WRAP-EM/PPN Pediatric Emerging Issues Call Series – Special Session "Impacts of the Public Health Emergency Discontinuation" Tuesday, April 4, 2023

This document provides a detailed, yet summarized, review of the call held on 4/4/23, and is supplemented by the presenter slides. If you would like access to a recording of the event, please contact Nancy Abdo at Nancy.Abdo@ucsf.edu

Information and Resources Provided by HRSA MCHB PPN Project Officer Team:
As you are likely aware, as a result of the expiration of continuous Medicaid coverage requirement authorized during the COVID-19 pandemic an estimated up to 15 million people, including 5.3 million children, will be disenrolled from coverage, and 6.8 million are expected to lose coverage despite still being eligible.

In 2020, CMS waived certain Medicaid and CHIP requirements to help prevent people from losing health coverage during the COVID-19 pandemic. A new law was signed in December 2023 that ended the continuous enrollment condition as of March 31, 2023. States have up to 12 months to initiate renewals—a process commonly referred to as "unwinding." Most adult Medicaid enrolled families are unaware. This is an important moment to get the word out and partner to help our youngest children and families avoid losing existing or get connected to new coverage.
Resources:

- Unwinding Homepage: The centralized location where states and stakeholders can learn more about Unwinding and access resources to help them plan and prepare.
- Unwinding Communications Toolkit: The Unwinding Communications Toolkit provides key messages and materials for states and stakeholders to use when communicating with their networks about Medicaid and CHIP Continuous Enrolment Unwinding
- 50-State Unwinding Tracker
- Child Uninsured Rate Could Rise Sharply if States Don't Proceed with Caution – Center For Children and Families (georgetown.edu)
- **Beyond the Basics** released two sets of frequently asked questions (FAQ) on unwinding Medicaid continuous coverage. The first set explains how unwinding the Medicaid continuous coverage requirement will work, the challenges Medicaid beneficiaries may face during the process, and what enrollment assisters such as health centers can do to help. The second set offers outreach and enrollment tips to assist people retain coverage.

Speaker 1: James G. Hodge, Jr., JD, LLM
Peter Kiewit Foundation Professor of Law
Director, Center for Public Health Law and Policy
Director, Western Region - Network for Public Health Law

Read-ahead document: Hodge JG. "Out like a lion:" Terminating the COVID-19 national public health emergency. Journal of Law, Medicine & Ethics. 2023 (forthcoming – available now on SSRN).

Key Presentation Points (no slide deck):
-Declarations do not determine the end of the response needs, COVID continues to claim lives
-Review of how we negotiate legally against the backdrop of discontinuations

Timetable
1. National Emergency (NE) Declaration – ended Monday April 10, 2023 when signed by Pres. Biden
2. Public Health Emergency (PHE) – still slated for a Thursday May 11, 2020 termination per HHS
3. PREP Act – Not scheduled for recission anytime soon, but not clear at this time if it will coincide with the PHE recission. This could have impacts on the use and administration of medical countermeasures (MCM) provided under Emergency Use Authorizations. Some MCM may not be available for lawful use, and others may have to undergo additional review by FDA. FDA has additional EUA declaratory power that may continue after May 11. Unclear how long.
4. Status of State Based Declarations – Only 8 of 50 states have active declarations, anticipated that all will rescind on or around May 11. Many state based power will change.

What Does This Mean?
1. EMTALA Waivers – will go away when National Emergency Declaration ends, as these waivers require both an NE and PHE.
2. HIPAA waivers – also require both NE and PHE.
3. COVID Medicaid Enrollments – As of April 1, states were allowed to start rescinding. As many at 15m Americans may go off the Medicaid rolls. NY Times covered this in detail
4. Emergency SNAP Benefits – Food-related benefits already being rescinded
5. Specific Liability Protections – Especially if PREP Act is rescinded, guaranteed protections for providers and manufacturers around administration of vaccines and other MCM will be more limited or eliminated
6. Disease Surveillance Efforts – may be reduced or shut down
7. Crisis Standard of Care – Invoking of CSC is tied to declarations, will be harder without them. Your ability to implement CSC will be challenged in the event of another surge
8. Vaccine Mandates
9. Licensure Reciprocity
10. Scope of Practice and other liability protections tied to emergency declarations

However, some services will continue:
1. Access to COVID vaccines - secured for ACA related plans and Medicaid beneficiaries.
2. Emergency Use Authorities – for MCM that FDA issues – should be in place for additional months
3. Telehealth Initiatives – working hard to keep those in place with Congressional support
4. Access to Controlled Substances – through telehealth will likely stay in place ped HHS
5. Some Liability Protections – as a result of sustainment of PREP Act, these can prove valuable for MCM responses needed for ongoing disease control.

Speaker 2: Marie M. Lozon, MD
Professor of Emergency Medicine and Pediatrics
Chief of Staff
University of Michigan Health

1. Special Considerations – for PPN partners, children's hospitals, and our kids
2. Sources of Information that may be valuable
    a. Kaiser Family Foundation – 10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision
    b. CMS.gov – Waivers, Flexibilities, and the Transition Forward from the COVID-19 PHE
    c. AAP – Preserving Medicaid and CHIP Coverage
    d. AAFP – PHE Ending: 6 Things to Know
    e. CHA – Children's Hospital Association

    f. Medicaid – Unwinding and Returning to Regular Operations after COVID-19
    g. Georgetown U Center for Children and Families – Unwinding Medicaid Continuous Coverage
    h. HHS – Post-PHE Roadmap
3. Potential Threats
    a. Procedural – lack of awareness of disenrollment initiated, lack of understanding of how to maintain enrollment, etc. – This is an area that pediatric practices can be impactful to help keep patient covered. Look at AAP resources.
    b. Administrative – Must update contact information with the state Medicaid agency and/or Medicaid managed care plan; must be on the lookout for official notices from the state; must complete and return any forms requested promptly; must be aware that other options may be available should they lose coverage
    c. State by State – Each state may be different, some states moving quickly, others not as much. The Georgetown resource noted above includes a 50-state tracker
    d. CMS Roadmap – Many subtleties within multiple healthcare delivery sectors, can be guidance and technical assistance available but very complex.
    e. PREP Act – Protections remain for some MCM, not all. CRS Report
    f. Controlled Substance Dispensing – changes for people undergoing substance use disorder treatment
    g. Testing and Treatment for Kids – As a result of the American Rescue Plan Act of 2021, coverage for vaccines, testing and treatment will remain, but slated end 9/30/24
    h. Medicaid Telehealth Flexibilities – will continue to be available after the PHE ends, check out the State Medicaid and CHIP Telehealth Toolkit for more. However**,** private insurance may be different
    i. Post-PHE Roadmap – Many states may keep telehealth flexibilities in place, but it will vary by state
    j. For practicing providers – There will be impacts on supervision via telehealth, especially for Medicare. After the PHE, only teaching physicians in residency training sites located outside of an MSA may be the presence for the key portion requirement through audio/video real-time communications technology Could impact residency programs that have used telehealth

Speaker 3: Merritt "Chip" Schreiber, PhD
Professor of Clinical Pediatrics
Department of Pediatrics
Lundquist Institute
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David Geffen School of Medicine at UCLA|

1. Data Report – NW Washington (2018) – Average of 26 phone calls to secure mental health treatment for a child, evidence of a crisis that existed prior to COVID
2. Bottom Line Up Front (BLUF)
    a. Many tele-behavioral health services will continue through 2024, per CMS
    b. However, it is unclear how this will align with the unwinding of Medicaid services
3. Worsening Situation – increased reports of sadness, hopelessness, suicidal ideation, especially for girls, and increased suicide attempts
4. Telehealth Use – 2000% increase during COVID by adults, use increased as well in the past decade for kids using school based health centers (271% from 2007-2018). Most growth was seen in rural schools and sponsored by hospitals
5. AAP Workgroup – Outcomes and Utilization of Telehealth
6. Emerging Data – Adolescents and their caregivers report that telehealth is "highly acceptable" for mental health care and other services. However, adolescents report being more concerned about confidentiality than caregivers, and ¼ reported some technical difficulties
7. Opportunity in this area, but the "Digital Divide" remains an issue with variable access to broadband, and DEI related access issues

8. Review of Permanent Medicare Changes – see slide deck
9. Temporary Changes through end of PHE – see slide deck
10. Temporary Changes through 12/31/2024 – see slide deck
11. Notable variation across states with implementation/augmentation of services during PHE
12. PsyPact – Interstate treatment by psychologists for up to 30 days
    a. CA will not be joining
    b. Limited to psychologists
    c. Unclear how many pediatric trained providers are in the system
    d. Unclear/limited utilization reporting
13. CA has invested $5B in MH/BH for kids, including $250M for digital solutions.
14. PsyStart – Investment and project in WRAPEM and growing in PPN. Has proven successful in Washington state and Sonoma to link children's needing ongoing care to tele-behavioral health services. Could be effective in a CSC/altered standards of care situation. Dr. Tona McGuire in WA has moved it forward substantially
15. Digital Health Solutions – Anticipate, Plan, Cope has linked with CalHope, hope to go live with the full CA digital platform in January 2024
16. Linkage between Digital Divide and Health Professional Shortage Areas in CA, worth exploration to ensure as tele-behavioral health is rolled out that it reaches everyone
17. Linkage between tele-behavioral health and 988: goal to reduce transport to ED, and dependency on law enforcement. Opportunity to insert digital solutions?
18. Much of this is posted on WRAP-EM - https://wrap-em.org/index.php/mentalhealth

Q and A Session:

1. **Any awareness of 988 shifting to state funded model? CS:** 988 has been funded by SAMHSA, some state may have provided additional resources and augmentation, and even some counties.
2. **ACA filling in gaps? Do you see their plan expanding as Medicaid coverage wanes? Is that where we should look in the hospitals to promote? JH:** We are going to lose a number of people off Medicaid shortly, and across the US they will have some options, such as getting subsidized care from ACA through the exchanges. These exchanges will have to cover required items. This is a patchwork approach, you will see some persons kicked off Medicaid in some states and may not be able to be eligible for the subsidized plans or afford the coverage. We must be worried about the large number of Americans, in the millions, that are unable to access plans and coverage for testing, vaccination, and treatment for subsequent variants of COVID.
3. **How can we advocate on specific issues, such as Medicaid unwinding? JH:** Appeals to state regarding how quickly they rescind these benefits, to state level Medicaid agencies. ML: States have latitude. Most of us in healthcare systems, leverage hospital associations and government relations staff at hospital to ensure and advocate for continued payment for services, and this could impact revenue. AAP has templated patient letters for clinicians to send to patients. There may be barriers for many people.
4. **Is there a defined notification process to individuals and families, or might they be surprised at their next office visit?** ML: There were some recommendations provided for this notification to state from CMS, but not clear if states are compelled. Multiple national organizations are sending out guidance. This may be an issue for some families, as changing addresses, phones, or email addresses may limit effective outreach and notification to many service users. It is very likely that someone will show up for a visit, only to find that they are not covered. This may also result in increased visits to EDs. The AAP guidance for pediatric offices may be helpful, to directly reach to their own patients.

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