourth Quarter of CY 2017 related to Cultural Competence item will be due from providers January 15, 2018, Attachment VII. • Annual QA Monitoring Report for LEs/Contract programs related to Cultural Competence items will be due January 15, 2018, Attachment VIII. • The MHP will perform an interim status check that will track providers' progress in the implementation of the annual CC training for both DO and LE programs will be on July 1, 2017.

Attachment VI	Changes to Contract Boilerplate
Attachment VII	Quarterly Monitoring Report
Attachment VIII	Annual Quality Assurance (QA) Report
Attachment IX	Changes to Directly Operated and Contracted Agency Monitoring Reports
Attachment X	Online Cultural Competence 101 Training
Attachment XI	DMH Policy 401.03 Clinical Documentation for All payer Sources
Attachment XII	DMH Policy 614.02 In-Service Training
Attachment XIII	DMH Policy 1100.01 Quality Improvement Program

ITEM 3	**SECTION B**	**AUTHORIZATION**
Question No.1a		
Regarding the Treatment Authorization Requests (TARs) for hospital services: Are the TARs being approved or denied by licensed mental health or waivered/registered professionals of the beneficiary's MHP in accordance with Title 9 regulations?		
Findings		
The MHP did not furnish evidence it complies with regulatory requirements regarding Treatment Authorization Requests (TARs) for hospital services. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: Policy and Procedures regarding the TAR process (that are all in the process of being authorized). However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. In addition, DHCS inspected a sample of two hundred and eight (208) TARs to verify compliance with regulatory requirements and found one (1) TAR to be out of compliance.		

County of Los Angeles – Department of Mental Health
Mental Health Plan
Medi-Cal Consolidated Specialty Mental Health Services Audit: February 8-February 12, 2016
Plan Of Correction

Corrective Action
The Los Angeles County Department of Mental Health (LAC DMH), functions as the Mental Health Plan (MHP). The LAC DMH Managed Care Division, Treatment Authorization Request Unit (TAR Unit) functions as the Point of Authorization. The TAR Unit receives approximately 2,500 TARs from contract and non-contract Fee for Service hospitals that provide psychiatric inpatient services to Los Angeles County beneficiaries. The LAC DMH TAR Unit employs 17 licensed multidisciplinary staff to review submitted TARs. The staffing pattern includes 2 Psychiatrists, 10 Registered Nurses, and 5 Licensed Clinical Social Workers. One psychiatrist is dedicated to reviewing documentation referred by the multidisciplinary staff for questionable or lacking medical necessity documentation for admission or continued stay for receipt of acute inpatient psychiatric services. The TAR Unit staff use the medical necessity criteria found in the California Code of Regulations (CCR), Title 9, Chapter 11, Section 1820.205. In addition, the MHP in its capacity as the Point of Authorization uses criteria found in CCR, Title 9, Chapter 11, Section 1820.220 as timelines when receiving, and reviewing TARs, Attachment XIV. The LAC DMH TAR Unit also employs nine (9) clerical staff to support the process of reviewing TARs and subsequent submission of these authorizations to the State. During the February 2016 DHCS review of the Protocol, specifically the Authorization Section 1.a., 208 completed TARs were randomly pulled as evidence that the MHP is performing its review responsibility. Unfortunately, one TAR lacked the signature of the psychiatrist. The DHCS Exit Conference held on February 11, 2016 was attended by the key managers and supervisors of the Managed Care Division. These attendees received feedback from the State that the TAR review process employed is a very good one; however it was noted that one of the 208 TARs reviewed lacked a psychiatrist signature. Subsequent to the February 11, 2016, DHCS Exit Conference, the LAC DMH Office of the Medical Director Bureau held its bi-monthly meeting with managers and supervisors; this meeting is chaired by Ms. Pansy Washington, District Chief. The attendees were informed of the feedback and findings presented in the DHCS Exit Conference; all were tasked with enhancing existing workflows and/or employing new workflows to ensure the mandated authorization requirements are met. On March 4, 2016, the TAR Unit, in its bi-monthly meeting discussed the review findings pertinent to the TAR Unit. Included in the discussion was the regulatory requirement that all approved TARs or TARs with partial or full adverse decisions regarding hospital requests for MHP payment authorization, based on medical necessity criteria, shall be reviewed and approved by a physician. The psychiatrist's signature is the evidence that the documents have been reviewed by a licensed mental health professional. Please see Attachment XV. To ensure this finding does not occur in the future, a dedicated staff is assigned to review all TARs post review and prior to submission to the State. The review completed by the staff includes ensuring that all mandatory elements are present. The review staff confers with the clinical staff and the psychiatrist regarding any concerns or corrections such as missing denial dates, dates that are not in sequence or not noted, missing psychiatrist signature, etc. Please refer to Attachment XVI. The existing Policy and Procedure in reviewing TARs was revised in July, 2016 to reflect more accurately regulatory provisions that a licensed mental health professional signs all TARs received for review. Please see Attachment XVII.

Attachment XIV	Timelines for Initial Submission of a TAR
Attachment XV	TAR Unit Clinical Meeting Summary of March 4, 2016
Attachment XVI	Tasks and Activities (Process) for Post Clinical TAR Reviews, Chart Auditing and Out of County Billings
Attachment XVII	Policy TAR Unit 1- Process for Reviewing Medical Necessity Criteria for Treatment Authorization Requests (TARs) from Acute Psychiatric Inpatient Hospitals

ITEM 4	**SECTION B**	**AUTHORIZATION**
Question No. 3a		
Regarding payment authorization for Day Treatment Intensive and Day Rehabilitation Services: he MHP requires providers to request advance payment authorization for Day Treatment Authorization and Day Rehabilitation in accordance with the MHP Contract: 1) In advance of service delivery when services will be provided for more than 5 days per week.		
Findings		
The MHP did not furnish evidence it requires providers to request advance payment authorization for Day Treatment Authorization and Day Rehabilitation. DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&P #CA1 – Payment Authorization for DTI Providers and mental health services delivered concurrently with day treatment. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and /or contractual requirements. Specially, the policy needs to be updated to reflect the verbiage "in advance of service delivery" when the treatment is provided for five (5) *[sic]* or more days per week. In addition, DHCS inspected a sample of sixteen (16) DTI/DR advanced payment authorizations. There was one authorization for day treatment for seven (7) days that was approved for authorization after the start date.		
Correction Action		
The MHP's Managed Care Division Day Treatment Unit is staffed with five licensed mental health professionals who oversee the authorization requests from 14 Day Treatment providers. The completion of the day treatment authorization requests is being monitored on a daily basis by clerical support staff and the Program Manager to ensure that all approved authorization are pre-authorized. Protocols, such as counseling sessions, correction of workflows, etc., are in place to address any out of compliance findings. The DHCS' Exit Conference held on February 11, 2016 was attended by the key managers and supervisors of the Managed Care Division. These attendees received feedback from the State that the Day Treatment review and authorization process employed is a good one; however it was noted that one of the 16 advanced payment authorizations reviewed did not demonstrate it was pre-authorized. Subsequent to the February 11, 2016 DHCS Exit Conference, the LAC DMH Office of the Medical Director Bureau held its bi-monthly meeting with managers and supervisors; this meeting is chaired by Ms. Pansy Washington, District Chief. The attendees were informed of the feedback and findings presented in the DHCS Exit Conference; all were tasked with enhancing existing workflows and/or employing new workflows to ensure the mandated authorization requirements are met. On February 24, 2016, a meeting was held with the staff of the Day Treatment Authorization Unit where the DHCS Review Protocol pertaining to		

Day Treatment Authorization was reviewed with the staff. The staff members were reminded of the regulatory mandates that require pre-authorization of Day Treatment Services when treatment is provided for more than five (5) days in a week. The staff members were informed of the newly implemented quality assurance workflow where Day Treatment Authorization activities will be continuously monitored to ensure adherence to the regulations as defined in CCR, Title 9, Chapter 11, Sections 1830.215 (e) and 1840.318 and the MHP Contract.

Please see Attachment XVIII.

On April 7, 2016, a letter from the LAC DMH Medical Director was sent to the Day Treatment Providers via e-mail. The letter reminded the Providers to request payment authorization prior to rendering DTI or DR services as well as prior to rendering MHS that will be provided concurrently with DTI or DR services. Additionally, the providers were informed that the MHP has up to 14 days to make a determination on a submitted authorization request. Providers were encouraged to submit their requests at least 14 days prior to the anticipated start date of services to ensure that determination on a submitted authorization request is made before the proposed start date.

Please see Attachment XVIX.

The Policy and Procedure for Day Treatment Authorization was also updated to reflect that Providers must request payment authorization in advance of service delivery when day treatment intensive or day rehabilitation will be provided for more than five days per week.

Please see Attachment XX, Procedures, 4.8

Two completed Authorization Detail Forms are being submitted as evidence that DTI and DR requests are being reviewed and pre-authorized.

Please see Attachment XXI.

Attachment XVIII	Day Treatment Staff Meeting Dated February 24, 2016
Attachment XVIX	Letter dated April 7, 2016 from the Medical Director to Providers and Programs Providing Day Treatment Intensive Services, Day Rehabilitation Services and Concurrent Mental Health Services
Attachment XX	Policy CA1 Payment Authorization for Day Treatment Intensive Day Rehabilitation and Mental Health Services Delivered Concurrently with Day Treatment, Procedure Section 4.8
Attachment XXI	Completed Authorization Details of Day Rehabilitation and Day Treatment Intensive

ITEM 5	**Section B**	**AUTHORIZATION**
Question No: 5a and 5e		
Regarding Notices of Action (NOAs): 1) NOA-A: is the MHP providing a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible for any SMHS? NOA-E: Is the MHP providing a written NOA-E to the beneficiary when the MHP fails to provide a service in a timely manner, as determined by the contractor (MHP)?		
Findings		

The MHP did not furnish evidence it provides a written NOA-A to the beneficiary when the MHP or its providers determine that the beneficiary does not meet the medical necessity criteria to be eligible to any SMHS. DHCS reviewed the following documentation, presented by the MHP as evidence of compliance: P&P #200.04 Beneficiary Problem Resolution Process; P&P #302.07 Scheduling Initial Clinical Appointments; and, the MHP's policy regarding NOAs A-E. DHCS also reviewed the MHP's intake and assessment log to determine if NOA-As and NOA-Es were sent to beneficiaries in all instances where it was required during the specified time period. It was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specially, the MHP does not have a standard process to verify the NOAs are sent to beneficiaries and to monitor compliance with this requirement. In the review of the intake and assessment logs, DHCS determined the MHP did not comply with this requirement in all instances.
Corrective Action
The MHP will begin monitoring the issuance of NOA-As and NOA-Es to ensure that assessed beneficiaries who do not meet medical necessity criteria are provided with an NOA-A and beneficiaries who are not provided a service in accord with the MHPs established timeframes are provided with an NOA-E. A Phase-In process is being implemented for directly operated providers and legal entity contracted providers over the course of calendar year 2017. The process will allow the MHP to adhere to compliance to verify that NOA-As and NOA-Es are provided to assessed beneficiaries that do not meet medical necessity criteria and for those that are not provided a service within the MHP's established timeframes.

Attachment XXII	Phase One Time for directly operated and contracted providers, Phase Two for directly operated providers NOA-A, Phase Two for directly operated providers NOA-E, Phase Three for contracted providers NOA-A and NOA-E.

ITEM 6	**Section G**	**PROVIDER RELATIONS**
Question No: 2b		
Regarding the MHPs ongoing monitoring of county-owned and operated and contracted organization providers: Is there evidence the MHP's monitoring system is effective?		
Findings		
The MHP did not furnish evidence it has an ongoing and effective monitoring system in place that ensures contracted organizational providers and county owned and operated providers are certified and re-certified per Title 9 regulations. DHCS reviewed documentation presented by the MHP as evidence of compliance. The MHP has a process for ongoing monitoring of providers, However, DHCS also reviewed its Online Provider System (OPS) and generated an Overdue Provider Report (dated January 16, 2016), which indicated the MHP has 5 providers overdue for certification and re-certification.		
Corrective Action		
The MHP has implemented the following actions that will ensure that directly operated and contracted providers, as well as, contracted organization providers are re-certified according to the requirements specified in CCR, Title 9. Effective March 8, 2016, certification staff were instructed to schedule on site re-certification visits with providers 3 months prior to providers re-cert date instead of 1 month prior as was the previous process before the State Audit. This would allow for the increased time needed by some providers to respond to Plans of Corrections.		

Certification staff were also instructed to request submission of a fire clearance 6 months before a provider's re-cert date. This would allow increased time for the Certification staff to work with providers in regards to problems with delays related to fire clearance issues (Attachment XXIV). A ten (10) Months Due Re-Certification log is used to track that fire clearances and site visits have been received and scheduled accordingly (Attachment XXIII). Effective June 2016, the five providers identified as being overdue during the system review were in compliance with their certification (Attachment XXV and XXVI). Currently the MHP is 100% in compliance and there are no providers with overdue re-cert dates. Program Review Section, Program Manager will provide education to the Service Area Liaisons during the Countywide Quality Assurance Liaisons meeting, on February 9, 2017, advising on the importance of timely re-certification as pursuant to findings in the System Review and Title 9 requirements. The meeting will cover issues that impact timely re-certification including issues related to fire clearances and corrective action to conduct re-certification site visits with provider 3 months prior to providers re-cert date.	
Attachment XXIII	Certification/Re-certification Schedule 2008-2017
Attachment XXIV	Agenda from March 8, 2016 Medi-Cal Certification staff meeting that confirms staff education on timely re-certification, system review findings and plan of correction was provided by Program Manager.
Attachment XXV	Medi-Cal Certification and Transmittals
Attachment XXVI	On-Line Provider System Reports (lasted updated 12/5/2016)

ITEM 7	**Section H**	**PROGRAM INTEGRITY**
Question No. 2e		
Regarding the MHPs procedures designed to guard against fraud, waste, and abuse: Is there evidence of effective training and education for the MHP's employees and contract providers?		
Findings		
The MHP did not furnish evidence it has procedures designed to guard against fraud, waste and abuse regarding effective training and education for the MHP's employees and contract providers, DHCS reviewed the following documentation presented by the MHP as evidence of compliance: P&Ps: 614.01 Continuing Education; 614.02 In-service Training and 106.10 Compliance Training. However, it was determined the documentation lacked sufficient evidence of compliance with regulatory and/or contractual requirements. Specially, there is no mechanism to ensure mandatory annual training is completed for all staff and contract providers.		
Corrective Action		
The MHP is actively working to develop policies and to insert language in our legal entity boilerplate that will designate the requirement for annual compliance training and monitoring to guard against fraud, waste and abuse. This effort requires large scale system-wide changes and challenges including working with LAC Department of Human Resources to develop and implement an electronic method to train track and monitor the training status of over 5000 DMH employees. Collaboration and consultations with various other County Departments have been ongoing for legal		

clarifications and consideration of additional technological mechanisms that are needed to link adequate informatics to the responsible reporting structures. LAC DMH has narrowed the most feasible options for monitoring contracted agencies Compliances Programs. Current options in analysis include adding this component to the Department's contract with LAC Auditor Controller; a new contract monitoring unit to evaluate contractors compliance programs or requiring contractors to submit self-evaluations and attestations of compliance to LAC DMH Compliance Division. The MHP will report back to DHCS within three months with additional details of timelines for implementation. The training is designed to inform the LAC DMH workforce about their responsibility to adhere to Federal, State and local laws, policies, local healthcare program requirements, ethics, integrity and compliance audits. The False Claims Act, the Code of Organizational Conduct, non-compliant behaviors, investigations, discipline and enforcement of anti- fraud and abuse rules are also addressed. The training concludes with providing information on the mechanism and contact information to report fraud, waste and abuse and a test of learning. (See below Attachments)	
Attachment XXVII	http://lacounty.govwebcast.com/Presentation/Flash/LACounty/857e8053-fb4d-4aa1-83ce-0e74e3c4661d/Compliance%20V2.swf
Attachment XXVIII	 Web-based Compliance testing.m

ITEM 8	**Section H**	**PROGRAM INTEGRITY**
Question No: 4		
Does the MHP ensure that it collects the disclosure of ownership, control and relationship information from its providers, managing employees, including agents and managing agents as required in CFR, Title 42, Sections 455.101 and 455.104 regulations and in the MHP Contract, Program Integrity Requirements?		
Findings		
The MHP did not furnish evidence it collects the disclosure of ownership, control and relationship information from its providers, managing employees, including agents and managing agents as required in regulations and the MHP contract. The County collects Form 700 for its employees; However, the MHP does not collect disclosure of ownership, control and relations information from its contracted providers.		
Corrective Action		
The MHP has established a time-line for phasing in contracts with legal entities that will contain language requiring provider(s) collection of disclosure of ownership, control and relationship information. All legal entity contracts between the MHP and providers expire on June 30, 2017. New contracts effective 7/1/2017, will have the new contract language that requires providers to adhere to disclosure of ownership, control and relations information. The MHP created a new form, Ownership/Controlling Interest Disclosure (Attachment XX) for providers to complete disclosure information as part of the contracting package. The Contracts Development and Administration Division (CDAD) will house completed		

disclosure forms in locked files in a secured, limited access area. The disclosures will be available for DHCS review. On December 16, 2016, the changes to the legal entity contract boilerplate were sent to the Los Angeles County, Senior Deputy Counsel for legal review. Upon release from County Counsel CDAD will proceed in the implementation of the revised legal entity contract boilerplate for use of legal entity contracts that will be effective 7/1/2017.	
Attachment XXVI	Ownership/Controlling Interest Disclosure form