

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

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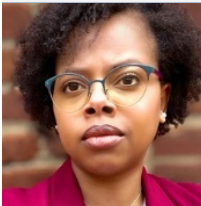
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This project was supported by the Commonwealth Fund, a national, private foundation based in New York City that supports independent research on health care issues and makes grants to improve health care practice and policy. The views presented here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

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An interview with Dr. Sara Salek

Sara Salek, MD, Chief Medical Officer of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency.





Covering telehealth means covering telematernity

As part of an effort to better serve people covered by Medicaid, Arizona significantly expanded telehealth services effective October 1, 2019. The state revamped significant areas of telehealth policy, including lifting restrictions on where care could be obtained and delivered, which medical disciplines would be reimbursed for services delivered via telehealth, what kinds of services would be reimbursed, and through which modality.ⁱ “It all comes down to the codes,” according to Dr. Sara Salek, Chief Medical Officer of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency. Covering telehealth requires implementing Medicaid policies that allow the provision and coverage of a much broader range of reimbursement codes, such as codes included in the Healthcare Common Procedure Coding System (HCPCS), or Current Procedural Terminology (CPT) set. For example, prior to October 1, 2019, Arizona Medicaid only covered telemonitoring for patients with congestive heart failure (CHF); after the telehealth policy changes, there were no restrictions on telemonitoring. This change made it possible to provide some of the core components of telematernity, such as remote monitoring of maternal blood pressure or weight.

Similarly, changing telehealth coverage policy regarding where care can be received and delivered was useful in enabling telematernity services. After October 1, 2019, Arizona Medicaid removed place of service restrictions for patients so they were not required to travel to a health provider's office for care. Essentially, explained Dr. Salek, the 2019 Arizona Medicaid telehealth policy changes allowed health care practitioners to provide services “based on standards of care, scope of practice, and provider and patient preference.” Highlights of Arizona's major telehealth policy decisions are highlighted in Exhibit 1.

Exhibit 1. Arizona Medicaid October 1, 2019 Telehealth

Arizona Medicaid Telehealth Coverage Pre-Pandemic Telehealth Policy Changes (October 1, 2019)

-  Broadening of POS allowable for distant and originating sites
No restrictions on distant site (where provider is located)
Broadening of originating site (where member is located) to include home for many service codes
-  Broadening of coverage for telemedicine, remote patient monitoring, and asynchronous
-  No rural vs. urban limitations
-  MCOs retained their ability to manage network and leverage telehealth strategies as they determine appropriate



Policy Change Summary Chartⁱⁱ

How Arizona is supporting telematernity

When thinking about supporting the provision of telehealth for maternal care services from a state policy point of view, it is important to note there are not specific telematernity codes. Arizona approached this issue by making policy changes that removed discipline restrictions for telemedicine, removed diagnostic restrictions for telemonitoring, and expanded place of services for telehealth. Instead, Arizona gave guidance to providers that if a service is medically necessary, cost effective, and within the scope of practice of the provider, it can be reimbursed when delivered via telehealth.

For example, a provider might recommend a patient monitor their weight or blood pressure during pregnancy. Arizona Medicaid allows the provider to order the scale and blood pressure cuff as durable medical equipment (DME) and these devices are provided to the patient. In the case of blood pressure monitoring, the provider can also bill Medicaid for a telehealth visit to teach the patient how to use the cuff and report information back.

Arizona Medicaid reimburses maternity care through a bundled payment model. Providers can leverage telehealth when clinically appropriate for maternity care and code the applicable telehealth modifier for the service provided. The Arizona approach is to give the Medicaid provider, working closely with the patient, the latitude to decide which care modality works best for which maternal care visit. If some prenatal visits can be provided via telehealth, for example, AHCCCS permits those visits to be provided within the bundled maternity rate with no reduction in reimbursement.

Finally, Arizona Medicaid allowed the provision and reimbursement of the full range of telehealth modalities, including audio-only visits, before the COVID-19 pandemic and plans to continue to do so at least until December 31, 2021. Dr. Salek noted 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 broadband coverage or data speeds that are needed to support synchronous video visits. Whether the state will continue to cover audio-only services, according to Dr. Salek, will depend on multiple factors including current utilization trends, performance measure steward allowances, clinical appropriateness of audio-only, and member access to technology that supports synchronous visits. “We covered audio-only visits before, then greatly expanded access to this approach with our coding changes beginning October 1, 2019. We will re-evaluate in the coming months to determine what should continue.”

Advice for other states

Prior to the pandemic, about 10% of Arizona’s Medicaid members had one or more telehealth claims, but as of February 2021, about 30% of members were receiving one or more services via telehealth.ⁱⁱⁱ As states move up the telehealth policy learning curve, Dr. Salek had two big takeaways. First, she told us, “This is here to stay.” In the area of behavioral health in particular, it seems Medicaid providers and patients want to use telehealth approaches for care. In Arizona, the top utilization type for telehealth is behavioral health, and opioid use disorder has been the most common diagnosis within the telebehavioral health category. Notably, patients rarely fit into a single category of care, so policymakers thinking about continuing telebehavioral health should recognize supporting behavioral health is an important component of supporting telematernity as well.

Second, Dr. Salek recommended state Medicaid agencies engage in extensive outreach to stakeholders, including providers and if applicable, Medicaid managed care organizations (MCOs). Along the same lines, states need to think holistically about how providers deliver care and are paid for care by the provider’s entire range of payers. For example, Arizona has put into statute payment parity, requiring commercial payers to reimburse providers at the same amount, whether care is delivered in-person or virtually in certain circumstances.^{iv} This law will support Arizona Medicaid in its efforts not to exacerbate existing inequities in access to care.

Finally, during our interview Dr. Salek acknowledged change is hard, and change takes time, but her advice for other states is to, “Embrace the change and be flexible.” For example, 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.

What's on the horizon? (AKA What we aren't thinking enough about)

Dr. Salek flagged two key issues Arizona Medicaid is working on as they continue their policymaking efforts related to telehealth. Both issues will also have an impact on how and whether a state Medicaid program is able to support the provision of telematernity.

TELEHEALTH MODALITIES BEYOND VIDEO AND AUDIO

It will be important to think about modalities such as chat, instant messaging, and information sharing in patient portals, as telehealth delivery matures. Dr. Salek said, AHCCCS “is not currently covering those, in part because there hasn't been a big push for it, but as more providers and patients want to use these types of modalities to interact, states will be asked to consider coverage.”

QUALITY

It is important for states to think through which quality measures are being used to monitor Medicaid managed care organizations (MCO) when telehealth is being provided. “We need to make sure our codes are aligned with the different quality measures, but right now we aren't sure exactly what will count,” said Dr. Salek. “If a measure steward doesn't allow it, it won't be counted toward our performance,” Dr. Salek continued, highlighting the important link between telehealth coverage policies and the role performance measure stewards play. Arizona is looking into creating questions to measure patient satisfaction related to telehealth as a way to measure quality of care delivered by health plans.

Conclusion

Telematernity should not be treated as a policy issue completely separated from other state health policy concerns. As telehealth continues to grow and evolve, the National Committee for Quality Assurance (NCQA), a prominent quality measure-setting body, is starting to make adjustments to some of the Healthcare Effectiveness Data and Information Set (HEDIS) measures used to assess health plan performance to allow care being provided via telehealth to “count.” While there are only a few HEDIS measures with new telehealth accommodations as of now, an important quality indicator related to telematernity is in that starting list. The Prenatal and Postpartum Care measure has been modified to allow telephone visits, e-visits, and virtual check-ins as permitted modalities for measuring the Timeliness of Prenatal Care rate component of the measure in the 2021 plan year.^v

As a state considers changes to telehealth policy, our discussion with Arizona Medicaid's medical director clearly shows the importance of thinking about telehealth not as a monolith, but through the lens of specific types of provider disciplines and patient needs.

ⁱ AHCCCS ASD Advisory Committee, *Meeting Notes* (AHCCCS, March 26, 2020),

<https://www.azahcccs.gov/shared/Downloads/ASD/CombinedFiles2020-03-26.pdf>.

ⁱⁱ MACPAC Panel Discussion, *What States are Learning from Expanded Use of Telehealth* (MACPAC, April 2021),

<https://www.macpac.gov/wp-content/uploads/2021/04/Panel-Discussion-What-States-Are-Learning-From-Expanded-Telehealth-Use.pdf>.

ⁱⁱⁱ MACPAC Public Meeting (MACPAC, April 2021), https://www.macpac.gov/public_meeting/april-2021-macpac-public-meeting/.

^{iv} Arizona House of Representatives, HB2454, 2021 Fifty-fifth Legislature, First Regular Session (2021), <https://www.azleg.gov/legtext/55leg/1R/laws/0320.htm>.

^v NCQA, *HEDIS Measurement Year 2020 & Measurement Year 2021 Volume 2, Summary Table of Measures, Product Lines And Changes* (July 16, 2020), <https://www.ncqa.org/programs/data-and-information-technology/telehealth/covid-driven-telehealth-surge-triggers-changes-to-quality-measures/>.