Telehealth & Maternity Care

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

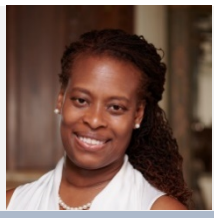
AUGUST 2021

M2 Health Care Consulting

With support by the Commonwealth Fund

Telehealth and Maternity Care

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

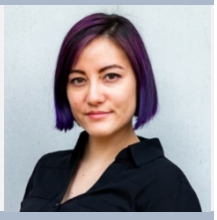


Laurie Zephyrin, M.D., M.P.H., M.B.A.
Vice President, Health System Equity, The Commonwealth Fund

Brenda Gleason, M.A., M.P.H.
President, M2 Health Care Consulting

Brittany Blizzard, M.S.
Doctoral Candidate, American University
Consultant, M2 Health Care Consulting

Jennifer Bohn, M.P.H., M.B.A.
Consultant, M2 Health Care Consulting



Neko M. Castleberry, M.P.P.
Doctoral Candidate, American University;
Consultant, M2 Health Care Consulting

Jo Palmer, M.H.A.
Consultant, M2 Health Care Consulting

This project was supported by the Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here are those of the authors and not necessarily those of the Commonwealth Fund, its directors, officers, or staff.

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
Wyoming: An interview with Dr. James Bush

Telematernity Policy: A View from Medicaid Managed Care
AmeriHealth Caritas: An interview with Karen M. Dale

Redesigning Prenatal Care: The Role of Telehealth
An interview with Dr. Alex Peahl and Dr. Michelle Moniz, University of Michigan

Telematernity Policy Toolkit for State Policymakers and Payers

TELEMATERNITY POLICY: A VIEW FROM MEDICAID MANAGED CARE – AMERIHEALTH CARITAS

An interview with Karen M. Dale, R.N., M.S.N.
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.

Managed care organizations need Medicaid policy to support telehealth

When COVID-19 shut down Washington, D.C. in early 2020, the D.C. Department of Health Care Finance (DHCF), which oversees the Medicaid program, "communicated with precision and agility" about the emergency telehealth changes they were implementing,[i] explained Karen Dale, Market President of AmeriHealth Caritas District of Columbia, and Chief Diversity, Equity, and Inclusion Officer for the AmeriHealth Caritas Family of Companies. This was particularly important to Medicaid providers who work with an average of five to seven managed care organizations (MCOs), according to Dale. As an example, before the COVID-19 emergency, many MCOs in D.C. already allowed a patient's home to be an originating site for the provision of telehealth, but fee-for-service Medicaid did not provide that flexibility. Dale explained the pressure of the pandemic, combined with "the highly consistent messaging [from DHCF] led to positive uptake" of telehealth services by providers and patients, because it was clear that such care would be covered by the agency.

How Medicaid MCOs can support telematernity

One of the most important ways the Medicaid agency supported MCOs in providing telehealth, including some components of maternity care, was coverage of audio-only visits. Before the pandemic, AmeriHealth Caritas D.C. was not paying for audio-only visits, but when DHCF allowed audio-only care to be reimbursed in Medicaid, the flexibility ensured AmeriHealth Caritas D.C. was still able to connect with people. "This was very helpful," said Dale, "because some members even before the pandemic were not comfortable letting people into their home environment."

For those members who chose a video visit for maternity care, telehealth reduced the hassle and burdens of getting to an in-person appointment, such as getting time off work, finding childcare, or negotiating travel. Additionally, "telehealth access with remote patient monitoring and health coaching based on their data was really helpful in terms of increasing health literacy for pregnant patients." said Dale. As a result of the more robust telehealth coverage, providers talked about a practically zero no-show rate for appointments, which Dale had clearly thought deeply about: "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?'"

Advice for supporting telematernity

"Start with a conversation," said Dale, explaining that AmeriHealth Caritas D.C. talks to a broad range of stakeholders, starting with members and providers, but also asks standing advisory groups and health adjacent organizations for input. "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 covering 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."

AmeriHealth Caritas D.C. also knows from having conversations with providers about the burdens they are under in trying to work with multiple payers with different coverage and payment policies. Large health systems are better resourced and have been building an infrastructure to support population health and telehealth services for years. However, solo and smaller group practices need more support to build capacity so they can implement or sustain member access improvements such as telehealth. "We need to think by provider type," said Dale, "and really think about how to assist smaller providers with all the change that is happening." The MCO has started gathering information to see what new patterns of care occurred after the COVID-19 pandemic policy changes. "It is important to go back and look at the data and look for patterns" so we can decide what to do next, Dale advised.

What's on the horizon? (AKA What are we not thinking enough about)

REMOTE PATIENT MONITORING

A significant issue on the horizon from Dale's perspective has to do with patient-specific information. In the case of telematernity, the most relevant use case is blood pressure monitoring. "We could help build health literacy, and drive health and well-being with 'next-level' remote monitoring," said Dale, referring to remote patient monitoring systems that allow the generation of clinically reliable information over many days, weeks, or months, without putting a burden on members to collect the information.

CAPITATION FOR TELEHEALTH

Of particular concern to managed care organizations is the interplay of how telehealth services are considered in capitation rates. Dale explained that if D.C. Medicaid decides to stop covering audio-only visits in the future, AmeriHealth Caritas D.C. could continue reimburse providers for those visits, but those wouldn't count as "encounters" by the Medicaid agency or for quality measures, which would in turn lower the MCO's capitation rate. It will be imperative to think carefully about this policy going forward. Dale encourages states to gather data and have conversations with a broad range of stakeholders in advance of a policy change. "MCOs and providers will need months of notice if we don't want to cause an abrupt truncation of service," explained Dale; "it could be devastating to turn this off suddenly."

Conclusion

Offering telematernity in Medicaid managed care requires more than just a consideration of codes. As telehealth policy, coverage, and reimbursement changes, telematernity should be analyzed from a slightly different perspective. Dale explained, "What I want most for us in health care is to be *health* focused!" Maternity care is an excellent example of care that should be re-imagined with input from members to focus on reducing barriers, enhanced social and medical care and supportive options such as doulas and peer support. Including a broad range of stakeholders, and incorporating their perspectives into policy, is likely to go a long way in enabling telematernity as a maternal health modality choice for patients.

[i] District of Columbia Department of Health Care Finance, *Telemedicine*, https://dhcf.dc.gov/page/telemedicine.