# Telehealth & Maternity Care

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

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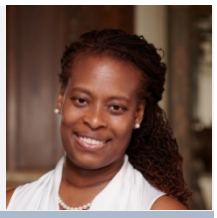


M2 Health Care Consulting

With support by the Commonwealth Fund

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



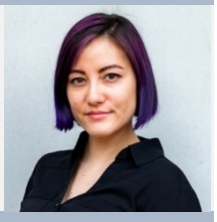
**Brenda Gleason, M.A., M.P.H.**
President, M2 Health Care Consulting



**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



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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**
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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 STATE MEDICAID PROGRAMS – NORTH CAROLINA

An interview with North Carolina Medicaid (May 2021)

M. Kathryn Menard, MD, MPH, Upjohn Distinguished Professor of Maternal-Fetal Medicine, University of North Carolina School of Medicine.

Velma Taormina, MD, MSE, FACOG, Senior Policy Consultant Women's Health, North Carolina Medicaid, Division of Health Benefits, North Carolina Department of Health and Human Services.

Beth Daniel, MSN, RN, Associate Director Medical and Behavioral Health, North Carolina Medicaid Clinical Policy, Division of Health Benefits, North Carolina Department of Health and Human Services.

Ginger Webster, RN, Nurse Consultant, North Carolina Medicaid Clinical Policy, Division of Health Benefits, North Carolina Department of Health and Human Services.

Shannon Dowler, MD, Chief Medical Officer, North Carolina Medicaid, Division of Health Benefits, North Carolina Department of Health and Human Services.

### Covering telehealth means covering telematernity

When COVID-19 started to appear, North Carolina hit the ground running with telehealth. "It was really important for us to keep people already in care safe," Beth Daniel told us, explaining the agency did not want pregnancy care for Medicaid members to be disrupted as in-person visits became difficult or impossible in early 2020.

Coincidentally, a team of providers and policy experts, including our interviewees, had recently asked a Medicaid agency telehealth committee to reconsider parts of the existing telemedicine model, as it was primarily consultative and did not provide for ongoing care. "The reimbursement policy just wasn't working," explained Dr. Kathryn Menard.

For example, before COVID-19, North Carolina Medicaid restricted reimbursement for a telehealth visit providing maternity care to only those visits that were conducted site-to-site. The patient was required to register for services at a provider's office at one location while the consulting provider was at another office location. As the state moved forward with temporary Medicaid telehealth policies generally,[i] this team looked at existing policy related to perinatal services, determined what was missing, and what needed to change, and put together a new set of policies.

### How North Carolina is supporting telematernity

In order to make telematernity useful for Medicaid providers and patients, a team of providers, including Dr. Menard and Dr. Velma Taormina, came up with a "wish list" for use by North Carolina Medicaid to support prenatal and postpartum care during the COVID-19 pandemic. Some of the most

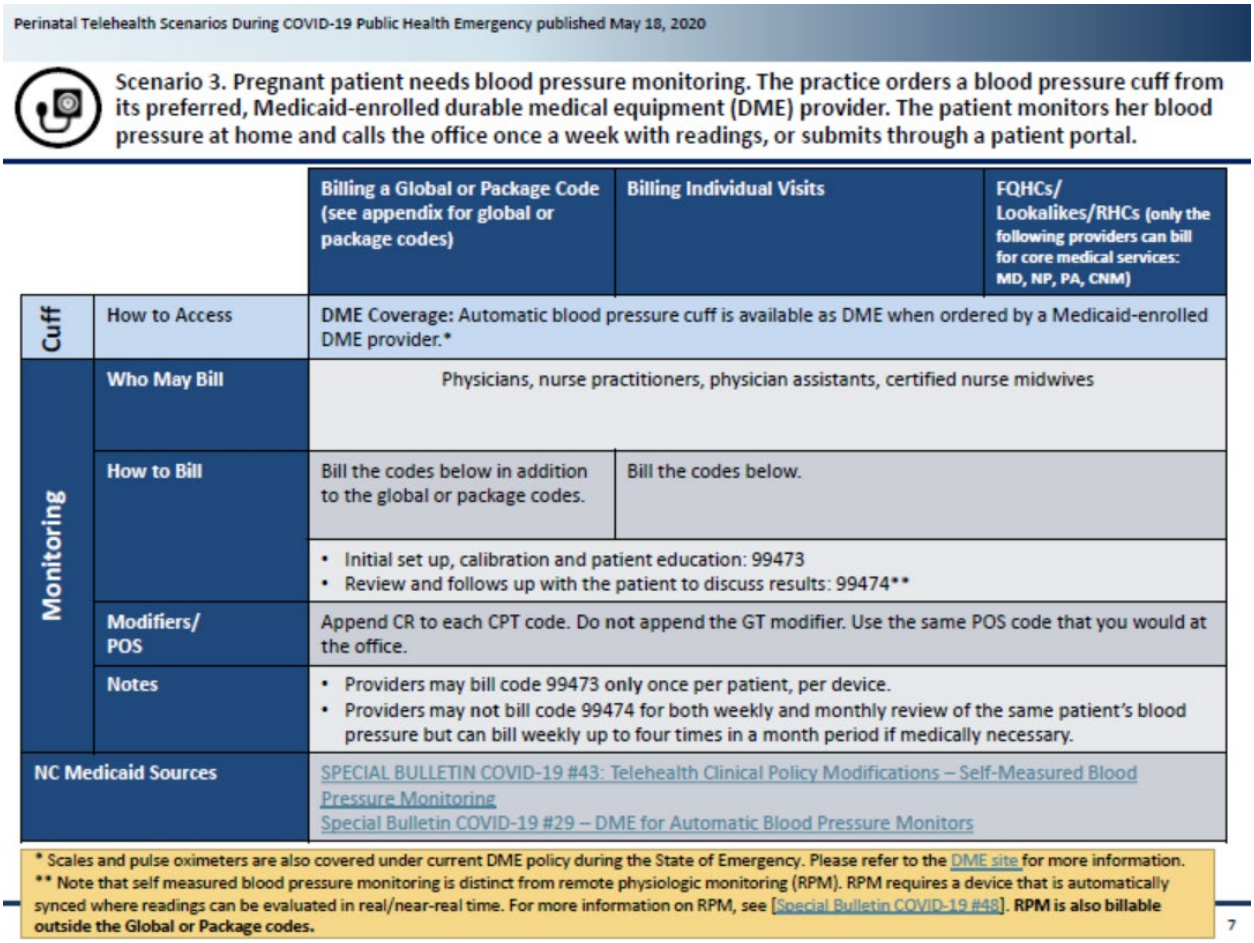
important items on the list related to improving accessibility of medical devices useful in maternity care, including:

- 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.

The provision of blood pressure cuffs and monitors might seem simple, but the complexity of this change is illustrative. First, the device must be included on the list of the Medicaid agency's covered durable medical equipment (DME). Second, providers must have a process for prescribing from the DME list. Many maternity care providers are not accustomed to ordering DME. Third, a properly sized blood pressure cuff must be sent to the patient, and, after the patient receives it, they must be trained to use it by a provider. Fourth, the patient must actually use the device as recommended. Finally, the data must be transmitted back to a provider for their use in treating the patient.

The payment and operations issues just for blood pressure cuffs and remote patient monitoring of blood pressure are dizzying. How much should the provider be paid to review blood pressure data they receive? Is that time billed separately from the remote visit with the patient? Does the patient get to keep the blood pressure monitoring cuff for life or does it need to be returned at some point post-partum? Should every telematernity patient receive a blood pressure cuff? How about a cuff that permits remote monitoring, or should those only be supplied to high-risk pregnant patients? The team created several scenarios specific to telematernity to help address this complex range of possibilities with clear policies. The scenario for a pregnant patient needing blood pressure monitoring is shown in the chart below.

**Exhibit 1. North Carolina Medicaid Billing for Blood Pressure Monitoring in Pregnant Patients**[ii]



Perinatal Telehealth Scenarios During COVID-19 Public Health Emergency published May 18, 2020

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.

| | | Billing a Global or Package Code (see appendix for global or package codes) | Billing Individual Visits | FQHCs/ Lookalikes/RHCs (only the following providers can bill for core medical services: MD, NP, PA, CNM) |
|---|---|---|---|---|
| Cuff | How to Access | DME Coverage: Automatic blood pressure cuff is available as DME when ordered by a Medicaid-enrolled DME provider.* | | |
| Monitoring | Who May Bill | Physicians, nurse practitioners, physician assistants, certified nurse midwives | | |
| | How to Bill | Bill the codes below in addition to the global or package codes. | Bill the codes below. | |
| | | • Initial set up, calibration and patient education: 99473<br>• Review and follows up with the patient to discuss results: 99474** | | |
| | Modifiers/ POS | Append CR to each CPT code. Do not append the GT modifier. Use the same POS code that you would at the office. | | |
| | Notes | • Providers may bill code 99473 only once per patient, per device.<br>• Providers may not bill code 99474 for both weekly and monthly review of the same patient's blood pressure but can bill weekly up to four times in a month period if medically necessary. | | |
| NC Medicaid Sources | | SPECIAL BULLETIN COVID-19 #43: Telehealth Clinical Policy Modifications – Self-Measured Blood Pressure Monitoring<br>Special Bulletin COVID-19 #29 – DME for Automatic Blood Pressure Monitors | | |

* Scales and pulse oximeters are also covered under current DME policy during the State of Emergency. Please refer to the DME site for more information.
** Note that self measured blood pressure monitoring is distinct from remote physiologic monitoring (RPM). RPM requires a device that is automatically synced where readings can be evaluated in real/near-real time. For more information on RPM, see [Special Bulletin COVID-19 #48]. **RPM is also billable outside the Global or Package codes.**

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Advice for other states

The North Carolina Medicaid team we interviewed gave some valuable advice other states might use when considering how to implement telematernity. First, the team acknowledged the importance of having a champion for change. In the case of North Carolina, it is Shannon Dowler, MD, the Chief Medical Officer of North Carolina Medicaid, who is a "huge advocate for maternal health and population health programs."

Second, "look at the data," advised Dr. Taormina. It is important to "let data guide" these policy decisions, she continued. "Transformation to telematernity during the COVID 19 pandemic was a natural experiment in options for access to care," explained Dr. Menard, so North Carolina now has more than a year's worth of data to help guide the state's Medicaid telematernity policies going forward.

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

*OUTCOMES DATA AND PATIENT EXPERIENCE INFORMATION*

All the states we talked with acknowledged there are still issues to figure out as telehealth starts to become the standard of care. One issue every state mentioned was the lack of telematernity outcomes data and how hard it is to measure outcomes, especially during COVID-19. The North Carolina team has

anecdotal information on telematernity, and it is positive. “Providers have new tools available that help patients take control of that connection,” explained Dr. Taormina. Additionally, patients are finding the tools empowering as it helps them “participate in their prenatal care on their own terms,” she continued.

*SYSTEM LEVEL EQUITY WILL REQUIRE INTENTIONAL DESIGN AND IMPLEMENTATION*

States need to think intentionally about equity as telematernity services are rolled-out. For example, North Carolina Medicaid realized quickly that providers and patients in rural areas, in particular, needed to conduct at least some prenatal visits via phone only (no video) due to limited internet access. “There are several questions we need to ponder going forward, including access to broadband in rural areas and who might be disadvantaged by this type of care,” said Dr. Menard.

Thinking about equity, some North Carolina practices also purchased or received donations of blood pressure cuffs for use by patients served by the state’s safety-net system, such as departments of public health. “What we do for one, we’d like to do for all,” said Dr. Taormina, explaining the importance of providing this basic level of maternity care even for patients who are not insured.

Finally, at the broader system level, the North Carolina team noted large health systems in the state were able to pivot quickly to set up telehealth services because they had an existing infrastructure in place. For some community centers and local health departments, that pivot was much more difficult and may be difficult to sustain.

## Conclusion

At this point, North Carolina Medicaid plans to make several of the emergency changes put in place to cover perinatal services via telehealth permanent. According to Ginger Webster, RN, the hybrid model with a supported visit will continue, as will risk screening, child birth educational sessions, behavioral health care services for high-risk pregnancies, and tobacco cessation support. As North Carolina continues its broader system transformation efforts, including transitioning to a Medicaid managed care environment, efforts to incorporate telematernity into existing Pregnancy Medical Home and Global Obstetric Payment Package payment and delivery reforms will also continue. As with the other case studies in this series, telematernity must be considered in context of other Medicaid policy changes to be implemented in a way that supports providers and patients.

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[i] North Carolina Medicaid, Division of Health Benefits, *COVID-19 Telehealth*, https://medicaid.ncdhhs.gov/about-us/covid-19-guidance-and-resources/providers/covid-19-telehealth.

[ii] North Carolina Medicaid, Division of Health Benefits, *Perinatal Telehealth Scenarios During COVID-19 Public Health Emergency, Guidance for NC Medicaid Perinatal Care Providers* (May 18, 2020), https://files.nc.gov/ncdma/covid-19/Perinatal-Telehealth-Scenarios-COVID.pdf.