Telehealth & Maternity Care

Strategies and Resources for State Policymakers and Payers To Improve Access to Telematernity

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M2 Health Care Consulting

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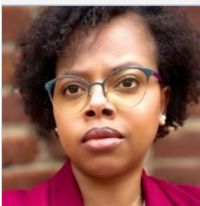

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Telehealth and Maternity Care

Strategies and Resources for State Policymakers and Payers
To Improve Access to Telematernity

Content guide *(this document is highlighted in gray below)*

Policy Overview

Telehealth and Maternity Care: A COVID-19 Policy Crossroad

Telematernity Policy: A View from State Medicaid Programs

Arizona: An interview with Dr. Sara Salek

Telematernity Policy: A View from State Medicaid Programs

North Carolina: An interview with North Carolina Medicaid

Telematernity Policy: A View from State Medicaid Programs

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AmeriHealth Caritas: An interview with Karen M. Dale

Redesigning Prenatal Care: The Role of Telehealth

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Telematernity Policy Toolkit for State Policymakers and Payers

TELEMATERNITY POLICY TOOLKIT FOR STATE POLICYMAKERS AND PAYERS

COVID-19, TELEHEALTH, AND MATERNAL HEALTH – AN OPPORTUNITY FOR CHANGE

As recently as 2017, health care delivered via telehealth was considered uncommon in the U.S., despite having the technology to deliver such services. Before 2020, just 0.1% of pregnancy-related care visits were conducted via telehealth, but as with other categories of care, telehealth visits for maternity care rose significantly during the COVID-19 pandemic.

Many providers and patients have been able to flip the switch to virtual care because they already had the infrastructure, devices, and access to broadband or data in place, but this switch was not equally easy for everyone. Research shows, for instance, "the transition to virtual prenatal care was more challenging for patients with Medicaid" compared to those with commercial insurance. Additionally, people who lack access to devices or internet connections, whether that is due to low income or lack of access to broadband based on geography, are likely to be left behind unless specific measures are taken to equitably expand telehealth for maternity care.

Transforming maternity care in the U.S. in a way that reduces maternal morbidity and mortality and eliminates health disparities will require supporting maternity-specific telehealth.

To aid in these efforts, M2 Health Care Consulting, with support from the Commonwealth Fund, created this toolkit to assist state policymakers in their efforts to improve access to telematernity services, especially in Medicaid. The toolkit includes:

- Important features of equitable telematernity policy
- Checklist: Specific Features of Equitable Maternity Policy
- Advice from other states who are moving forward with telematernity
- On the horizon (What are we not thinking about?)
- Contextual considerations for telematernity
- State policies to improve maternal health outcomes
- Resource list

BACKGROUND

U.S. maternal mortality rates are much higher than other industrialized countries – nearly 10 times higher than in Italy and about three times higher than in Australia. Additionally, in the U.S. there are considerable racial and ethnic disparities in pregnancy-related deaths. American Indian/Alaska Natives experience nearly three times higher and Blacks nearly four times higher pregnancy-related death rates than whites. Concurrently, there is inequitable access to digital connectivity across the U.S. based on population density, geography, and socioeconomic status although those "digital inequities do not neatly conform to societal inequities."

States are in the process of determining how they will cover telehealth services in Medicaid after the COVID-19 public health emergency ends. Not only are Medicaid agencies determining how they will cover telehealth in the future, state legislatures are also considering bills establishing various components of telehealth policy. State health policy must change to support telematernity, but policies will need to incorporate a broad range of policy issues in order to address "the complex and interconnected public health and social service shortcomings" that contribute to poor maternal outcomes and inequities. Telematernity care is likely to be an essential component of reducing "racial and ethnic disparities in maternity outcomes," but that is unlikely without the creation of supportive health care finance and delivery system policies.

This toolkit aims to serve as a resource for state policymakers aiming to reduce unequal maternity outcomes through policy that supports telematernity services, especially in Medicaid.

STRATEGIC ISSUES FOR TELEMATERNITY POLICY

Improving access to telematernity care relies on several other policy components, in particular, state policies to improve maternal health outcomes and state policies to improve access to telehealth services broadly, as detailed below. States should keep in mind several overarching strategic considerations as they develop policies that will support the provision of telematernity services:

- **Covering telehealth is covering telematernity, but all telehealth is not the same**
- **Improving patient access to services outweighs the risk of fraud and abuse**

Covering telehealth is covering telematernity, but all telehealth is not the same
For a state to cover telematernity, it must also cover a range of telehealth services, as detailed elsewhere in this toolkit. But policymakers must keep the following important strategic consideration in mind: *all telehealth isn't the same*. Dr. James Bush, the Medicaid Medical Officer at the Wyoming

All telehealth is not the same,
*so all telehealth **policy***
shouldn't be the same.

Department of Health is also a member of the Medicaid Medical Directors Network (MMDN) Telehealth Advisory Committee, which published Perspectives on Telehealth Modernization in March 2021. The report proposes telehealth policy recommendations based on a state environmental scan and survey responses from state Medicaid agencies. Combining his own experience as a state Medicaid Medical Director with what he learned from the MMDN committee work, Dr. Bush told us in an interview that telehealth reimbursement is unlikely to be the same for every type of care, so was very important for

states to think about different payment methodologies for different services. [For more information: Telematernity Policy: A View from State Medicaid Programs – Wyoming]

In the case of telematernity, policymakers should remember prenatal is a wellness state and the timeframe for coverage of prenatal care is discrete. As such, payment for remote patient management reimbursement codes originally designed for more complex patients over longer periods of time may not be optimal for reimbursing for remote monitoring provided as part of telematernity care.

Improving patient access to services outweighs the risk of fraud and abuse
Policy advisors at the federal and state level continue to struggle with whether to recommend permanent telehealth coverage expansion. An overarching strategic issue is how best to balance choice and access with program integrity. In other words, policymakers must decide whether the value of providing care via telehealth is outweighed by the risk of fraud and abuse.

Dr. Sara Salek, Chief Medical Officer of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency told us in an interview that concerns about the importance of avoiding fraud, waste, and abuse in Medicaid can have an outsized influence on telehealth coverage policy. “The majority of providers and patients will be doing the right thing, and we can’t let the possibility of bad defeat the reality of good,” argued Dr. Salek. She offered a reminder that states have their own Office of the Inspector General (OIG) and letting them do their job and stop the bad actors when they act should be the preferred mode of action for states looking to improve access to telematernity and telehealth services more generally. [For more information: Telematernity Policy: A View from State Medicaid Programs – Arizona]

> *“We can’t let the possibility of bad defeat the reality of the good.”*

Contextual considerations when creating telematernity policy
While not the focus of this project, our interviews uncovered a few contextual considerations of note. Telematernity policy decisions need to be made in the context of several other policy concerns, most importantly, issues related to equitable access to telematernity services regardless of a person’s race, ethnicity, language spoken, or geographic location. Additionally, access to behavioral health services via telehealth should be closely coordinated with behavioral health care that might be part of maternity care, as should care that is delivered by providers such as doulas or midwives.

State policymakers must also consider broader quality and payment issues, especially if Medicaid services are provided via managed care organizations. A range of issues related to the provision of any

type of service via telehealth, including telematernity services, must be evaluated so providers and managed care organizations are paid fairly for the care they provide.

For a deeper dive on reimbursement, especially in Medicaid managed care, see below and take a look at other resources developed as part of this project including:

- The View from Medicaid Managed Care: An Interview with Karen Dale, AmeriHealth Caritas
- Telematernity Policy: A View from State Medicaid Programs – Arizona

Contextual Considerations for Telematernity

Equity

Equitable access by race, ethnicity, language spoken, geography, etc. should be part of policy design

Quality & Consumer Experience Measures

Value-based payment & alternative payment models

Doulas & Midwives

A range of provider types can deliver care via telematernity

Behavioral Health

Behavioral health screening and treatment is an essential component of maternity care - including care delivered by telehealth

STATE POLICIES TO IMPROVE MATERNAL HEALTH OUTCOMES

Because state Medicaid programs cover 42 percent of all births in the U.S. and 65 percent of births to Black mothers, states play a particularly important role in "improving maternal health outcomes and reduce racial inequities." In addition to temporary telehealth flexibilities, some states had already initiated changes to improve access to maternity care through telehealth.

A comparison table of 25 high-value state policy approaches in the areas of coverage and benefits, care delivery transformation, and data and oversight shows a vast array of mechanisms that could reduce gaps in maternal health care quality and outcomes, including telemedicine services for pregnancy care. Before COVID-19, only nine states explicitly reimbursed Medicaid providers for telemedicine services for pregnancy care: Arizona, California, Colorado, Illinois, Massachusetts, Missouri, Texas, Virginia, and Wisconsin.

STATE POLICIES TO IMPROVE ACCESS TO TELEHEALTH SERVICES

In addition to policies addressing accessibility and quality of maternal health, states are likely to need to make changes to their telehealth coverage policies generally to best support telematernity. For more

information on state legislative changes to support the coverage of telehealth in Medicaid and the state-regulated health insurance market check-out these resources:

- State Telehealth Legislative Tracker from the American Telemedicine Association
- Telehealth Policy Finder from the Center for Connected Health Policy

CHECKLIST: SPECIFIC FEATURES OF EQUITABLE TELEMATERNITY POLICY

Broadly, covering telehealth is covering telematernity, and many of the contextual considerations for policymaking that support telematernity overlap with telehealth coverage generally. However, there are specific features of equitable telematernity policy. State policymakers aiming to support telematernity in Medicaid should consider the following:

- **Cover devices specific to maternity care**
  The experts we interviewed from the North Carolina Medicaid agency recommended a clear, short list of devices that states should provide Medicaid coverage for:
  - ✓ An automated, reliable, and appropriately-sized blood pressure cuff and monitor for home use;
  - ✓ A scale for measuring body weight for home use (if the patient does not already have one); and
  - ✓ Video-enabled equipment in the home, with sufficient data speeds and/or minutes to enable the patient to use telehealth services via broadband or cellular networks.

- **Cover remote monitoring specific to maternity care**
  Remote patient monitoring is critical for prenatal visits, including weight and blood pressure, as discussed in several of the interviews conducted for this project.

- **Make telematernity coverage site-neutral**
  Many states are lifting requirements for the patient and/or provider to be at a brick-and-mortar health site in order for telehealth services to be provided. To support telematernity, states should allow a patient to be at home, or at a location besides a health site (e.g., car, outside, place of work, etc.), when receiving a telematernity service that does not require an in-person visit.

- **Cover audio-only telematernity care services**
  Patients and providers, especially those in the Medicaid program, need access to telematernity services that are provided via audio-only. Policymakers should cover audio-only telematernity services, at least for a pilot period, in order to avoid building systemic inequity where people and providers that are part of large, well-resourced health systems have access to telehealth, but no one else does. For a deeper dive on this issue, see ***Why Coverage of Audio-only Service is Essential for Equitable Telematernity Care*** on the next page.

Why Coverage of Audio-only Service is Essential for Equitable Telematernity Care

1. Not everyone has access to adequate broadband and devices for video visits

It will not be possible to provide equitable telehealth services, especially to Medicaid patients, until several types of infrastructure are in place, most obviously, access to adequate fixed or mobile broadband and devices necessary for synchronous video visits.

The Medicaid and CHIP Payment and Access Commission (MACPAC), which makes recommendations to Congress and states on issues related to Medicaid and the State Children's Health Insurance Program (CHIP), held a panel discussion on What States are Learning from Expanded Use of Telehealth during its April 2021 Public Meeting. Notably, all three Medicaid agency leaders who presented during the panel discussion, representing Arizona, Colorado, and Virginia, noted the importance of continuing audio-only coverage in telehealth policy design because of broader infrastructure issues.

Dr. Sara Salek, Chief Medical Officer of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, told us that during the COVID-19 pandemic Arizona Medicaid has equalized reimbursement, including audio-only, in part because "in their Medicaid population, not everyone has access" to the broadband coverage or data speeds needed to support synchronous video visits.

Similarly, Dr. James Bush, the Medicaid Medical Officer at the Wyoming Department of Health told us during an interview: "Remote patient monitoring is critical for prenatal visits – weight, blood pressure, doppler – but all of these services require access to a certain level of broadband, and this is a challenge." "We know there are fewer missed appointments when we cover telehealth," he continued, "and if we shut off telephonic care, that will close access to care in frontier, isolated, and tribal areas, which creates problems of equity."

2. Not every provider can afford to build or maintain a telehealth infrastructure

A constant refrain in the interviews we conducted for this project concerned the divergent infrastructure being built that enables providers to offer telehealth services. A May 2020 Kaiser Family Foundation Issue Brief on Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 c and Beyond explained, "Prior to the start of the COVID-19 outbreak, more than 50 U.S. health systems already had telemedicine programs in place, including large health centers like Cleveland Clinic, Mount Sinai, Jefferson Health, Providence, and Kaiser Permanente." However, the significant financial and workforce investment necessary to build a telehealth infrastructure is much more difficult for small practices, or providers who primarily serve people with coverage through Medicaid or without any health insurance.

The issue of differential provider infrastructure in telehealth is already on the minds of federal policymakers. During the January 2021 Medicare Payment Advisory Committee (MedPAC) public meeting, commissioners discussed how a policy allowing audio-only visits to be reimbursed a rate lower than video visits ignores the investment that must be made by the provider to allow a patient to choose between different telehealth modalities.

Commissioner Dana Safran, Sc.D., was blunt, saying that a policy that sets lower reimbursement rates for audio-only visits "could drive disparities in access…if providers feel like it's not worth it to bother with audio calls for the populations…who don't have access to broadband for video."

PUTTING IT INTO PRACTICE

The North Carolina Medicaid agency created guidance for providers delivering telematernity care, including billing information, in a helpful resource other states may be able to adapt. Perinatal Telehealth Scenarios During COVID-19 Public Health Emergency Guidance for NC Medicaid Perinatal Care Providers May 18, 2020 provides detailed information of seven relevant scenarios:

- **Scenario 1.** Patient receives a routine prenatal visit via telemedicine.
- **Scenario 2.** Telephone call between the patient and provider.
- **Scenario 3.** Pregnant patient needs blood pressure monitoring. The practice orders a blood pressure cuff from its preferred, Medicaid-enrolled, durable medical equipment (DME) provider. The patient monitors her blood pressure at home and calls the office once a week with readings, or submits through a patient portal.
- **Scenario 4.** Established pregnant patient receives hybrid telemedicine visit with supporting home visit from an appropriately-trained delegated staff person.
- **Scenario 4 (continued).** During the hybrid telemedicine with supporting home visit, the patient receives a vaccination, urinalysis, fetal non-stress test, blood draw (sample sent to a lab for review), and a COVID-19 swab test.
- **Scenario 5.** Patient receives Postpartum Depression Screening via telephone call prior to the postpartum visit (same day).
- **Scenario 6.** Patient receives consultation for medical lactation immediately postpartum via telemedicine.
- **Scenario 7**. Pregnancy Medical Home (PMH) Participants: Incentive Payments.

ADVICE FOR STATE POLICYMAKERS

- **Keep in mind, telehealth is here to stay**
  While the COVID-19 pandemic is moving to its next stage, our interviewees were clear that telehealth is here to stay. While certain services may be less likely to be delivered via telehealth in the future, a hybrid model of maternity care is on the horizon. Dr. Alex Peahl from the University of Michigan is leading a team to consider how the typical prenatal visit schedule and content of those visits should change, including incorporating telehealth visits. [For more information: Redesigning Prenatal Care: The Role of Telehealth]

- **Community outreach is essential (aka patient preferences should be solicited, not guessed at**)
  To find out what patients prefer when it comes to telematernity care services, ask them! Including patients, their families, and the local community in care delivery and financing decisions is essential. Karen Dale, the Market President, AmeriHealth Caritas District of Columbia, told us in an interview, “In our haste to implement change, we often go with what we believe, but we need to maintain the discipline of being more inclusive when we are crafting solutions and making policy decisions.” Dale used the coverage of audio-only visits noted above as an example. “We learned from members and providers by talking to them that it was a good

thing to do audio-only for some visits because some members didn't have access to broadband speeds to support video visits," she explained. As the organization determines what is next for telehealth and telematernity, Dale said they will definitely be using these "context-building discussions to improve our efforts." [For more information: The View from Medicaid Managed Care: An Interview with Karen Dale, AmeriHealth Caritas]

Advice from other states

Telehealth is here to stay	States are advised to embrace the change telehealth has brought, and be flexible about policy making. Telematernity can provide an additional avenue of access to important care for patients.
Community outreach is essential	It is essential for states to engage in extensive outreach to stakeholders, including providers, patients, and the community in general, to ensure equitable access to telematernity.
Data should guide decisions	Data about which services were delivered via telehealth should guide decisions, but it is only one component to consider. Patient preferences about how they access care will be paramount going forward.

- **Data should guide decisions, but it is only one component**
  The case of the declining no-show rate: The data viewpoint
  Dr. Bush, the Medicaid Medical Director in Wyoming, told us in an interview, "We know there are fewer missed appointments when we cover telehealth." The Medicaid and CHIP Payment and Access Commission (MACPAC), which makes recommendations to Congress and states on issues related to Medicaid and the State Children's Health Insurance Program (CHIP), held a panel discussion on What States are Learning from Expanded Use of Telehealth during its April 2021 Public Meeting. Dr. Chethan Bachireddy, Chief Medical Officer of Virginia Medicaid, shared some key data points about telehealth:

> **"The COVID-19 pandemic has really highlighted the potential that telehealth can play in ensuring equitable access to care, to health services, and, of course, this is nowhere more important than in Medicaid. What we're learning is that almost 70 percent of primary care providers, at least in Virginia, were motivated to use telehealth to meet patient needs and reported lower no-show rates with telehealth compared to in person, and I saw this in my own clinic as well where we went from 27 percent no-show rate to a 3 percent no-show rate when we were primarily using virtual care."**

The case of the declining no-show rate: The design viewpoint
Similarly, Karen Dale, the Market President, AmeriHealth Caritas District of Columbia, a mission-based Medicaid Managed Care Organization in Washington, D.C., and the Chief Diversity, Equity, and Inclusion Officer for the AmeriHealth Caritas Family of Companies, told us in our interview that as a result of the more robust telehealth coverage during the COVID-19 emergency, providers talked about a practically zero no-show rate for appointments.

But Dale had clearly thought deeply about missed appointments from a person-centered design viewpoint:

> **"In D.C. Medicaid, we cover the cost of transportation for members who need it to get to an appointment with a provider, she explained, "but this doesn't address the scarcity of time" a member might have. The system considers a missed appointment an issue of patient non-compliance, but we should be thinking about it differently, Dale advised. "We should be asking 'what would have helped you keep your appointment,' instead of 'why didn't you come to your appointment?'"**

Dr. Joia Adele Crear-Perry, the Founder and President of the National Birth Equity Collaborative, shared a similar person-centered design viewpoint in an interview with us:

"Our world view is so much more powerful than data," Dr. Crear-Perry explained. "Right now, the entire health care system meets the needs of the system, not the person. This is not a system based on the value of what patients need."

Going forward, equity, patient preferences, and human-centered design should guide policy related to telehealth and telematernity. Dr. Crear-Perry offered the following question as a way for policymakers to remember this important principle:

"How might we think about the design of telehealth if we were seeing through the eyes of people who are not centered?"

TELEMATERNITY POLICY: KEY TAKEAWAYS FOR STATES

1. Telematernity should not be provided without full coverage of audio-only care at this time
The American Medical Informatics Association (AMIA) calls access to broadband a social determinant of health. Clearly, a lack of broadband services and ownership of devices such as computers and smartphones prevents equitable telemedicine access. While health care delivered via audio-only may be considered of lower quality by providers, a policy that does not reimburse health care providers for conducting audio-only telehealth visits will lead to immediate access disparities and is likely to lead to systemically inequitable access to telematernity over time.

2. Telematernity needs to be piloted post-pandemic before permanent policy is made

It is clear that telehealth data and experiences during COVID-19 should not be the sole proof points for whether telematernity led to positive health outcomes. Advisors are urging policymakers not to treat the delivery of telehealth services during the pandemic as a pilot. More time is needed to determine whether and how telematernity services might increase access to care and improve health outcomes.

Dr. Courtney Lyles, a health services researcher specializing in how health information technology can be used to reduce disparities in health and health care outcomes for low-income and racial/ethnic minority populations, shared a similar point-of-view, but specific to the provision of telehealth in maternity care: "Policy needs to be open to supporting telemedicine. You would cut off a ton of work and innovation [if you stopped now]. There is so much going on with COVID-19, it's really hard to say if telemedicine is working or not. We need more time to figure that out."

3. Equity must be part of the policy design

Telematernity policymakers should consider equity in the policy design phase. The Office of the National Coordinator for Health Information Technology (ONC) recently appointed leader, Micky Tripathi, Ph.D., M.P.P., is re-directing nationwide health information technology (IT) efforts to incorporate health equity by design. As he explained during a health IT roundtable in March 2021, health IT policymakers have sometimes "embraced technology and moved forward with standards and processes that didn't explicitly take into account the consequences that our actions and activities might have on health equity." He continued, "And then you catch up later, and you sort of do some measurement, and you realize, 'Oh wow, this created some health disparities we didn't realize, and now we have to go back and rectify and mitigate.'"

ON THE HORIZON

As state policymakers design and implement coverage policies to support the delivery and financing of telematernity services, it is important to maintain flexibility because the telehealth landscape is moving rapidly. When we asked interviewees to comment on issues on the horizon that policymakers aren't thinking enough about, they told us:

- Health equity will require intentional design and implementation
- Telehealth modalities are changing fast
- Telematernity data comes in all forms
- Medicaid alone cannot create change

Additionally, the prenatal schedule of visits recommended in the U.S. hasn't changed since the 1930s. Dr. Alex Peahl from the University of Michigan published a paper proposing a redesign of prenatal care that includes delivering some visits via telehealth, and is leading work on prenatal care redesign that will be published by The American College of Obstetricians and Gynecologists (ACOG) soon.

On the horizon

Health equity will require intentional design and implementation	Telehealth modalities are changing fast	Telematernity data comes in all forms	Medicaid alone cannot create change
Telehealth depends on infrastructure that is not yet in place in many areas. Patients need adequate access to broadband, minutes, and devices, to properly use telehealth. Additionally, some patients and providers may prefer audio visits to synchronous video visits.	Fast on the heels of video visits, states will soon need to think about coverage for modalities such as chat, instant messaging, and consultation and information sharing via patient portals.	Measuring telematernity outcomes is a challenge, and states will need to determine what quality measures and outcomes will be monitored to assess telehealth services, both qualitatively and quantitatively. Patient satisfaction surveys are one tool that can be used to evaluate care delivered via telehealth.	Telehealth needs providers to champion its use, and payers besides Medicaid need to support telehealth for it to be deployed successfully. Providers may not be willing to change their workflow and embrace telehealth if it is not covered by a majority of payers.

See next page for resource list

RESOURCES

Health Policy and Maternal Health

Improving Maternal Health Access, Coverage, and Outcomes in Medicaid: A Resource for State Medicaid Agencies and Medicaid Managed Care Organizations, Institute for Medicaid Innovation

Improving Maternal Health Outcomes: State Policy Actions and Opportunities, Center for Health Care Strategies (CHCS)

Maternal Health Hub, a compilation of resources and best practices to advance a vision for high-value and equitable maternity care, Health Care Transformation Task Force with support from the Commonwealth Fund

Medicaid's Role in Maternal Health, Medicaid and CHIP Payment and Access Commission (MACPAC)

Momnibus and Black Maternal Health, Black Maternal Health Caucus

State Policies to Improve Maternal Health Outcomes, The Commonwealth Fund and Center for Health Care Strategies (CHCS)

Telemedicine and Pregnancy Care, Kaiser Family Foundation

Telehealth Policy Generally

Federal Telehealth Legislative Tracker, American Telemedicine Association (ATA)

Overview of Telehealth and Medicaid, MACPAC

Perspectives on Telehealth Modernization, Medicaid Medical Directors Network

State Telehealth Legislative Tracker, American Telemedicine Association (ATA)

Telehealth Policy Finder, Center for Connected Health Policy

Telehealth Policy Action and Access to High-Speed Internet, Tufts University

Telehealth Policy and COVID-19

Changes in Telehealth Policies Due to COVID-19, MACPAC

Policy Considerations for States Expanding Use of Telehealth: COVID-19 Version, Centers for Medicare and Medicaid Services (CMS)

Telehealth Payer Policy in Response to COVID-19, American Academy of Pediatrics

Tracking Telehealth Changes State-by-State in Response to COVID-19, Manatt Health Solutions

Using Telehealth to Care for Patients During the COVID-19 Pandemic, American Academy of Family Physicians