Telehealth & Maternity Care

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

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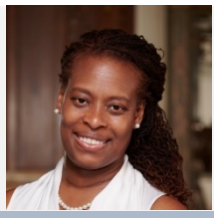

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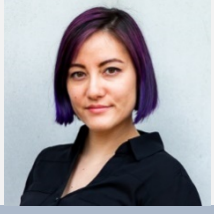

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TELEHEALTH AND MATERNITY CARE: A COVID-19 POLICY CROSSROAD

As recently as 2017, health care delivered via telehealth was considered uncommon in the U.S., despite having the technology to deliver such services. The COVID-19 pandemic made the uncommon common. In 2019, 0.3 percent of ambulatory services paid for by commercial health insurers were delivered via telehealth, but by June 2020 nearly 25 percent of ambulatory visits were virtual. The rise continued as 2020 and the pandemic wore on—by the middle of the year, the Centers for Disease Control and Prevention (CDC) reported 30 percent of health center visits were being conducted via telehealth.

Similarly, telematernity visits rose significantly during 2020. Before 2020, just 0.1 percent of pregnancy-related care visits were conducted via telehealth; after COVID-19 essentially shut-down the U.S. in March 2020, OB/GYN providers adapted quickly. For example, a group of practices in New York City delivered 87.3 percent of post-partum visits, 47.8 percent of return prenatal visits, and 29.3 percent of new prenatal visits virtually in the last week of a five-week period from March 9 to April 12, 2020.

The COVID-19 pandemic has upended the traditional model of delivering maternity care. 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. One of the primary drivers for this transformation is policy. In addition to creating a culture of equity and a value-based system, the Health Care Transformation Task Force notes: "Policy change is also a critical lever to be able to address the complex and interconnected public health and social service shortcomings that often contribute to pregnant persons' poor outcomes and widening disparities."

In this issue brief, we review current federal and state policy approaches to telehealth that are likely to impact the provision of telematernity and discuss what policymakers need to do next to ensure state telehealth policies are instruments for improving, not worsening, maternal health outcomes.

COVID-19, Telehealth and Maternal Health – An Opportunity for a Change in Direction

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, there are considerable racial and ethnic disparities in pregnancy-related deaths in the U.S. 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, though those "digital inequities do not neatly conform to societal inequities."

This digital divide means inequitable access to telehealth is likely to exacerbate already disparate maternal health outcomes. However, current federal and state policy related to telehealth will need to be adapted in order to incorporate elements that would address inequities that may contribute to poor maternal health outcomes.

Key Federal Telehealth Policies

An enormous number of policy changes have been made federally to create flexibilities during the COVID-19 pandemic. Related to the provision of telehealth the most notable include:

COVID-19 Public Health Emergency
The U.S. Department of Health & Human Services (HHS) declared a public health emergency effective January 27, 2020 and has extended the emergency several times, including most recently on July 19, 2021. These declarations allow a myriad of federal flexibilities in the provision of health care, including telemedicine flexibilities in Medicare and Medicaid.

The CARES Act
The Coronavirus Aid, Relief, and Economic Security (CARES) Act, signed into law March 27, 2020, includes a number of changes that support the provision of telehealth services, including providing grants to health care organizations to offer telehealth services, increasing Medicare telehealth flexibilities during the public health emergency, and revising certain payment rules for services provided by Federally Qualified Health Centers and Rural Health Clinics during the emergency.

Emergency Broadband Benefit
On February 25, 2021, the Federal Communications Commission (FCC) approved a new program that provides discounts for broadband service for households with low incomes. The Emergency Broadband Benefit provides a one-time $100 discount to purchase a computer and $50 per month discounts to purchase broadband services.

Key State Health Telehealth Policies

Medicaid COVID-19 Emergency Authority Flexibilities
The Medicaid agencies in all 50 states and the District of Columbia expanded coverage or access to telehealth services and introduced licensure flexibility through emergency authority during the COVID-19 pandemic. Additionally, 42 states and the District of Columbia created payment parity between in-person and telehealth visits for at least some services.

State Policies to Improve Maternal Health Outcomes

Because state Medicaid programs cover 42 percent of 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 9 states explicitly reimbursed Medicaid providers for telemedicine services for pregnancy care: Arizona, California, Colorado, Illinois, Massachusetts, Missouri, Texas, Virginia, and Wisconsin.

Private Payer Parity Laws

In addition to Medicaid, states can require the health insurance companies that they oversee to provide certain coverage types or amounts of services. One way to support the provision of telehealth is to require health plans to pay providers for services delivered via telehealth at parity with services delivered in person. As of April 2021, eight states had such laws: California, Delaware, Georgia, Hawaii, Massachusetts, Minnesota, New Mexico, and Virginia.

Notable Federal Policy Proposals Affecting Telematernity

Black Maternal Health – Momnibus

In an effort to address the maternal health crisis in the U.S., members of the Congressional Black Maternal Health Caucus, led by Congresswoman Lauren Underwood (D-IL), Congresswoman Alma Adams (D-NC), and Senator Cory Booker (D-NJ), have introduced the Black Maternal Health Momnibus Act of 2021. The Momnibus is a compilation of 12 standalone bills each aiming to address an aspect of improving maternal health and reducing disparities, including investments in social determinants of health and promoting innovative payment models. Most relevant to telematernity is the Tech to Save Moms Act (S.893 and H.R.937) which includes a provision that would "require the Center for Medicare & Medicaid Innovation to consider models that improve the integration of telehealth services in maternal health care."

Medicare Telehealth Proposals, MedPAC

Despite the federal and state policy flexibilities put in place during the COVID-19 pandemic and the radically increased use of telehealth modalities to deliver care, policy advisors are mixed on whether to recommend permanent telehealth coverage expansion in Medicare. At 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. The Medicare Payment Advisory Commission (MedPAC), which advises Congress on Medicare issues, discussed telehealth expansion in Medicare during its January 2021 meeting and presented its recommendations in the March 2021 Report to the Congress: Medicare Payment Policy (see Exhibit 1).

Two important concepts of telehealth policy design were discussed during the January 2021 MedPAC meeting that we should use to inform telematernity policy. First, these policy decisions must take infrastructure costs and provider type differences into consideration. Consider the issue of covering audio-only health care visits. A policy change needed to make telematernity care more accessible, and accessible in a way that reduces inequities, would be to allow telematernity care to be provided by phone. Similarly, Commissioners acknowledged Medicare beneficiaries sometimes required the use of audio-only services either because they did not have access to synchronous video capabilities or because a video visit failed and had to be continued via audio-only.

In considering whether to continue coverage of audio-only visits in Medicare, a proposed approach is to reimburse audio-only visits at a lower rate than synchronous video visits. The commissioners noted that a policy allowing audio-only visits to be reimbursed a rate lower than video visits, however, 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."

Exhibit 1. Policy Option for Expanding Fee-For-Service Medicare's Coverage of Telehealth Services after the Public Health Emergency (PHE)

Under this policy option, policymakers should temporarily continue the following telehealth expansions for a limited duration (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use this evidence to inform any permanent changes. During this limited period:

- *Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location.*
- *Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit.*
- *Medicare should temporarily cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.*

Source: MedPAC, *Report to the Congress, Chapter 14, "*Telehealth in Medicare after the coronavirus public health emergency" (March 2021).

Second, these policy decisions need more time. The Commissioners noted that telehealth services could be reimbursed by Medicare where the evidence shows that the service balances cost, access, and quality, but, where evidence is lacking, the services should be pilot tested before adoption. Commissioner Marjorie Ginsburg, the founding director of Center for Healthcare Decisions Inc., was clear in saying: "I don't think what we've done with the pandemic can be considered pilot testing."

In interviews we conducted for an upcoming Case Studies Series highlighting state approaches to implementing telematernity, 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."

Notable State Policy Proposals Affecting Telematernity

Medicaid Telehealth Proposals, MACPAC
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.

As with the MedPAC meeting where telehealth policy after the public health emergency was discussed, two important concepts of telehealth policy design that we should use to inform telematernity policy were discussed during the April 2021 MACPAC meeting. First, telehealth policy decisions must take broader infrastructure issues into account. All three Medicaid agency leaders who presented during the panel discussion noted the importance of continuing audio-only coverage. Dr. Sara Salek, chief medical officer for the Arizona Health Care Cost Containment System, clearly connected the issue of disparities with the need to reimburse Medicaid providers who provide audio-only care:

> *We are evaluating audio-only coverage and weighing three major factors, including clinical appropriateness, health care access in regards to that ongoing concern related to broadband access for our members, and from my perspective and what I've heard, both from the provider as well as member experience, audio-only coverage is critically important until we have that broadband coverage issue resolved…*

Second, these policy decisions need more time. Dr. Chethan Bachireddy, the chief medical officer for Virginia Medicaid, explained the Commonwealth was reckoning with what telehealth looks like for the future, noting "a big part of that…has to do with reimbursement and policy." Dr. Bachireddy told the Commissioners:

> *We're just at the beginning of this journey. It's not enough to just open up policies…This new modality that increases access, of course, will have an impact on outcomes as well, and I think the question is how much and for what conditions. So I think we're at this really exciting time, but I think of it as the beginning of really investing in telehealth.*

Unifying Telehealth and Maternal Health Policy Proposals – What's Needed Now

As the previous examples show, the COVID-19 pandemic has created a policy crossroad for telehealth and maternity care that could lead to a redesigned person-centered approach that reduces maternal morbidity and mortality and eliminates health disparities. States are in the process of determining how they will cover telehealth services in Medicaid after the 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 must 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. Before state policymakers proceed with telehealth changes that may affect the provision of telematernity care in Medicaid, we recommend a close examination of three key factors policy advisors and policymakers at the state and federal level are encountering:

1. 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.

2. 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.

Three Key Factors for Telematernity Policy

1. Telematernity needs to be piloted post-pandemic before permanent policy is made.
2. Telematernity should not be provided without full coverage of audio-only care at this time.
3. Equity must be part of the policy design.

3. Equity must be part of the policy design.
We recommend telematernity policymakers 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.'"

Conclusion

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 brief is part of a larger project on ways states can implement supportive telematernity policies.