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Date: 2/3/2021

Event: Managed Long-Term Services and Supports Meeting

StreamBox

at that meeting in the past.
I'm the guy that --
>> Yeah. And talks about behavioral health issues which is what I'll continue to be.
Thank you for having me. I hope whoever nominated me will not be embarrassed and I look forward to serving with you.
>> Okay welcome, Lloyd. I'm a.
>> I've been to some of these meetings before. I'm representing the brain injury team today.
>> Thank you for representing the community.
>> Welcome, Monica.
>> I'm a new member. I. Name is Ali Kronley. I'm with SCIU health PA. I'll filling the seat occupied by deputy Walderman and has been at several of these meetings as an observer or filling in for him and really excited to serve and here really representing the 20,000 direct care workers across the state of Pennsylvania that our organization represents. Y.
>> The agenda is providing COVID-19 update that we've been giving since back in the spring. Some additional information about our monitoring and update on our person-centered service plans and this is coming after some of the information that we shared on changes being made to people's plans based on the CHC MCO's doing a lot of reassessments that are required under the CHC agreement and making -- we had a lot of questions about decreases to service plans. So we pooled some information.
>> Linda and Luba. We still have some folks that aren't on.
It looks like we have the majority of the individuals are now on.
>> Okay. Do you still want to take attendance at this point or do you want to wait?
>> You can go ahead and take attendance. If others join, we can let you know.
>> CHAIR: It looks like we'll .
>> LUBA: I'm Luba Somits the vice-chair for the subcommittee.
At this point, what I'll do is take the member attendance.
Ali, are you on the line?
>> Good morning. I'm here.
Hello.
>> LUBA: Good morning. And Cindy, I have you down. Neil Brady. Okay. We'll go on to the next person. David Johnson.
>> Hi, good morning, Luba.

>> LUBA: Good morning, David.
Denise, are you on the line?
Denise Curry. Okay. Gail Weidman.
>> Good morning. I'm on.
>> LUBA: Good morning, Gail.
German, are you on the line.
>> Buenos dias, can you hear me, Luba?
>> LUBA: Yes, good morning.
Heshie, are you on the line.
I recognize Juanita Gray. Linda is on the line. Lloyd Wertz, are you on the line?
>> Yes, I am.
>> LUBA: Good morning. Matthew Seeley.
>> Good morning.
>> LUBA: Mark, are you on the line. Mark Gusek. Okay. How about Mike? Are you on the line?
>> Yes, I am. Thank you.
>> Good morning.
>> LUBA: Monica.
>> Yes, I am, Luba. Good morning.
>> LUBA: Good morning. Richard Farr.
>> Luba, Sherry Welsh is on for Rich Farr, and she should be unmuted.
>> Hi, there. I am here.
>> LUBA: Richard Wellins. And Sarah. Sarah Glasheen.
>> I don't see Sarah.
>> LUBA: Sister Catherine.
>> She's here. She just stepped out for a moment.
>> LUBA: Okay. Thank you. And Steve, I know you're on the line. Tanya. Good morning, Steve. Tanya.
>> I don't see Tanya.
>> LUBA: Okay. And William Spotts.
>> Yes, good morning.
>> LUBA: Good morning. Okay.
Thank you. Should we go on to the housekeeping talking points?
>> Since we're not in person, so I'll just go through the fact that we are being recorded today and if everybody keeps their language professional, we'll be fine with that. Oh, I can't say her last name. Is Mana here to talk about the dental?
>> Yes. Good morning. I'm on the call.
>> Hi. We can go ahead with your information, that would be great.
>> DR. MOZAFFARIAN: Sure. Let me just make sure I'm sharing my screen.
>> While we're doing that, I wanted to mention that Jamie will not be available for this call due to a conflicting obligation. But Jill and Randy would be available to take any questions that we may have.
>> DR. MOZAFFARIAN: I am sharing the screen. I believe I just have two screens and I don't know which one you all are seeing. Are you seeing the PowerPoint presentation or are you

seeing the few different windows?
>> CHAIR: The PowerPoint. How do you pronounce your last name?
>> Reporter: Mozaffarian.
>> CHAIR: Okay.
.
>> DR. MOZAFFARIAN: Could you confirm if you're only seeing slide one or other things?
>> CHAIR: I guess it would be slide one. Comment HealthChoices.
>> DR. MOZAFFARIAN: Perfect. So we can get started. As you can all see in the subject line, I just want to talk about the importance of oral health and also what the community HealthChoices looks like for Pennsylvania. It's going to be a very simplified short presentation on the impact of poor oral health on overall health as well as what the dental coverage looks like. I'm going to give a quick warning for those that are not used to seeing clinical pictures, but it was important to share it to show what can happen without proper mouth care. Although the picture on the left side of a patient that was using meth, unfortunately, identical results can happen with chronic poor oral hygiene as well as poor nutrition that can be damaging to the teeth. The nutrition counseling and conversation about oral health is a little bit different than the information that's usually used for nutrition for the overall health, just to point that out.
>> I'm sorry, Mana. Can you please say a visual description of what the images are, please?
>> DR. MOZAFFARIAN: Sure. The picture on the left, which is of the mouth, that's technically a picture of a patient that was using meth. However, I can share that the same outcome and the same results would look like from simply poor hygiene. So it could be just as aggressive as someone that was using drugs, because the biology and the ideology and all the things that happens in the mouth is very similar. When you're looking at the pictures on the right side, which is of the of the arm, those are pictures are what infections can lead to if the initial stages of an infection isn't taken care of. The reason I have pictures of both the face and the arm is to share that whether this infection or abscess is happening in the mouth and the face is no different than it happening anywhere else in the body. It's just with the mouth, it's usually covered, so it can be missed often and not, you know, seen the same way as the other areas of the body. I will share that it's understandable that with patients in long-term facilities, they might have higher challenges to keep up with proper mouth care due to different cognitive or physical conditions they have. So it's just that much more important to individualize the care they would need to be able to not only increase their hygiene and access to oral health but also, you know, the different conversations with the different nutritional foods and drinks to, you know, stay away from home -- or just the need to look at every aspect of oral health.
Another very important oral disease is periodontal disease which is the picture on the left of the mouth. And that is basically the infection of the gums and the bone underneath it that will eventually lead to the bone loss of the jaw. You can compare these two pictures. The other picture of the foot is an infected foot, ulcerated. You can see things are red and swollen. These two pictures, believe it or not, are having the exact impact on the overall body, because they both are producing inflammatory processes that are circulating in the whole body. And if you can imagine how painful it would be with the picture with the foot, for someone to try to put pressure on it and stand and walk on that foot, it's the same level of pain for the patient on the mouth side with the periodontal disease to attempt to try to choose and masticate and function

and eat. It can often have additional issues with malnutrition for the patient. When it gets as advanced as this picture, you have to have -- it's no longer something that can be arrested or reversed through just regular home care, and it requires procedural intervention by a dental professional.
Acknowledging periodontal disease as the chronic inflammatory disease that it is, it's easy to understand the bidirectional direct and indirect link its has to other conditions. Some examples are diabetes, cardiovascular disease, respiratory disease is nursing home aQuaid pneumonia, dementia and even some initial studies that the inFrahm Torre process that comes from the mouth, that it's circulating eventually in the rest of the body could potentially contribute to Alzheimer's disease and many other linkages.
Basically the impact that any chronic inflammatory infectious disease would have on the body, periodontal disease is doing the same. Again because it's usually covered by the lip, it's often missed. It's also important to acknowledge the oral health is varying with different populations. Nearly half of the adults in the age group of 20-64 have untreated Carries. If they were in any of the listed categories. Non-Hispanic, Black, low income, less than high school education and smokers. Only about 20% of their counterparts. This picture is from CDC. They have a lot more information on different levels of disparityes for the different group populations, ages, if you're interested to look that information up. So in Pennsylvania for the community HealthChoices, we have a few different managed care organizations that manage the oral health benefits, and there are health care UPMC, PA has enrollments and the measurement to ensure that every recipient is receiving some level of oral health care is annual dental services referred to as ABB measure. It basically tracks at minimum one dental service of any level in a calendar year, although we always recommend that they focus on preventive service instead of just, you know, any service. But any service qualifies. Overall, any treatment that is found to be medically necessary is a covered benefit. There is an administrative process in place that, again, you probably have heard of, which is the benefit limit exception, and that has been added to the 2021 agreement, and you can see the four bullet points of the reasons that -- of the steps that would be used to review each case to make sure that if a case is being approved for these specific services, are things that without which there could be a significant impact on the individual's life. But again, anything that is found to be medically necessary is supposed to be a covered service. It's authorized to be less restrictive if they choose to.
Acknowledging that some of the patients that patients may have more challenging times to keep up with proper mouth care, I just wanted to point out this book that a lot of the experts would recommend. UNC, civil look and this is a book that's called mouth care without a battle. The reason for the name, there was a [not audible]
without a battle. They wanted to keep the names similar. It's basically going through the steps of why a patient might have particular needs and be reacting a certain way to and what can be done to make the process easier for the mouth care. And they have a work sheet that's available for everyone to go on their website.
The website link is at the bottom of the screen here. You can Google and see what informationinformation. That's all that I have. I don't know if there are any questions. I don't know if people are typing questions or if -- I'm not sure exactly how we will do questions. I'm available if anyone has questions.

>> I do have a question.

>> This is Juanita Gray. How are you? I'm sorry. I listened to the medical necessary aspect of the need for [not audible].

Do MCOs have the determination to allow for the medically necessary aspect of the dental care. I am such a survivor, and I have a lot of medical issues from that. Also I have [not audible] and my teeth, and I sent the gentleman at health to bring up his portion to speak on this topic today, but when dentures aren't capable of taking care of your problem, and like I said, I have underlying -- I have multiple underlying problems, and my teeth are in bad oral health, and it causes infection in my body, and I asked about permanent -- I'm sorry. I have a lot of -- it takes me a while.

I asked about a permanent treatment instead of a temporary treatment which I'm not care to give for partial dentures and stuff because of my problem, medical problems. And I asked about dental implants where we ask that the law help us, for some people that's not able to afford that help of the permanent for our health for eating, for our -- to not keep getting infections, because I'm a person that continues to get those infections.

>> DR. MOZAFFARIAN: If I understand you correctly, it's a little bit difficult for me to specifically speak to your case, because of course I haven't examined you, nor seen your graphs or things like that. But in general, there are standards that -- by the American Dental Association on a national level of what is the standard of care and what is medically necessary for a patient. So at this time, implant placement is not part of -- I guess it could be a medical necessity, let's say, if someone has a deformity or if they have, you know, a portion of their jaw removed due to cancer or different things. But in general, that's not part of standard of care routinely.

However, your process prothesis whether it's possible or full must be functional for you. So there could be conversation around that, that you would have to discuss with your provider specifically. It's outside of even the MCOs or even myself.

It would be a conversation with a dental provider that shares -- evaluating the patient and seeing the patient and seeing what they find to be necessary to then submit the paperwork to ask for the approval. I don't know if that answered your question. But the best way to approach is to talk with the provider, the dentist or hygienisthygienist.

>> I guess what I'm asking is because of the fact -- I'm asking for them to try to implement that for the care. I understand that there are extreme situations. Like you said, poison and it becomes poisonous and your teeth can affect your brain and everything, and it affects your eating and everything, and implants are not -- not implants but partial dentures are becoming somewhat infected --

ineffective, and it infects insects because they have to keep coming out and being cleaned and everything. That's not being something that is good for people to have diseases as myself. And so I'm looking to have something implemented and changed where we use that. It's not the dental plant and what's in place. It's not working for us for people like myself and a lot of others.

>> I definitely understand that you are struggling with the prothesis and it's understood all the things you're experiencing. But what you're asking for is about the national standards are care that is implemented in dental education and training. It's not about coverage situation. I'd be more than happy to have a conversation with you specifically outside of this to kind of go through the systems and that the request you have is not about coverages and the system.

>> I am asking -- yeah. It should be -- because it's not in the plan. I am asking that we be advocated for changes for that to be implemented in the plan and which it should be fair to go individual that is receiving benefits. But they're not -- it would be a part of the benefits for us as participants and all of them. Yes, I am asking that it should be.
>> I hear you. I can assure you that I'm always keeping in touch with what the standard of care in the United States is updated to be. If that ever happens, absolutely, we would be doing the same with whatever the national recommendations are.
>> We want to who is who on the national recommendation. Who is fighting for us for that? Who is our voice? I want to know who that is?
>> It's the American Dental Association uses the information to make changes to dental care.
>> So I understand who is speaking on behalf of the disabled and that intellectually disabled and physically disabled and speaking on behalf of them.
>> DR. MOZAFFARIAN: I think it might be better for us to discuss this offline, only because I think the explanation I'm providing about the different systems is not sufficient right now.
>> Okay.
>> DR. MOZAFFARIAN: It's that the science needs to change first.
>> Okay.
>> DR. MOZAFFARIAN: But I'd be more than happy, because I want to make sure I give you the information you need.
>> Not a problem. I just wanted to let them know that it's a detrimental to your health like you explained. I'm glad you showed us photos and explanation, because we can die from dental disease, absolutely.
Thank you.
>> DR. MOZAFFARIAN: I agree.
>> Good morning. I have a question. Does OMAPS have a system in place to monitor there's adequate dental providers that accept medical assistance or Medicaid?
Especially the CHC.
>> DR. MOZAFFARIAN: Excellent question. I don't know if there's anyone on the call [not audible] ends up needing to go into that much detail. I can tell you it's part of the contractual for the MCOs to routinely show network with having the providers and making sure that each recipient is able to get the care that they need.
>> This is [Name]. One of the things we monitor the provider network advocacy and monitor it to ensure there's adequate providers within the network.
Each of the MCOs have different mechanisms that they use medical providers to provide services.
So we do monitor that to ensure if there's any issues with services, if somebody calls up and says hey, we can't find any dentists in the area. Then the MCOs are responsible to ensure they have access to a dentist.
>> Thank you.
>> Sure.
>> Hi. I'm wondering if there is any understanding or ability to corelate the number of people with severe dental issues that end up either being served or not being served in the CHC program, and the number of those folks who have behavioral health issues in their past, mental

illness or substance use? I'm wondering if there is anybody checking that out, thus increasing the level of intervention for services for folks with those histories?
>> DR. MOZAFFARIAN: That's an excellent question. It can get a little bit tricky, because the liability is always --
liability/responsibility, authority really lies with the specific dental provider. They do the examination of the patient. Once the treatment plan is documented, then they have to provide all the care that is needed for that patient.
That is true for any dentist/patient relationship.
It's difficult to dictate to a provider who has to move forward. However, if there's ever a recipient that feels that the provider is routinely, you know, neglecting them or not providing care for them or anything like that, obviously, there's other things in place where they can, you know, seek putting in a complaint or something like that to have that particular situation looked into. But systemically, it's difficult, as I mentioned, to dictate that on a provider to have to move forward. I do agree with you, though, that behavioral health and mental health and patients have specific needs, and I'm doing a lot of work to kind of link the providers with each other so that they can give a better care to each individual patient.
>> I wouldn't think it would lie with the provider and the dental service. I would think it would lie with the MCO and service coordinators who are assessing if they find a behavioral health issue with a person's background, then perhaps an increased priority for dental care might come to bear which would of course reduce health care costs later down the road.
I don't see it as being part of the dental provider's responsibility. I find it as being part of the MCOs.
>> This is Randy. Our response throughout the person-centered planning process and identify any issues or concern or needs for participants. So if they identify that somebody needs dental care or podiatrist care or any other care, it's their responsibility to ensure that cares.
It is their responsibility no matter what their background is, to find an appropriate dentist for somebody who may have a behavioral health issue that needs treatment. It's the person-centered planning process to identify those issues with the participant.
>> The priority directed towards folks with behavioral health issues, Randy.
>> For the participant if they need dental care. It is the responsibility if somebody does have a mental health issue and may need to see a specialist or maybe see a dentist that is willing to put them undery isidation -- under sedation or whatever. It is the CHC's responsibility to do that care.
>> CHAIR: .
>> I have a situation that happened. All of my teeth are capped except for one. So they're rigid and capped, and I had a lot of work done by a dentist here in Pennsylvania, and then when I moved to Nevada, I had somebody else do the work.
And then I came back to Pennsylvania, and I was lucky enough to get with the dentist that I had previously had. The reason that I'm saying is I was a nurse. I was making good money, and I could afford to have that. I had a 2-piece bridge come out, and then right after that, we were on --
anybody in the nursing system, was not allowed out of the building. So I can see changes have taken place so now my worry is what's going to happen? How much is going to have to be done

in order to do the repair and so on? So it is basically going to be a cash situation when I get free from here to be able to go and see him.
>> DR. MOZAFFARIAN: If I understand your comment, this is because of the pandemic that you could not leave.
>> Correct.
>> DR. MOZAFFARIAN: I wish I had a good answer for you. What's been an issue with the pandemic, especially with dental care, that's across-the-board for everyone. Because there was a period of time that all the dentistry was reduced to only emergency care, and even that was encouraged to only be done remotely whenever possible.
It's a national issue for every age group, you know, every population, even the pediatric patients. We are aware of it, and we know that there's a lot of compassion that needs to happen. It's unfortunate with the pandemic. We have to do the priority of --
>> The across-the-board way of handling it is to [not audible]
instead of trying any other way of fixing this situation. You know, I had a lot of work done. First of all, if they did anything, they would just be pulling out the nubs that are underneath.
>> DR. MOZAFFARIAN: Well, that's what I was going to share again.
It's difficult without seeing your particular case, but usually, when a crown or a cap comes out, unfortunately, it happens because what was underneath and was holding it up is no longer viable to have that. Again, I would have to see the particular patient case.
But the pieces that are left behind would need to be removed to prevent, you know, advancement of the infection and all those things. The decision is made based on if what remains is fixable or if it's to the point where it just -- there's nothing that can be done, you know, and it's best just to remove the source of the infect at that point.
>> I wanted to speak on what she's saying. I believe what she's saying is -- this is Juanita again. Is saying that some of the only options they give you to fix our teeth since we can't afford to get them properly taken care of is just pull them and leave us without teeth and adequate -- and then we can't get the resources to repair or replace our teeth.
And for our health.
>> DR. MOZAFFARIAN: I can tell you in practice myself, to me, it was never an issue of payment. I would always look at the different treatment options and, you know, situation, where there was nothing else that could be done for that particular tooth. Then the only option would be to remove it to avoid the furtherance of the infect. If there's other alternatives that are medically necessary, even if they're more costly, they would get approved.
But it has to be a medically necessary standard, which is a national standard. It has nothing to do with Pennsylvania.
So it's not that everything is just constantly being removed based on payment. There's a lot of, you know, medical and dental information that goes into that.
>> Right. And it usually is cosmetic. They don't consider it -- I came with only [not audible] now, and I want to keep them. So if I hadn't been able to go right away to the dentist, the outcome may have been different.
>> I believe we're trying to change it from being cosmetically but it's not. Your teeth are essential to your health. So we need that aspect of it changed. That's what we're trying to ask for.

>> DR. MOZAFFARIAN: There's a contract conversation in every aspect you can think of. It is health care. Every conversation is about things like bleaching teeth or getting veneers, you know, things like that. That is cosmetic. But everything else in dental health care, oral care that is all essential in every aspect you can think of.
That --
>> Thank you so much. Okay.
>> DR. MOZAFFARIAN: Absolutely.
Dentistry is part of medicine for sure.
>> Okay. Thank you so much. I appreciate that answer. Thank you.
>> DR. MOZAFFARIAN: No problem.
Linda and Luba, there are additional questions. But it's 10:45. We're running late. We could ask if they could respond offline to the questions.
>> DR. MOZAFFARIAN: Sure that sounds good to me. If it's a specific question for me, please send them to me or if it's for the MCOs, it would be great if you can forward it to them as well.
>> Okay. We may have a few we can cover in the specific question-answer session as well.
>> DR. MOZAFFARIAN: I can't stay past 11:00. But thank you, everyone, for your time. I really appreciate the interest, because I agree with every comment that oral health is important and that's why I did the presentation, to make sure that you know, we see the significance of what it can do and why it's important to prevent as much as the advancement of the disease as possible. Thank you.
>> You're very welcome. Thank you so much, Linda.
>> Did you want to move on to Abby with the CHC's dental benefits data.
>> CHAIR: Yeah, that would be great.
>> ABIGAIL: Good morning, everybody. I'm Abby Coleman the program director of analytics within the Office of Long Term Living and today we're going to talk about some data updates, and I'm going to start and take -- piggyback off Dr.
Dr. Mozaffarian's presentation and kick it off with some dental data. Next slide, please. Just a quick overview of what we'll be covering today. I'll cover the dental data and then pause for questions, if there are any, while we still have Dr.
Dr. Mozaffarian available. Then we'll move into the MCO statewide goals. This is listed as people tackled on the agenda and what people stat really is.
Our monthly meetings that we meet with the secretary on different topics, including serving more people in the community, employment, and other quality measures. We'll be reviewing some of the data that has been discussed with both secretary Milner and the MCOs, and then finally, we'll conclude with some next steps. So next slide, we'll jump right in to the annual dental visit and we can go straight to the next slide. The annual dental vIFT is a measure we're using on a rolling quarterly basis. It covers a year, but we're calculating it at the end of every quarter. So it's basically for data for any participants who are continuously enrolled with the MCO within the previous rolling calendar year, and it does allow for a 45-day enrollment gap, and I want to point out that when we are looking at data, it's important to keep in mind that we are on about a 6-month delay to allow the providers to submit the claims to the MCO, the MCO to adjudicate the claim, and ultimately, that information is sent over to the state.
Dr. Mozaffarian did point out this particular measure, if the participant receives any dental

service within that previous year. So this first slide that we're looking at today is for quarter 2, 2019 through quarter 1, 2020. Then we'll also be looking at quarter 3, 2019, through quarter 2, 2020. And because we don't have a full year's worth of data for phase three, and we won't have that until about July, we'll only be looking at the southwest and southeastsoutheast. So here you can see the annual dental data for both southwest and southeast, and in some of my later slides, I do break it out by regional differences. But here, we're looking at the breakdown by age, 21-59, 60 to 64, and then 65 plus. And you can see there's not a whole lot of differences between the age group. And just keeping in mind this does start to cover quarter 1, 2020 when the pandemic first hit, but for the most part, this data is looking the year back, so it is mostly covering the period of time prepandemic except for, you know, that last period of time in March. So you can go to the next slide. And here we are looking at the quarter three 2019 to quarter 2, 2020. You can see from the previous slide, the numbers are already start to go down likely to what Dr.
Dr. Mozaffarian pointed out with the effect of dental from the pandemic. As you can see, not a huge difference between the age group in terms of utilization.
Next slide, please. So here we are breaking out the data by the southwest only, and again, just focusing on that overall total for the three MCOs, we're really in the high teens in terms of utilization of any dental service for the southwest through quarter one 2020. If we go to the next slide, you can see that the total number drops to the lower to mid teens just factoring in that one quarter of the pandemic. If we go to the next slide, we're going to see a similar pattern in the southeast. The southeast numbers are definitely higher than in the southwest numbers in terms of utilization, but we do, if you look at those total numbers on the far right there, they're ranging anywhere from about 20% to 29%, and then next slide. Here, they're dropping down to 17 to 25 percent for three MCOs. You can really start to see that effect of the pandemic on our numbers here.
Next slide. So this slide is looking at annual dental visits by population group. You can see that there is definitely lower utilization for the NFI population group, and definitely higher utilization for both of our nursing facility groups, both dual and nondual. And then next slide. Again, you can see these numbers for all populations, starting to drop off from what they were in quarter 1, 2020 as opposed to quarter 2, 2020. And that is my last slide on dental. I will pause here before moving on to see if there are any additional dental questions for me or Dr. Mozaffarian while we still have her.
>> So Abby, there are some questions from the audience, although I think -- I'm trying to see, most of the ones we have, we're going to ask the MCOs to specifically answer.
But you did hit on one thing that did come in was the impact of the pandemic on receiving serviceservices. Annette hall asked because of COVID-19, patients like myself [not audible] to receive treatment? And how is medically necessary defined?
>> For that, I would defer to Dr. Mozaffarian.
>> DR. MOZAFFARIAN: I was going to say, medically necessary is not one definition for dentistry. As I mentioned, it's set by American Dental Association which is the national association for dentistry. Using evidence-based information, they -- for every dental procedure that you can imagine, they have set very specific criteria that, you know, a clinician is who is really read and understand the language, because it's very medical/dental specific. So yeah.

Every procedure -- and also in conjunction with medical information. You know, because dental care does not look identical to someone who is without any medical condition compared to someone who is going -- they're going chemo, radiation, or diabetes or different conditions. So it's a really long list of information that a doctor has to kind of take it all into consideration and find out what truly is the need for the patient's function and medical needs. And as far as the limitations with the pandemic, I don't know exactly what the question was, but as I mentioned before, it's across-the-board, every state, every population, because of the limitations. It is starting to pick back up again. But it is a slow process, because there is a lot of need that due to the pandemic, it has to be prioritized that people's physical health was taking priority. I hope I answered those questions.
>> Thank you. I think maybe one more for you before you have to leave. It's our understanding that at one point, the department was working with [not audible] to identify certain health conditions that count as serious health conditions for the benefit limit exception request. Is the department still working on this guidance?
And has it been published?
>> DR. MOZAFFARIAN: I understand the question. It has not been published yet. With the pandemic, it's been a little bit delayed. I can tell you, though, that even without this being published, the only thing that documents was referring to was for the MCOs, if someone has a significant medical condition to look in their database and confirm the serious medical conditions that way instead of requiring the information from the practitioner. So it's not that it was a change in policy about someone who has more significant medical conditions to have a different level of care. Any time you have serious medical conditions, your level of care needs to match the standards of care. But it was just a policy to remind MCOs that they can cross-reference their medical information with their dental instead of requesting it from the actual clinician. And it has not been published yet. We are working on it, though.
>> Do you have a target date for publishing the guidance?
>> DR. MOZAFFARIAN: It's in the hands of policy, and unfortunately, I'm not aware of what their dates would be.
>> Okay. Thank you. And then Abby, I think there's a couple data-related questions if you want to take a few of those.
And some of them again are specific to the MCOs that we can ask during the MCO question and answer section.
>> Sure.
>> So -- actually, it all -- I should say they all sort of fit in the MCO, because they are asking about the variance between the MCO performance -- I don't know if you've done analysis on that or want to have the MCOs speak to that.
>> ABIGAIL: I'll let the MCOs speak to that. If that's okay.
>> Okay. Sure. Yeah. I will just hold those until we get to the MCO-specific section. There is a question from Pam Walls.
Are they thinking about why the annual dental visits is so different for dual versus nonnondual long-term care population.
>> ABIGAIL: I have very limited knowledge as to what Medicare covers and does not cover. That's definitely something that we could dig further into for future meeting.

>> Yeah. This is Jill. I think that we would have to follow up with the [not audible] as well. There may be certain benefits under the d snips that Medicare fee for service individuals might not have available to them. That could also impact the data.
>> Okay. All right. I think the rest, then, we'll hold for the MCO section. Linda, if you want to have Abby move on to people stat.
>> I'm sorry to interrupt.
David Johnson, the question for the department. To help make sense of the data we're looking at here, the annual dental visits by population group. The annual dental visit, this is the benefit available through community HealthChoices.
Correct?
>> Yes. This is any service that they receive through the MCO that is considered a dental service. So it would include all of those.
>> Okay. And as Pam Walden mentioned, interested in the difference between the rates of dual to nondual care. The question is I'm wondering is does the department or managed care plan have any data on Medicare dental benefit utilization which would most likely be through a Dee snip or is it looking through utilization through community health choices?
>> This data would just be looking at utilization through the community health choice MCO. It would not include any type of Medicare utilization.
>> Would that also include something like Medicare cost sharing potentially?
>> ABIGAIL: If the MCO paid for any of it, then it would be submitted as an encounter to us.
>> Okay. Thank you.
>> ABIGAIL: Am I moving on to the next section.
>> CHAIR: Yes.
>> Is that okay, Linda?
>> CHAIR: That's fine.
>> ABIGAIL: In these next set of slides, we're going to be talking about some measures that we discussed. I said monthly, but really it works out we meet with the secretary most weeks on the different topics of -- that we'll be discussing today, whether it's quality, employment, serving more people in the community, et cetera.
And we are presenting this data to Secretary Miller and other DHS leaders and having discussions about what we're seeing in the data, how we can improve the data, and then we also started having individual meetings with the MCOs to talk about this data that we're presenting and their thoughts on it. Then we were ultimately asked by the secretary to establish statewide goals. So what you're going to see is --
I'll go through the data, explain it a little bit, and then talk about the goal and really the goal was developed in conjunction with the three MCOs.
They were all asked and all provided their input as to what the statewide goal should be, and when we say statewide goal, you're going to see on some of these measures that some MCOs are already exceeding the goals and some MCOs are not. And so really we want the MCOs to focus on the areas that they need to improve. So just so you know, that's part of our thinking on that. So the first slide is on rebalancing and we can go --
great, thank you. So this is just a slightly different presentation of how it's usually presented to this group, usually in our database, we see it on a statewide bubble.

It's not broken down by MCOs.
Here we break it down by region and MCO. Each of our region has a very different percentage of the population who are being served in the community as opposed to the nursing facility.
So you can see here that the statewide average for the southwest is 60.4% as of December 2020.
When these goals were developed with the MCOs, we didn't have all of this data available to us at that point.
So for each of the rebalancing goals, it is -- what we asked was that the goal be a 4% increase over what the data was in September 2020. That's where the 62.6% came up with. You can see back in September, the number was 58.6. And on a statewide basis, we are seeing just shy of a 5% increase year over year. So we felt that the 4% increase was a reasonable goal for the southwest. And then, of course, you can see where each of the MCOs stand, the line at the top of UPMC, the greenish yellow line is CHW, and the blue line is Amerihealth and Keystone First.
Next slide, please. So again, here you can see the statewide breakout, both overall is 83.6, and where each of the MCOs stand. So you can see already in the southeast, we are serving a much larger percentage of the population in the community as opposed to the nursing facilities, and again, blue is Amerihealth, the green line is PHW, and purple is UPMC.
So the statewide goal in term of September 2021 will be 87.4%.
Next slide, please. Okay. And then again, same thing for phase three. We're looking at each of the 30 CHC MCOs. It will be to get to 67.7%. We're asking each of them to get to that number, not have a statewide average between the 3MCOs. We want each of the MCOs to try to get to that number. If the MCO is above it to maintain where they're at a minimum. Next slide, please.
So next slide.
So now, we are looking at the number of nursing home transitiontransitions by each MCO, and you can see the numbers that the MCOs have transitioned out of the nursing facility from the beginning of January all the way through November. You can see in March and April, it's not surprising that we see a drop-off of the number of participants who are being transitioned out of the nursing facility. And then see that number start to pop back up again in June and July and now maybe we might be seeing another little dip here in November. So overall, again, working with the MCOs, we came up with the goal of 300 transitions per year per MCO. So 900 total or approximately 25 transitions per month per MCO. Next slide. And then, of course, we want participants to be transitioned safely and making sure they have all their services in place when they leave the community and so we also wanted to look at the percentage of participants who remain in the community six months after transition. This slide is showing you how many participants by MCO returned to the nursing facility after six months of transitioning out. I will note for May, those participants -- and June, those participants really had not been in the community for a full six months yet. But it does give it for the first 4 or 5 months that they were in the community of how many participants were reinstitutionalized. The statewide average at the time we were developing these goals was 4.3%. And while we would like to see that, it's not realistic and thought the 4.3% per MCO was a reasonable goal. Next slide, please. So now, we are going to move into the LTSS measures.
These are measures that are submitted to MPQS by the MCOs.
So the data that we're sharing is for the southwest only for the time period of 2019. And the reason that we do that is because there is what's called a continuous enrollment period, and

basically, our participants would have been enrolled long enough in order to qualify for the measures. So at this time, we are looking at, again, just the southwest -- it would have been reported in 2020 for calendar year 2019. So we can go to the next slide, please.
And so on this slide, what you're looking at is comprehensive assessment and update. And sorry, I'm getting lost in my -- there we go. What this is looking at is did the MCO perform timely assessment and did it meet the components, the MCQA required for the measure? And then the supplementary measure has nine additional measures that MCQA says you need to look at these measures too. And so you can't meet the second measure if you don't meet the first measured goal. In other words, if you didn't meet the 12 components on the first measure, that personperson -- you couldn't have met the 12 and the nine. So that's what that is looking at on that measure. And so these are new measures for MCQA. At this point, they don't actually publish benchmarks data for these measures, because they are new. And so what they did instead was provided what they were calling preliminary data on the plans who had actually submitted these measures, and the number of plans who are submitting these measures across the nation are actually really pretty small. But still, nonetheless, it is some national data that we can look at and compare where are the MCOs at to the national data. And so really for all of these measures, we took the national information and for the comprehensive assessment measures, the national average was 77% and set our goal at 75%.
And then again, because you can't achieve the second one, if you don't achieve the first one. The goal for the supplementary one has to be lower, so we set that one at 74% for this particular measure. Next slide, please. So this measure is similar to the first one. It's looking at the plan care update.
It's looking at the number of members who had a comprehensive care plan and nine core elements documented within I think it's 120 days of enrollment for new members or annually for existing members. And then the same thing. The supplementary one looks at nine additional or 4 of 9ine supplemental additional elements to be able to meet that one. And again, we looked at what MCQA published pass preliminary national data, and the national average for both both of these measures was 73 on both of the measures. We set that as the goal for the DMQ.
Next slide. So the next slide is the reassessment and care plan update after communication discharge. This is looking at what is the person reassessed of that they had an in-patient stay t needs to be done within 30 days of the discharge. And then the second one is basically the same thing, looking at additional components as part of that measure. The national averages on this one were pretty low. 23% and 18%. So we did set higher than the national average goals, because our plans are -- we want them to stretch and get better and improve --
really improve this measure. So we did increase the national --
from what the national measure is on these two particular measures. Next slide. And then this final measure is did the MCO share the care plan with the participant's primary care PRAKPRAK -- practitioner? You can see that we had pretty low rates on this one. The national average was at 64%, but because we were pretty low and there's a little bit of work to do on this measure, we set the statewide goal at 50% per MCO. Next slide, please. All right. Now we will move into the cap HP data. And so this is the consumer assessment of health care provider and systems health plan survey which not to be confused, we'll also be looking at the HCBS cap on the next set of slides. This particular survey looks at participants' satisfaction with their health care over the last

six months, and it includes their experience with their primary care provider, any specialists they may see, and of course, their satisfaction with their health plan. Oh, sorry. Next slide.
So I do want to do a little bit of explaining on this slide.
You will see that each MCO has two bars and Amerihealth and Keystone First has four.
They're required to submit each of their organizations separately by MCQA. That's why they're broken out here as opposed to being combined on some of the other slides. But for each of the MCOs, we require them to conduct two surveys with different subpopulations. For the aligned bars, this includes anyone who is is a nondeal or anyone who is a dual but receives their Medicare through the same parent company as the CHC MCO. The other is all other dual who is receive their Medicare through another avenue such as a different Medicare advantage plan or fee for service. And we did this so that if there were any confusion as to which provider was their Medicaid provider or their Medicare provider, at least for the aligned group, we would know that participant was answering it for the same parent company as the CHC MCO. So you can see the top set of bars are the statewide numbers when you average out all four of the submissions. And the black bar represents the nonaligned. So the people who are getting their Medicare from someone other than the CHC MCO parent company. And again, the colored lines, they get both their Medicaid and Medicare through that parent company. You can see how each of the different MCOs falls and whether they're doing better with their aligned population or an aligned population and the goals that we set for the -- I don't think I'm allowed to share the actual MCQA benchmarks and what percentage these are, but these were based on MCQA benchmarks. So we're setting the goal of 79.5 and for the unaligned, stretching to 85.78%.
Next slide, please. Okay. Next slide. So this slide is looking at the home and community-based services cap, and this is really designed to look at home and community service benefit here.
It bears repeating. Long-term serviceservices support and covers topics like services, communication with providers and case managers, choice of service, medical transportation, personal safety, community inclusion, et cetera. So this particular measure is participant overall satisfaction which is a combination of several measures on the survey, and I think that that has been presented here before, but this is 2019 data broken out by MCO and I'm not going to speak to the racial breakdown, because that will be included in the MCO's individual presentation.
So they'll be speaking to that specifically. When we were working with the MCOs on developing a goal for the 2020 survey, was already well under way, and so the statewide goal of 84% will be -- for the survey will be conducted in 2021. Next slide, please. Okay. The last set of data slides are on employment, and this data is based off of our ops22 report which is the employment report that the MCOs submit to us on a monthly basis. Next slide, please. The first slide is looking at the number of participants who have employment as a goal on the person-centered service plan, and you'll see that it's normalized and what that simply means in nonstatus talk is we took the number of people who have employment as a goal and decide divided it by the MCOs overall population.
Per 1,000 members, this is how many people have employment as a goal on their person-centered service plan. We limited the population to the HCBS enrollees who are age 21-64, because that is who is being reported on the Ops report. So the goal is that the MCOs will each reach a hundred participants who have employment as a goal in the person-centered service

plan per thousand HCBS participants who are aged 21-64. Next slide, please. So this is the number of authorizations. Again, normalized based on the MCO's population. So per 1,000 participants, and the reason the goal is 100 here is that the Ops '22 report specifically states that, you know, if the person has it on a goal and begins suffers and employment within the next year. This is being if that's truly the case they're ready to work towards employment as a goal, then they should also have services authorized. So the goal here is the same as the goal for the number of participants who have employment as a goal on their person-centered service plan.
Next slide, please. So this number is looking at the number of participants who are employed. Again, based on --
this is how many participants who are employed per 1,000 HCBS participants. And the goal of 55 comes from a report from the employment first commission where basically the goal was for OLTL to increase our 2018 numbers by 200 participants, and so, looking at our population, that works out to be about 55 participants per 1,000 that we would like MCOs to try to get to. Next slide. And then the last one is looking at the participants who have kind of integrated employment and of course this number has to be lower than or lower or equal to the number of participants who are employed on the previous slide. So we have heard from the MCOs there have been some challenges in being able to confirm whether or not it's competitive integrated employment. So the numbers look a little bit low here, but it's our understanding that systems are being put in place to be able to start to capture that information more effectively.
So that's why you'll see the statewide goal of 40. And I believe that is my last slide.
Next. Any questions?
>> Do any committee members have questions? No? Of course. I have a few from the audience. The first is is the goal for rebalancing for [not audible]
rather than statewide?
>> ABIGAIL: Yes. Those goals are region specific with, you know, that ultimately translating to an increase overoverall on a statewide level.
>> Okay. The next one is from Pam hower. You can give a definition of the LTSS in the community. Are you counting assisted living in the community?
>> ABIGAIL: Are you able to help me out on that one, Ellie?
>> Sure. This is Jamie. So Pam, are you asking if assisted living facilities are included in LTS specific services or home and community-based services? I guess I need some clarification on your question.
>> Yes. I think her question is when you're doing the count of the transition, are you saying assisted living facility is a community location like someone living in an independent apartment or in their home, or is this counted as not being in the community? Which I think was part of the national nursing of transition definition.
>> So transitions -- I guess, you know, I'm troubling which side she's asking for the count to be on. So transitions from assisted living into their own apartments?
>> [Not audible] someone from a nursing facility into a community setting. Is that community setting include the facility? Or is it just an independent apartment or home?
>> Okay. I'm sorry.
>> So an example -- okay.

>> Yeah. So I think typically, it would not include an assisted living residence.
>> Okay. The next question is from Brendan dare in regards to the nursing transitionidate amp it's also important we see data representation of those who are found ineligible for transition and why they were found ineligible. I don't know, Abby, if that's data that's collected on Ops '22.
>> ABIGAIL: So we do collect participants who are pending transition, and for example, what their barriers are. We do collect information on those participants who opt to continue the nursing home transition process prior to being discharged. That would be the data element that we would have available.
>> Okay. So I think Brenda's suggestion, then, is that you would capture those that are determined not to be eligible.
The next question is from Janice minor. Is there a measure for capturing the number and percentage of CHC participants who receive a copy of their person-centered service plan?
ABC
>> ABIGAIL: We do not collect that data. I don't know if the MCOs can speak to that, but we do not collect that in whichation.
>> Okay. And then employment data question. In reference to employment, is it full-time or part-time?
>> ABIGAIL: So we ask them to report on the number of hours that their employees for. I'm trying to think here. So they would report both of those.
>> Okay. It would be both full-time and part-time?
>> ABIGAIL: Uh-huh.
>> Okay. Then another employment question from Kelly Barrett. Employment is a goal for participants -- actually, I will save this for the MCO section. It's really what are the MCOs doing.
>> I have a question. Do the consumer care plans get uploaded into the health information exchange?
>> Not that I'm aware of. I again would let the MCOs speak to that.
>> In the physician's office, we obviously have a copy of it, because the physician's office in most cases belongs to the HIE.
>> Abby, are you still there?
>> ABIGAIL: Yeah, I'm here.
>> Okay.
>> ABIGAIL: I'm sorry. Was there a question?
>> David, was there a question.
Or were you making a comment?
>> I'm not sure if you were referencing me. I had no question or comment.
>> Okay. All right. We had a question from -- and I'm thinking we probably need to move o can you explain HCBS satisfaction goals are higher for aligned versus nonaligned plans? Wouldn't you expect satisfaction to be higher where a plans are aligned?
>> Yeah. We absolutely would expect. We did see for 1MCO that it is higher for the aligned population, but that didn't hold true in the other cases. I think that probably is something that the MCOs would be able to speak to.
>> And you know, for Jessica pointing out, for the groups, for all of our duals, we don't know who they're answering the question about, whether it's the Medicaid or Medicare. So there is

still some ambiguity in the measure because they technically might be answering about the parent company, but it might be their Medicare product. There still is a little bit of ambiguity in the data, but you know, in terms of getting the best sense of how the CHCMC OVPTs are able to do.
>> This is David Johnson. It's interesting to it's not inn common for an alliance. Not have a clear misunderstanding of who is the Medicare provider and prefer to a small company and their insurance provider. I know there are certainly benefits like the call centers can communicate with one another and pull records as to when they call the CHC MCO versus the D snip. Medicare provider might spill over into their opinions of the Medicaid plan as well.
If there's an opportunity to drill down deeper and combine to help clarify on the Medicare or Medicaid program, that will be helpful.
>> Okay.
>> I guess and Abby, I'll do one last comment from Brenda and then a question. Related to that. People found ineligible for the system don't have the right to appeal. This being nursing in transition. We need to know how many people in facilities don't have a way out and then a question related to that is from Connie regarding who makes that decision.
>> ABIGAIL: I'm sorry. I nISZ missed part of it. Make which decision?
>> Who makes the decision that someone can't be transitioned from a nursing facility.
>> This is Randy. It's a decision that is made with the MCO seen working with the participant and their family and nursing facility to determine whether it can be a state discharge back to the community.
Some people may say they want to go back to the community living, and we understand that. But sometimes there's not a safe option for them to go back.
They have no namly, no house --
family or housing at this point in time. It may be determined based on that discussion that it would not be a safe discharge.
>> Okay. All right. So I guess I know we're over time. Linda, do you want to move on to racial disparity?
>> CHAIR: Sure. [Not audible].
>> Good morning, all. Thanks, Pat.
>> Sure.
>> So good morning, everyone.
My name is mike Wilkinson the division if of compliance within the bureau of integrated services within OLTL. I'm going to moderate and kick off a majority of this timeslot is dedicated to the MCOs to present some information and data to the committee and to the audience relative to racial equity and racial disparity. Before we move into the actual racial disparity data from CHC MCO, I want to our commitment to racial equity. It's committed to addressing racial equities that exist in the program we operate including the CHC programs and promoting diversity, equity and inclusion. Hopefully you're aware that DHS released a report that's available on the DHS website and shared on OLTL's liserves on the day it was released. We'll add it on the list serve. It's an important document that gives an overview of DHS's work throughout Pennsylvania in the areas of health equity, childhood justice, early child hed education, child welfare and human service. As part of racial justice, OLTL is committed to doing its parts where

racial inequity is found.
We collect data to measure possible racial disparities in the program. Today, we'll present some of that data to you, and we're actively looking for opportunities to present shall racial disparity or inequity in future MLTSS meetings. We'll ask each MCO to speak to the data we have and all the work they found around racial disparity. I wanted to raise some points before we kick off. Fact checking, I want to get us over to the MCOs so we can get started. Whether it's Pat or Meredith, I'd like to key up PA health and wellness and turn the microphone over to Anna key to present on those matters.
>> Are you guys able to hear me?
>> Yes.
>> Okay. Good. I'll be presenting for Pennsylvania Health and Wellness today. So good morning, everyone. My name is [Name]. I'm the director of program and strategies involving health and wellness.
Over the next few minutes, I'll talk about some of the things that Pennsylvania Health and Wellness is doing to address racial disparity. Next slide, please. So racial disparity begins at the leadership level including our planned presidency of Justin Davis. Pennsylvania Health and Wellness has implemented a division tool weekly. We offer an unconscious bias training that explores and evaluates multiple strategy to combat bias in the workplace.
In addition, we participate in what is called courageous conversation which is conversation that is faith-based work that people can listen to the current state of events in the current world today. And in addition, we have multiple trainings on topics such as equality and trauma and we go to our talents to ensure opportunities for all of our employees to grow at Pennsylvania Health and Wellness. For those who are not familiar, the national committee for quality assurance that offers distinction in multicultural health care.
That's a set of standards that evaluates how a plan collects race and ethnicity data, provides language assistance, our cultural responsiveness, the quality improvement or cultural and linguistics appropriate services and how we reduce the health care disparities.
Typically, this is sometimes just to check the box of certain organizations. Pennsylvania Health and Wellness is raising awareness through the organization by identifying things that may cause ununconscious bias behaviors. So about Pennsylvania Health and Wellness MANZ to get our station in '22. It takes time to document all the great things we're doing. So over the next few slides, I'll talk about our demographics. So the next slide let us us look at our home and community-based relation. We see that looking at all plans for PHW and in the zone's perspective, you can see that our top are African American and white and from an ethnic perspective, it's non-Hispanic.
Looking at these long-term care, on the next slide, you'll notice that the majority of our population is white and from a ethnicity perspective, the majority is non-Hispanic. Next slide. Now we'll be looking at this from a nursing home transitions perspective. A correlation to the population that you see on the next slide, you'll be able to see that we have a -- there. We had transitioned the majority of white and non-Hispanics. Next slide. So Abby touched on this a little bit during her presentation for the catch survey. The catch survey is a tool that is used to collect standardized inform ailing on patient both the participant's experience with health plan and the services and the providers.

So next slide, please. And Abby has indicated, it's between the two populations where the alliance is going to be participant who is have both PHW Medicaid and Medicare plan, nonaligned where they had PHW but not Medicare and looking at those two, you can see that from our alliance perspective, we did very well and performed well than we did on our nonaligned.
That's something we'll be revealing. Next slide. So when we take it down from a race and ethnicity perspective, what you see is that we have on our unaligned, the agent actually rated population rated as highest overall. We have a very low population. Then we look at the aligned, we see that participants who are categorized as white rated as the highest.
Next slide. So the other survey we participate in it the home community based survey. That measures the participant's experience with the medical home and community-based services portion, the provided by our providers. The next slide, you take a look at the overall satisfaction. You see that the American Indians rated highest.
And on the next slide, you'll see from ethnicity perspectives that the non-Hispanics rated us highest as far as overall plan satisfaction. Next slide, he's.
Okay. So then we'll talk a little bit about how we look at employment. So next slide. So we are looking at impact with employment. We impact based off of this slide the white and Black population the most. Next slide. Then when you look at it PR from an ethnicity perspective, we align with our population, have a stronger impact than non-Hispanics. Next slide. Okay. So some of the tools that we use when performing our service coordination includes various tools that allow us to make sure that in the vicinities, we make a plan with the participants.
Identify cares based off of our related disparities and see from our tool to specifically that question of a cultural consideration, do you have cultural needs or concerns that may be respectful that we may be respectful of to make this assessment more appropriate for you. Those are things we definitely make sure we take into consideration when developing care plans. Next slide. Okay. So I just want to talk a little bit about our marketing efforts. PHW ensures our advertising represents the population we serve by working with database inside marketing companies to make sure that what we provide is representative of the community as far as the design and the initiative we present and also demographics information in placing ads in local publications. We definitely try to work with and seek out local community partners that we trust to be able to help develop communities and then lastly, we use data for care management outreach to focus on key diagnoses that are recognized as having racial disparities as outcomes to treatment. Some of those is hypertension and heart failure.
Next slide. Thank you. So I just want to talk about targettargeting -- target with impact with racial disparities partner is key in partnering. So some of the things we have done is extend this at the aging center.
We sponsored a float at the June street parade, and we also participated in the Thanksgiving resource fair with the urban league. Next slide. Okay. And then lastly, for our participants advisory council, you can see the makeup of the participants who participate or serve on the council by zone.
You can see that we have a high population, which again, is based off of our current population, high in Caucasian and right behind that, you see the African American population is all who serve in the committee. I want to thank you guys for allowing me to talk a little bit about some

of the things that Pennsylvania Health and Wellness does for disparities and I'll pause here for any questions.
>> Thanks. If we are comfortable with this, I think Adam, if you're okay, we'll just hold the questions to the MCOs until we get through the three presentations because we're running behind schedule.
>> There's one question about a slide to make sure that PHW's --
in the slide, you referred to as long term care. Does that mean that it's data on the institutional care versus the earlier slide on home and community-based?
>> Yes. That's correct.
>> Okay. Thank you.
>> All right.
>> Yep.
>> Thank you very much. And so we'll cue up -- it looks like we have Amerihealth Caritas on deck.
>> Good morning. Can you hear me? Are you able to hear me?
>> Yes.
>> We can.
>> Okay, great. Thank you, guys and thank you for inviting me to speak. Just a moment of introductions first before we dive into the slides. A little background about our health equity approach for Amerihealth CHC other than known as community HealthChoices. My name is Danielle Brooks. I'm the director of health equity for Amerihealth car care Caritas. From a global standpoint for all of the health plans that we serve which represent around nine states and territories. My background really is understanding the internal and external needs of communities as well as providers and associates.
Before I dive into the review, I wanted to give a little background [not audible] we had been really focused on equity for [not audible] and we used principles as a really great way to really couch some of our health equity work. In that space, we had the formalized class committee and program for our community HealthChoices program which is an interdependental committee that foal focuses on the health equity needs with the department. Member engagement, community outreach, education, communication. So on and so forth. In addition to that, we also take a very strong look and use of our data and analytical tools to understand the communities we serve. We collect and stratify racial and ethnic data and also measure some other outcomes measures on a quarterly basis with an annual review to make sure that we are keeping on track and understandingunderstanding not only the health equity considerations that are experienced for our membership but also are able to look and solve around that. In addition to that, our organization has a lot of specified training that we provide for our staff. In order to basically make sure that our health equity considerings are at the forefront. From our perspective, all new hires have to go through mandatory health equity training, and then we have an annual updated training.
In addition to that, we serve and create a health equity council which is an organization that provides really pointed and specific conversations about --
with external leaders in areas that cover everything from vaccination strategies for COVID, LGBTQ health care, health care for specific demographics, racial and other bias and racial

discrimination issues. And then we follow that up with similar to the previous presenter created conversations where we have small group opportunities to discuss and learn further.
Also I'd add that we had the new verseversical specifically for equity, diversity and inclusion spearheaded from Carol Dale that I serve from her that has five main pillars that is work force and leadership diversity, really making sure that we improve and look the at diversity of our system across all levels of the organization not only in the short term but the long term.
We look at dULT and you are continuous learning that.
That encapsulated some of the equity training to make sure we're building an inclusive culture and supporting the mechanisms to reinforce it. The health equity has discussed and learning opportunities, strong and serious consideration is taken to the procurement to make sure we stand up and strengthen our commitment to the diversifiers to increase economic security in the communities we serve, health equity which is the space I represent, making sure we address the social determinants of life, health, education, economic improvement, access to food and housing and et cetera is look the at the interplay of systemic inequalities like racism and other bias and xenophobic issues that contribute to less health and less healthy lives for our members.
And then also we also are very strong in our strategic collaboration when looking at always expanding our outreach, to amplify a message both broad strategic partnership and advocacy to address policy to promote diversity, equity, and inclusion. I wanted to provide a little bit of that background.
And then finally, we pick our equity considerations very seriously, and we're also stood up training and opportunities to educate not only our providers but also support our members and other diverse groups whether it's to facility or LGBTQ sexual orientation and gender minorities and so on and so forth.
I wanted to give that background about our health equity approach. It's looking externally and internally about how we can support our communities and work and grow as anned vOicate and voice for them. Before I dive into this presentation, I wanted to say this is going to be a group presentation where several of my colleagues from the plan will help support some of the information that I'm providing today. Okay. With that, can you please go to the next slide to discuss the demographic outreach. Okay. So similar to the last presentation, we again collect racial ethnic and linguistics data on all of our members to make sure we serve them in the best ways possible.
As shown on this slide, we do have the diversity within our regions by race, the southwest region is our most diverse racial region with 29% or so African Americans served and 51% Caucasian. And then statewide, we serve around 40% African Americans, 37% Caucasian and 9% Asian, and then other demographics, around seven LRS.
We also and support our ethnic diversity as well. As you can see around statewide, we represent or rather support around 11% or 12% Hispanic population. Again, in our phase three region is around 19% is our largest. Next slide, please. Looking at the LTC demographics, next slide, please, again, looking at our LTC demographics, very similar to theidate a present -- data I presented in the previous slide, with the more diverse arounds around 32% African American or Black and just notate we do collect not only the demographic category of Black and African American because we are always understanding and supporting the ethnic sub ethnicities underneath a particular category. That could be Black and also mean Haitian, Jamaican and so

forth and also with our Asian ethnic categories.
Looking at the data present, we have a pretty consistent spread of non-Hispanic participants across our regions. Next slide, please. Okay. Next slide, please. This is our nursing home transition. Again, stratified by race and ethnicity. Again, we collect ethnicity between Hispanic and non-Hispanic categories and based on this data, again, the majority of these populations around 2% to 5% of Hispanic populations. Looking at again at the number of or ethnicity total, again, around 175 are non-Hispanic, three non-Hispanic. In the unknown category, that represents individuals that do not want to report themselves or racial --
their racial or ethnic information. We use a process where we collect state data and also this self-reported data.
Whenever we interact with our members or our participants rather, we do ask them to provide self-reported information, because it typically is more dynamic than state-reported information. Any time you are in the unknown category, that's something that defined state, they get an optional request or it is in a category where it's multiethnic.
Then we do have that data in specificity. For a rollup for this presentation, that's how it's categorized. Then looking at the number by race, we have around 117 white, seven unknown, other, nine. One Native American -- sorry, native Hawaiian or FTH other Pacific Islander. And next slide.
Okay. So we do our cap survey again. We stratify by this race and ethnicity to understand and respond to the needs of our demographic communities. As you can see here, for our statewide, we have our nonaligned and aligned categories. Again, it looks around to be a little less than 90% not aligned and then a little less than 82% not aligned. Next slide, please.
[9%]
Looking at the overall planned status satisfaction, blue is aligned with satisfaction scores. Black represents nonaligned. As you can see, we look at our reporting, we see that our African American white participants are aligned satisfaction. Our Asian participants have less alignment with the satisfaction. Our Native American Indian are also within the same distributions.
White, Black/African American participants. Next slide, please. Okay. Again, looking over the specific data, it's similarly in term of nonalignment. African Americans and our white participants are also aligned and unaligned in similar fashion. Our Asian and Pacific Islander participants have a less alignment. Again, our members are skewed a little bit because of female. We serve a majority of Caucasian white population and the next demographic is African American.
Again there's a little more of this alignment and nonalignment.
Our Native American is consistent with the percentages breakdown between African American, white, and Asian and less alignment again, keeping in scope the percentages of the demographic breakdown. Next slide, please. Okay. Next slide. Okay. Again, this gives a breakdown of our scores, again, broken down by race, African American, white, caw Kaying, pacific islanders and African American and other.
There's a consistent African of African Americans and white and less satisfaction for Asian participants, consistent for American Indian and other.
Again, keeping the scope of the participants base in line. Next slide. This is a breakdown by our satisfaction scores by ethnicity. Again, there is similar alignment across-the-board with our non-Hispanic and Hispanic participants, and within that deviation of the state satisfaction rate by

ethnicity.
Next slide. And our employment categories. Again, this is a breakdown of the goal and employed. As we can see here, our African American/Black hovers around 50% to 60%. Our white again, is -- within the same deviation of the space in the percentage points of their percentage of alignment compared to our goals and our achievements. I'm not sure if Missy would like to speak to these slides a little bit more.
I'm happy to continue with this presentation. Missy. Okay. If not, I can go to the next slide.
>> I'm sorry, Danielle. Are you able to hear me?
>> I can hear you. I didn't know if you wanted to talk a little bit about these employment goals. I'm happy to -- yeah.
>> Thank you, Danielle. We are working with our employment coordinator to get more information out to our participants and be able to work on our employment goals more as part of our person-centered plan. That's a goal for 2021.
>> Thank you, missy. Next slide. Then again, this is our breakdown by ethnicity and Hispanic and non-Hispanic. Non-Hispanic, we are 85% to 92% of our goal. We have -- I'm sorry. Enrollment is 92%. And so this space provides a little bit of the deviation between our ethnic breakdown and employment roll. We have a smaller Hispanic population, and of that, you know, 14% of our enrollments of our enumerators have employment access as well as 7.3% to our goal. Next slide. Next slide. Or is that --
>> I believe that is the end of the analysis.
>> Thank you so much. And I'll pause for the discuss for any questions. Thanks, guys.
>> Again, a clarifying question.
When you talk about the long-term care demographics slide, is that just nursing facilities? Or is it just home based or both populations?
>> Similar to the past, those are those that are facility based.
>> Okay. Thank you.
>> Thank you very much. And certainly last but not least, UPMC.
>> Hello. This is Katherine Connor. Can you hear me?
>> I can.
>> Okay. Next slide. From the director of analytics the UPMC, and I want to jump right into the data given our time and as we go, we'll talk a little bit about our other initiatives that are surrounding race and ethnicity. My first comment is that our HCBS, racial and ecnick makeup reflects the area that we serve. And in addition to that, our service coordination staff reflects the diversity of the regions they serve. We meet or exceed the level of diversity in each region. So the majority of our participants do live in the west, and that means that our diversity is going to look a little different than the statewide diversity. That mean that we tend to be slightly more Caucasian and have fewer Hispanics than some of the other plans. Next slide. Next slide, please. So the long-term care population, AKA nursing facilities population once again, the ethnic makeup is those we serve and typically diversity of a nursing facility in those regions. There are cultural differences in the desirability of living in a nursing facility. So we do see differences in the percentage just overall. You can see that if you look at the statewide Black and African Americans are only 12.2% statewide. In the southwest, we have the 9.1%.
And all UPSC is 10.8%. But there are racial differences, and we are the most diverse in the

southeast. In this population. Next slide. Okay.
Next slide again. So while African Americans and Blacks only make up 11% of our population, make up almost 27% of our nursing home transitions.
This has been a population in the nursing facilities -- it's comparatively small, and so we've had very few nursing home transitiontransitions to date for the Hispanic ponpopulationnpopulation, but we're planning to increase the number of transitions and we're ramping in the centric state and we believe those numbers will rise. Next slide. Next slide again. So we are very pleased with our health can plan scores and HCBS scores. It shows the effort we are putting into managing our HCSC population.
We is provide seamless experience for them, and we are working to improve that on our unaligned populations as well.
So we believe that the survey results indicate that we're doing a good job here. But we can always improve, and so on the next slide, we'll talk more about that. Okay. So when we look at the overall health plan satisfaction broken down by race, we see that satisfaction is lower among the Black population for the unaligned CHC group and lower for theinatin American population for the aligned group. I'll -- suggest the Native American population is relatively small, actually very very small. So it's hard to say that that's representative of all Native Americans. We had a member experience team that reviews the results in multiple ways to see how we can customize our approaches and increase satisfaction for our targeted groups. And we think that overall, that we're doing quite well, but we're also trying to make it even better. So in this -- also in this sample, I'm going to say in addition to Native Americans being a small subsection, you can see in similar situation in our Hispanic with very small as well. So amongst our aligned members, the Hispanic populationspopulations did score .3 better than average, and our African American population reported about .12 lower than the average. Within our unaligned population, our African American population had 117 respondents and reported about .25 lower than the average. So we're going to continue monitoring our satisfaction amongst minority groups and try to improve those in the coming year. Next slide.
So to continue to improve our scores in terms of participant overall satisfaction by rates.
We're communicating our survey results to providers and encouraging them to take innovative action to improve how they communicate and show respect to the members and are culturally competent. We're continually assessing and revisiting our plan requirements and processes that will impact process to care and treatments.
We're seeking opportunities from our partners and members to improve our processes and procedures. We also sought specifically good opportunities to provide an update on our MCQA health care distinction plan.
We're working on that this year.
It will cover not only CHC but cover our Medicaid plan as well.
We are adding customized questions surrounding the members' experience, and examples of these custom questions include topics related to language and culturally including race, ethnicity, or background, in conjunction, there will be additional race, ethnicity analyses on each matter to identify any responses. From there, the analyses will be input into our multicultural health care committee that will manage it to clarify any disparities and evaluate how MCH health plan can help our members and ensure the highest level of overall plan satisfaction while

working towards limiting barriers that affect our multicultural population. It's also added the CHC populations to a new dashboard for surveillance to allow us to drill down by disparities gaps by race, geoof graic location, urban versus rural and we've added race and ethnicity to other social determinants to all of our dashboards to to allow us to regularly monitor and input into our intervention plan. We have a comprehensive strategy for analyzing this going forward and anticipate that we'll be able to improve our scores with with these interventions. Next slide. So once again, we can see that our Hispanic respondents reported being slightlyslightly low are. I'll Meng again this was a very small sample. Hopefully in the next year we'll have a slightly higher sample and be able to see if there's been any improvement.
Thank you. Next slide.
Unemployment. You can see in 2020, added goals after employment counseling is complete. That's different from the other MCOs, and we have changed that since then. It does affect the number of goals that you see in here, and explains why there were only 57.
A lot of people are waiting to go through employment counseling. So we have shifted this definition to be matched the other MCOs. And in addition, we're implementing the new employment concierge service to keep our members engaged in the employment exploration process. Of our participants with an employment goal, post employment counseling, 43% are Black or African American participants. But only 6.5% identify as Black or African Americans. We believe this concierge program will be able to narrow this gap. We have improved resource guides to provide additional local resources to support these goals and our service coordinators. Next slide. In 2020, our employment among Hispanics was 1.5% of our employ. We have implemented a process that we believe will improve our barriers to employment and address them in a more effective way. Did you have anything you wanted to add on to this, Mike?
>> I think we can add your slides at the end.
>> Oh, okay. Yeah. I can go on to the next slide, then. Okay.
So I want to let you guys know that we feel very passionately about making sure that there's equitable access and equitable outcomes in health care. We are doing a lot of work behind-the-scenes to make that true. And what we do at the very beginning of all of this is we take the data that we receive from the state and add on to it.
We're getting information from electronic records and selfself-report self-assessments to better understand how our participants identify with race and ethnicity. We use that information and we're doing additional research to help understand what's going on in terms of pressing concerns of the day. So for now, I'm going to talk about two of them. We have other things as well we can get into. On COVID-19, we've been looking at the positive rate and COVID-related death statistics and looked at our vaccine data efforts and backup plan updates and vaccination assessments, and participant outreach and for all of these, we're considering whether or not we're doing our the best we can in terms of treating and getting out to each group. We've been look at our nursing facilities, and unfortunately, we're finding that minorities are more likely more quality facilities they're our white participants and exploring interventions with the facilities at the lower end of the spectrum to improve outcomes. So we've been doing all of that as well as the social justice series to make sure that our staff are able to learn and be more responsive to the concerns of our community, and that given an opportunity for Mike and crystal to jump in here with additional things from the clinical perspective.

>> Yeah. This is Mike Smith.
Can you hear me?
>> Yes.
>> Oh, great. Katherine, thanks for presenting all of this. I just want to Meng a couple of things that we do within service coordination. It is part of our data check and approach to match and work with participants around their cultural concerns and issues that they want, very similar to what CHW has presented as well as how Amerihealth does it as well within their person-centered planning process. To take cultural and ethic considerations into consideration when developing plan and be respectful of those cultures. We also, you know, in that multicultural committee that Katherine spoke of regarding our distinction process or MCQA distinction process, it's going to be really helpful for us as we move forward to identify those areas of opportunity and help us monitor and evaluate how we're doing to make changes as necessary. So we are doing all the things that Katherine stated as well as, you know, I'm excited about the fact that we're doing -- we're basically hiring and working with staff, developing staff that are representative of communities that we serve. So I just wanted to add that to the comments.
>> Hi. This is crystal from UPMC. And thank you to my colleaguecolleagues that gave us this great outline of our data and our previous speakers. The only thing I'd like to add is as many of the previous speakers have said, you know, a quality and access doesn't necessarily guarantee equity and outcome.
So as we look at this data, we also have to discover interventions that will help close some of these gaps and reach some of these goals. So as we develop our internal team's understanding of the impact of race and ethnicity and social justice on some of the things that our participants face, you know, it allows them to help discover and plan interventions that will help all our participants reach higher performance goals and close gaps, specifically, we have been look at race and ethnicity data for years, as many of you have, and we've had a robust diversity and inclusion program for staff measuring promotion, monitor all that very carefully. But after the loss of George Floyd last year, our CEO Diane holder kicked off a town hall across the entire organization, with the clear message that, you know, we need to focus on social justice and equity. And out of that, additional efforts were formed a diversity and inclusion committee that is aimed at social justice that has representation from across the entire state, and many, many of our cost centers and those individuals are all levels of the organization it's employee driven, not just leadership led.
They also are breaking up into focus groups to help us understand challenges that are more community based, like what are some of the real barriers and how do we really talk to them about some of the concerns around COVID vaccination, for example. So in addition to understanding the data, we're improving the staff understanding and leadership's understanding of why diversity and inclusion is important, how making people understand what racism is, what impact it has on health, and how we have to understand that to really close gaps that are occur not just from individual acts of racism but some things that are built in systemically that will continue on auto pilot without anybody doing anything unless we change that trajectory. So just wanted to add those two things.
>> Okay. Anything else from the UPMC team? Okay. Hearing none, pat, any questions specific to the UPMC team?

>> No, Mike.
>> Okay. I think that wraps up this portion of the agenda.
Unless there's some general questions before we move into the next agenda item.
>> I do have some questions from the general audience. Let me see, Linda, are there any questions from committee members?
>> None that have been given to me. This is Luba.
>> Okay.
>> Okay. I am the UPMC spoke to this a little bit, and quickly, so we can circle back from some of these outstanding questions.
So UPMC talked about what they were seeing related to disparities in the nursing facilities. So if the other MCOs could speak to that and a second part of that question is what are you seeing disparities, particularly in nursing facilities and also in the overall population with receiving the vaccine? And it may be a little early for nonnurse populationsment are you seeing any racial and ethnic disparities around that area?
And UPMC, do you want to answer the question related to the vaccine at this point?
>> I can attempt to do that.
And then I'll ask my colleagues on the line to jump in. But we've been monitoring this pretty closely. And really the vaccine distribution and administration has been a real challenge for us because of the data collection and how it's being developed or rolling out across the state. Our visibility and actually RATH KatherineKatherine might have been better to answer the question. The data is limited. We made the decision the other day that we're going to -- even with the nursing facilities is part of our general work with the facilities and look for and get correct data to vaccinations from the facilities. To do just what you're saying, to look for that difference in diversity in what's happening in the facilities. And yes, it is too early in the community-based side as well, but we've already developed our questionnaires and our ability to capture that information for our own understanding of how it's impacting, you know, our participants that are Black, Hispanic, and the minority, and make sure that we're not seeing, you know, disparity in the delivery of vaccines for that population. So right now, not a lot of visibility into it. But more to come. Hopefully as we get some clarity on the data points that are coming in and also just the, you know, really to provide a very high-level for folks on the call, is we need to work closely with, and we have reached out to every single D snip to understand their processes, because they're going to be also involved in sort of communicating the information around vac rein and vaccination.
We're in the process of developing this relationship and the sort of fortunate/unfortunate side of this, there's not a lot of vaccine in the field right now.
So we don't have a lot of data to collect. We're behind the eight ball in terms of getting a vaccine out in terms of the country. Thanks.
>> We have the team lead with our director and we're developing more robust communications and we plan to provide it to our participants.
Especially to early, but we are trying to come up with some methods to collect data at this time. And I got lost in the first question.
>> Yes. So the first part of the question, Malik, was what is your MCO doing to evaluate racial and ethnic pits tarities in the CHC population, specifically, participants in the nursing facilities

and then what you're doing in response to what you're seeing?
>> The response is to be able to gain some data. We can't put and follow up with our nursing home transition team. At this point we're trying to collect the data to see what, if any, disparities there are. At this point, we have our chief medical director who is charged and based off of the information that's come in to put some interventions in place.
>> Okay. And then for Amerihealth, the first part of the question is what are you evaluating to evaluate the racial and ethnic disparity, the impact of COVID-19, specifically in nursing facilities and the vast variation of that related to the vaccine.
>> Thanks for the question. As far as the evaluation of the ability of the vaccine within the community and within the nursing facility, the other 2MCOs have pointed out, the data we have on that is limited, but it is something that we're looking into, and especially within the vaccine and the community, we're seeing the same difficulties with the availability to the public at this time. So limited data on the vaccine distribution. We're also integrating information about the vaccine into all communication outreach activities. So we will be -- we are developing that as the other two MCOs are doing. As far as any diversity within the nursing facility population, with the vaccine, we're seeing a primarily the majority of our nursing facility participants are caw Caucasian and we'll be looking and drilling down to make sure we're not having any racial disparity within the populations as far as the distribution of the vaccine is concerned.
>> Great. Thank you. If there's no other questions from committee members, we can circle back to some of the outstanding questions starting with what we received on the dental side.
It's a combination between the department and the MCOs. So I think to start with, and this may be something that OLTL may provide need to provide some input on relates to what services require a benefit limit exception? And what services are not covered on the MAC schedule? Jill, I don't know if you or Jamie could speak to that.
>> Pat, I missed the first part of the question. I heard the benefit limit exception. Are they talking about what specific type of services, specifically dental services?
>> Yes. Specifically dental.
What would be something that would be a BLA?
>> So I need to refer to the dental handbook again. As I recall, any -- the first dentures are covered. Any additional dentures a person would need would require a BLE, I believe, from my recollection.
Other services that would require BLE is if you needed more frequent cleanings than was provided as part of the dental benefit, and I believe crowns are a dental benefit limit exception. This is from memory.
Im happy to send out the dental hand -- the fee for service dental handbook. I think that's what was being asked in the question. Each CHC MCO would have policies regarding this as well.
>> Right. That's a great transition. We'll turn to the MCOs then, if you can speak to your BLE process and any unique aspects to that. At this point, we'll start with UPMC the last time. So with Amerihealth.
>>nd I'm not sure, Dan, Chris, who would be able to speak to this.
>> This is Missy. I don't know that we have the right representation on the phone to be able to answer this question right now. It's something we could get back to this group.
>> Lubo, Jamie.

>> Thank Missy. How about for PHW.
>> Hey, Pat, it's Anna. Can you hear me?
>> Yeah.
>> Okay. So I would likely a couple of things. Our BLE exceptions are pretty much standard across Medicaid, but if participants have specific questions about it, they can refer to their participant handbook for PHW if they're a PHW member and/or contact our participant services at our 844-626-6813 number. One of the sections of the handbook also says that if a person doesn't know, they can contact their dentist and their dentist can also give them information about BLE that they're familiar with from the Medicaid program. A few resources to go find that information, but definitely contact the health plan, and they can pull it up, and also give providers that offer dental services.
>> Okay. And then for UPMC, I'm not sure who would be able to speak to that. -- speak to this question.
>> It's [Name] from UPMC. Our benefit limit is very similar to what Anna just said.
Participant can contact our team to request information on obtaining a benefit exception based on medical necessity of whatever the service is that is needed. The members can also contact member services if they are also asking questions about getting a benefit exception, although it usually does go in to the provider's name, whenever they need a benefit exception.
Member services can definitely help coordinate something for the member if needed.
>> [Not audible].
>> Okay. And I will post a copy of the fee for service schedule which outlines when a BLE is required. We'll put that in a post for folks who want to reference that. That helps provide some of the information around what is on the fee for service side. Then I think the next group of questions are interrelated for the MCOs. Is accessing dental care any different for residents of nursing facilities who are seeking treatment and having expense used as an other medical expense? And how does your plan provide dental services to nursing facility residents to ensure their dental health needs are met? And Anna, I think we'll start with you on this.
It's really general. How are your nursing facility residents receiving dental services? And what is the covered benefit whether it's covered as an OMD?
>> It's whatever the fee schedule says and how our handbook defines it.
Individuals getting dental services in the nursing facilities have had a bit easier access to doing that, because there are a lot of dentists that are willing to go into the nursing facilities and provide that support to participants through visitation. So I can get more information on that, Pat, but at this time, it wouldn't be any different than an individual who lives in the community?
>> Okay. How about for UPMC?
Andrea, is that one that you can answer?
>> Yeah. This is Andrea. The facilities do have dental benefits. There would be a primary benefit if they had Medicare and there was a Medicare benefit, this should be thought out first and then the CAC benefit would kick in as the secondary benefit unless there's full CHC. Then they would be able to ask their dental benefits. Our preference is a participating dentist that goes into the facility and then deals with the health plan directly thus using the member's benefits. The only time we would really expect them to use OME is if the dentist is not a Medicaid-participating provider.

And we have in the past asked our nursing facilities to let us know [not audible] and try to recruit them to becoming a participating dentist with us.
Our ultimate goal is to have the deathdeath -- dental benefits being submitsubmitted directly, but again, it's how fee for services. If a dentist is not a Medicaid dentist, because there are some of those, then they can use their OME. And then there's also the third party assisted out there. We are not receiving any claims from them. They do not submit claims. All we would see is the possible premium, insurance premium that would come over on the nursing facility claim. But it would be bundled in to OME. And we would only see that on an audit. We are trying to identify that within the nursing facilities also.
>> Okay. Thank you, Andrea.
And then turning back to Amerihealth. Missy, I don't know if you can speak to this.
I know [not audible] is on and being asked to be unmuted regarding the BLE.
>> Hi. This is Chris. I can speak to the OME and dental services in the nursing facility.
facility. We follow feedback processes and preference would be to utilize our in-network dentistsdentists for those services, but they would be able to do the billing through the OME process and use that same process that you would explore with UPMC would be in in place of Amerihealth and community HealthChoices.
>> Okay. Thanks, Chris.
>> Hello. Can you hear me?
>> Yes.
>> Yes. It's Jeff [Name].
Can you hear me okay?
>> Yes.
>> I'm terribly sorry. I had a lot of trouble getting unmuted.
If I could circle back for a second. Amerihealth and Caritas doesn't have the exception within the CHC benefits. It's not yet implemented. Where those services are required, BLE, we utilize clinical determination to determine that.
I believe that Jamie was correct that additional dentures, it's required a BLE. Crowns require a benefit limit exception.
Periodontal and endONTices require a benefit limit exception. Nursing facilities residents are exempt from the benefit limit exception process.
As I do believe some UPMC might have mentioned, the nursing facilities seem to have an increase in dental visits over the community and a lot is predicated on 3 or 4 large provider groups that go in and contract with different facilities tRUT throughout the state. They live a lot of utilization for those services.
Without the BLE, nursing residents get the exact same services. Dentures is on a process. I'm sorry I was calling back in if I missed any other dental questions.
>> No. I think there's one last dental question. And we'll start with UPMC again in the rotation. Can you talk about what type of oral hygiene products are available for CHC participants and then also talk about your access to dental providers particularly in rural areas. Andrea. Can you speak to that?
>> I'm sorry. Can you repeat the question. I was pulled away for five seconds.
>> Sure, Andrea. So what type of normal hygiene products are available to CHC members? And

then can you talk about your rural dental access?
>> So again, that would align with products depending on whether they're claiming their Medicare benefits primary and their CHC secondary or how they're doing that. When you say oral hygiene, are you talk over the counter type oral hygiene?
>> Yes. In the community and yes, from the way I'm reading the question, I believe it is over the counter.
>> Okay. So those are things that a member should be probably discussing with their service coordinator so that then we can do a review to determine on whether accommodations that we could provide for something along that line. Our snip products -- and I always want to exemplify this. The members really need to remember they have Medicare benefits. Any products that offer things over the counter plans within their Medicare plan, and some of the Medicaid plans do too. I think that it's something that the service coordinator could definitely assist with this. And then it would basically depend on what it is they're looking for. If they're --
depending on whether it's like a special mouth rinse that maybe the dentist is recommending or something along that line. And then they would perhaps [not audible] to ensure it is medically necessary. So that is basically how we would look at that type of stuff.
>> Okay. Thank you. For Amerihealth. I don't know, Missy, if one of you want to speak to the over the counter oral hygiene and rural central access.
>> Missy, I'll let you speak to the over the counter and I'll take the rural access.
>> Hello?
>> Missy T look like you're self-muted. There you go.
>> I was, sorry. So for the over the counter information, this is something I'm going to have to again, bring back to the committee. I need to make sure I have the right response for this.
>> Could I just discuss rural access real quick. One thing that additional, I do believe initially, we were having oral hygiene products with our welcome packet for the southeast and southwest zone. Rural access for all dental services is difficult for any to plan for sure, not only from a Medicaid perspective but also just from a general health perspective.
There is not specific to Medicaid. Specific to dental services, there are access issues in most rural counties with anybody trying to find a dentist. These problems are exacerbated somewhat when it comes to dental specialty such as oral surgeons or something along that line. We're always looking to recruit in rural counties. We do offer different incentives for dentives in rural counties to get them signed on.
And it is like I said, I'm sure it's across-the-board with all the MCOs.
>> Okay. Thank you.
>> And then for PHW, Anna.
>> Yeah. Thanks, Pat. Okay.
The first part for the hygiene items. Two pieces. One, I think, Andrea did a nice job explaining it. We would say the same thing.
The other side of that is the PHW does have a value add benefit for oral hygiene kits.
They have, you know, your basic items that a person would need, and they're available to our participants and can get access through our call center or service coordinators can access those and we can get them. As for access, I'll lean on the all rural access participants with go to our participant services line and our handbook. I believe there's a link on the website for providers

that we have in network across all of the commonwealth. In addition to that, access is also an issue ruralrurally for transportation to those. If an individual does have those dental issues and they can't access a service like MATP, then I would encourage participants to work with their service coordinator to get that transportation identified on their PCSP to use tokens and such as well. But definitely MTM in the rural areas to get to their dentists. So that's about all I have for that, Pat.
>> Okay. Thank you. So then that's all of the dental questions. And then we did get a question from one of the committee members, Mike Grier was asking if OLPL could provide an update on the IT procurement.
There may be limited information that can be shared. But Jill, Randy? Do you want to provide an update?
>> I'm sorry, Pat. What was the question.
>> An update on the ID, RFA.
>> I don't think we can provide an update right now.
>> We cannot [not audible].
>> Okay. Was someone going to say something? Mike? No?
Okay. Then we're going to turn back to data questions for the MCOs. And the first one is from Kelly Barrett. It's employment is a goal for participants, what are the MCOs doing to educate themselves on the medical assistance for workers with disabilities or MOD programs? I guess we are back to Amerihealth. I don't know who be speaking.
>> Jen Rogers.
>> Great question. The MOD program is a great program and it needs to be emphasized. That is what we're doing with our service coordinators is really trying to get that awareness about the program. And then where appropriate, leaning on benefits counseling and ow that overlays with the mod program in Pennsylvania so that participants feel empowered to know what is and is not available to them, how they get their health care needs met, if and when they reach the day where they want to be fully and competitively employed. So I appreciate the question. It's a good one. And I think we have a great opportunity in 2021 to talk more meaningfully about the employment. And what options are available for people.
>> Thanks, Jen. Anna, how about for PHW?
>> Yeah. I agree with Jen. I love this question. So what PA health and wellness is doing is we have enlisted what we're calling employment champions within our service coordinatination contracted partners. Each of the coordination partners have identified an employment champion that is responsible for the train the trainer approach with their employees, with the employees and service too hardinators across their organization to deliver on our employment results. And so each of these organizations -- we have ten. And that's coordinated effort with our employment team inside PHW to get individuals aware of benefits counseling and career development. Of the five services that are part of CHC that are specific to employment, what we have seen is a lot of individuals are interested in employment, but getting from I'm interested as a goal on the PCSP to getting enrolled or getting an authorization for benefits counseling, for example, we've had some gaps there. And so as we look at it, we have got to do more education with participants that they don't see it as I have a goal I'm interested in employment, and now I'm expected -- do I just jump into a competitive employment role?

There are some steps we can help them so it's not as much of a jump. And then we have all the information so they know their Medicaid benefits are protected.
Long answer, but love this question. And I really believe PA health and wellness is doing a lot in this area to close that gap between I'm interested in a job and then what are the CHC services that can help me actually get a job and be successful in it. Thanks, Pat.
>> Thanks, Anna. And Mike, how about for you? We have about two minutes left.
>> That's all I'll say. So this is a great question. We certainly want to see our employment members go up and part of what we're doing to do that is we've started an employment concierge's program within UPMC which is a support to the service coordination staff so they have resources to turn to help when they have identified people who want to be employed or even explore employment. As you know with the MOD program that these programs are complicated from the standpoint of individual participant perspective on, you know, getting involved in them, how they operationalize, what the reporting requirements are, and we just felt that our staff in addition to having training on this needed to have an additional set of hands that are available to help lift and move the process forward. That's what our concierge service does.
They really help work through a lot of counseling [not audible]
on the PCS [not audible] in support of and in support of the service coordinator that's involved. So the participant gets a couple of sets of eyes and ears on that, and this is an area that I think we all want to -- all three plans, I'm sure, want to see improved success over previous years moving forward. Unfortunately, this environment will remain a challenge for us. And I was just commenting to somebody, though, within every challenge there's a silver lining. I think the silver lining here is remote work and technology, in the coming year as we still struggle and work through the COVID bar variants that are coming out and the overall pandemic. So thanks for that.
Bye.
>> Perfect timing, Mike. So I'll send it back to you, Luba.
We're a little bit past 1:00.
>> LUBA: This is Luba. I'm assuming at this point we'll be able to close our meeting for today.
>> Okay. Thank you.