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SMFM Special Statement

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Society for Maternal-Fetal Medicine Special Statement: Utilizing telemedicine to address disparities in maternal-fetal medicine: a call to policy action

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The combination of deserts in maternal-fetal medicine coverage across the United States and the COVID-19 pandemic accelerated the implementation of telemedicine programs for maternal-fetal medicine care delivery. Although telemedicine-based care has the potential to facilitate timely access to maternal-fetal medicine services, which can improve maternal and neonatal outcomes, telemedicine is a relatively novel healthcare modality that needs to be implemented strategically. As with any medical service, telemedicine care requires rigorous evaluation to assess outcomes and ensure quality. Important health policy considerations, including access to services and insurance coverage, have substantial implications for equity in the implementation of telemedicine, particularly for reproductive healthcare following the 2022 United States Supreme Court decision in *Dobbs v Jackson Women's Health Organization* that overturned the constitutional right to an abortion. Investing resources and advocating for a rigorous, widely accessible telemedicine infrastructure at this crucial moment will establish an important foundation for more equitable pregnancy care. Key advocacy priorities for maternal-fetal medicine telemedicine include (1) expanding insurance coverage of telemedicine across payers, regardless of geographic location; (2) advocating for interstate licensure parity; (3) increasing access to affordable Internet and digital literacy training; and (4) ensuring access to reproductive healthcare, including abortion care, delivered via telemedicine.

Key words: access, advocacy, equity, health policy, maternal-fetal medicine, telemedicine

Introduction

The confluence of rapidly evolving telecommunications technology, a global pandemic, increasing restrictions on reproductive healthcare delivery at the state level in response to the Supreme Court decision to overturn *Roe v Wade*, and a United States (US) healthcare environment challenged by disparities in access to maternal-fetal medicine (MFM) care has created a unique moment in time to evaluate the role of telemedicine in MFM practice. Unlike healthcare fields focused on managing chronic conditions, obstetrics is exceptionally time sensitive, and convenient access to care is crucial to support maternal and fetal health. In addition, obstetrical patients may be disproportionately challenged by barriers to timely care access, such as childcare responsibilities and lower wages or inflexible jobs. MFM physicians provide essential pregnancy care, including obstetrical ultrasonography, fetal therapy, and management of maternal medical complications.[1] Telemedicine offers a novel platform to improve access and improve continuity of MFM care, which can promote positive obstetrical outcomes.[2]

Telemedicine utilization has grown exponentially over the past 3 years in large part as an emergency response to the COVID-19 pandemic, offering healthcare stakeholders an opportunity to study the natural experiment of widespread telemedicine deployment. Before the pandemic, telemedicine accounted for <1% of all ambulatory visits; however, telemedicine utilization increased to nearly 25% during 2020–2021.[3] This rapid and marked change in the state of telemedicine makes it essential for the field of MFM to thoughtfully consider how these changes can be leveraged—at clinical and policy levels—to improve MFM care delivery and access in the long term. In addition, the interplay of newly enforced and enacted abortion bans and restrictions on providing abortion care via telemedicine will continue to limit access to reproductive healthcare for high-risk pregnancy patients. In a recent issue brief, the Society for Maternal-Fetal Medicine (SMFM) Health Policy and Advocacy Committee outlined several strategies to consider

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in the implementation of telemedicine for advancing equitable access to MFM care.[4] In this article, we will review the existing practice of MFM telemedicine, discuss future directions, and highlight ways MFM subspecialists can advocate for best practices.

Barriers to maternal-fetal medicine care

Access to MFM for obstetrical ultrasound and high-risk pregnancy management enhances pregnancy care, including improving prenatal diagnosis of fetal anomalies and managing complex maternal conditions.[1,5,6] When evaluated in 2010, there were 1355 MFM subspecialists practicing in the US, and nearly all (98.2%) practiced in metropolitan counties with tertiary perinatal centers; data from 2021 suggests approximately 10% of counties have a practicing MFM.[7] Despite most states having more than 10 MFM physicians, the range of windshield time to see a specialist was between 3 and 6 hours.[8] Of note, 2 states—North Dakota and Wyoming—did not have a single MFM physician.[7] Geographic barriers to accessing healthcare in rural communities are well recognized and are especially problematic during pregnancy as care is time sensitive and may require unexpected escalation that requires input from subspecialists.[9] Counties without an MFM physician have higher preterm birth rates than counties with an MFM.[10] Because of the reversal of *Roe v Wade*, many states have limited or restricted reproductive healthcare, making geographic disparities in telemedicine even more acute. The state of MFM care in the US highlights wider system- and provider-level barriers to equitable healthcare delivery. Most pregnant patients across the country deliver in low-volume, low-acuity hospitals that perform fewer than 1000 deliveries per year and may not have convenient, in-person access to MFM physicians.[11] However, a large proportion of pregnancy complications occur in low-risk patients.[12] Timely access to MFM care for patients with unanticipated adverse outcomes can be essential to optimize maternal and neonatal health.

These geographic inequities in accessing MFM services may play a role in the concurrent surge in severe maternal morbidity (SMM) and mortality in the United States; the maternal mortality rate has doubled over the past 30 years, and nontransfusion SMM has increased by 20%.[13,14] Adverse maternal outcomes disproportionately affect patients in rural areas, who have a 9% higher likelihood of experiencing SMM than urban residents.[15] Moreover, there are well-documented disparities in obstetrical morbidity and mortality by race and ethnicity.[16,17] Most maternal mortalities (approximately 84%), and likely a substantial portion of maternal morbidities, are preventable.[18] Although the etiologies of maternal morbidity and mortality are heterogeneous, there are common contributors related to timely, accessible, and risk-appropriate maternal care. Proposed components of a multifactorial approach to reducing maternal morbidity and mortality include safeguarding reproductive healthcare access, optimizing continuity of care, managing chronic health conditions, ensuring close postpartum follow-up, and facilitating timely and appropriate referrals to higher levels of maternal care. These healthcare delivery strategies have the potential to reduce overall maternal morbidity and alleviate geographic and racial disparities,[18] as all these potential solutions revolve around navigating the barriers to care that disproportionately affect marginalized populations.[4] With thoughtful implementation, telemedicine has the potential to broaden access for those with the most need and who are also at the highest risk of adverse outcomes.

Advantages of maternal-fetal medicine telemedicine

Traditional care has considerable costs to patients and providers that might be alleviated by telemedicine visits. Of note, one study of more than 200,000 general ambulatory care visits in the US demonstrated that, although mean face-to-face time with a physician during a typical office visit is only 20 minutes, the total visit duration on average was 84 minutes, with an additional 37 minutes of travel time. The financial opportunity cost of a doctor's visit was $43 US dollars per visit on average, with total opportunity costs for all physician visits per year across the US estimated at $52 billion.[19] These findings have been corroborated by other studies of ambulatory care utilization[20,21] and, despite not being specific to obstetrics, highlight the high cost to patients of traditional in-person care; patients receiving standard prenatal care likely experience even larger costs because of the frequency of visits. From a patient standpoint, telemedicine appointments eliminate some of these costs by reducing travel time; the costs associated with gas, parking, or public transportation; the need for childcare; wait time; and lost wages. Moreover, the convenience of telemedicine appointments eliminates a barrier to care for patients who have difficulty arranging transportation or securing time off from work. From a physician's standpoint, telemedicine can improve continuity and efficiency of care, reduce no-show rates, allow for more flexible scheduling, reduce office overhead, and expand reach to underserved areas.[4]

In addition, MFM care delivered via telemedicine platforms may offer a unique opportunity to deliver timely, high-quality, high-risk obstetrical care to patients who are not well served by the current model, including patients located in rural areas, patients experiencing poverty, and patients who are subject to interpersonal and structural racism, all of whom experience disproportionate rates of obstetrical morbidity and mortality.[9,17,22] Prepandemic research demonstrated the ability of telehealth to reduce racial disparities in obstetrical care. For example, by improving blood pressure monitoring and follow-up for Black patients during the postpartum period.[23] Because telemedicine can extend MFM services virtually for all aspects of high-risk pregnancy care that do not require physical contact with a healthcare provider, it also offers the potential to eliminate geographic barriers to specialty care for the management of maternal medical complications, such as hypertension and diabetes

mellitus, genetics consultations, and interpretation of obstetrical ultrasound and fetal echocardiography. Many programs across the country have already been successfully developed and implemented to extend MFM care in these ways.[24–27]

Well before the COVID-19 pandemic, the lack of MFM access led some pioneering health systems to introduce telemedicine platforms to serve their rural populations. These programs were met with high patient uptake, patient and provider satisfaction, and comparable outcomes to traditional in-person care.[27–30] The High-Risk Pregnancy Program (formerly known as the Antenatal and Neonatal Guidelines, Education, and Learning System) based on the University of Arkansas for Medical Sciences is the longest standing of these systems, originally established in 2002. The model includes weekly telemedicine conferences between generalists and MFMs and telemedicine-based antenatal care, ultrasound interpretation, telephone consults, and triage and transport services.[27,31] Another program in Tennessee, Solutions to Obstetrics in Rural Counties, provided full-time MFM telemedicine coverage for all rural hospitals in addition to an advanced practice provider and sonographer to visit rural locations weekly in person.[30] A Pittsburgh-based program providing rural MFM telemedicine care demonstrated potentially scalable benefits, including cost savings of $90.28 per consult while maintaining comparable obstetrical outcomes and high patient satisfaction scores.[28] Before the pandemic, telemedicine had not been attempted on a large scale in urban or suburban areas, but COVID-19 led several institutions to develop care delivery models for high-risk pregnancies that used telemedicine whenever possible. This telemedicine-enabled care included diabetes mellitus and hypertension management, nutrition and genetics consultations, and counseling for the management of fetal complications.[32,33] Although data on the outcomes of these programs are limited to date, existing research demonstrates that patients with complicated pregnancies prefer a hybrid of telemedicine and in-person MFM care for continuity and convenience and that offering virtual care options decreases the number of canceled MFM appointments.[34] Moreover, published implementation strategies highlight opportunities to optimize MFM telemedicine going forward.

Telemedicine policymaking for access, equity, and quality

Given the duration of the ongoing COVID-19 pandemic and the reversal of *Roe v Wade*, which has caused many states to limit or restrict reproductive healthcare, this is an important juncture for clinicians to advocate for the healthcare policies that will enable continued utilization of telemedicine for MFM care in a manner that is sustainable and equitable. Although tele-MFM has promising patient and clinician benefits, challenges in the current policy landscape, including insurance coverage and reimbursement, interstate licensure, and technology access and quality, must be confronted to ensure that these platforms do not inadvertently increase health inequities. Nonetheless, there are feasible legislative and regulatory solutions to these problems (Table 1).

TABLE 1
Policy priorities for accessible and equitable maternal-fetal medicine telemedicine

Expand insurance coverage of telemedicine across payers, regardless of geographic location, including the following:
• Coverage for durable medical equipment
• Reimbursement parity for telemedicine vs in-person visits
• Reimbursement parity for audio-only visits when video is unavailable
Advocate for interstate licensure parity
Increase access to affordable Internet and digital literacy training
Financially incentivize providers to expand reach with telemedicine by reimbursing facility costs for creating and maintaining telemedicine infrastructure

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The success and scalability of telemedicine are determined, in part, by payor coverage. The federal government (via the Centers for Medicare & Medicaid Services) determines the levels of coverage and reimbursement provided by Medicare to healthcare providers and institutions. Before the pandemic, Medicare reimbursement for telemedicine services was highly limited and provided to rural areas only.[35] Moreover, federal reimbursement guidelines required telemedicine services to transpire via 2-way audiovisual communication. In some states, these restrictions were lifted during the pandemic so that audio telecommunication could be used, but ongoing coverage for expanded telemedicine utilization is unclear.[36] Medicaid agencies and commercial insurers determine reimbursement for telemedicine at the state level, and these policies remain variable.[37] Before COVID-19, only 3 states (Ohio, North Carolina, and New York) specifically addressed perinatal telemedicine in their Medicaid coverage plans, although most states had laws requiring private insurers to reimburse for telemedicine at a comparable rate to in-person care.[38,39] Similar to the federal criteria, every state allowed for Medicaid coverage of telemedicine, provided that videoconferencing was used.[40] Reimbursement for telemedicine care provided to patients across state lines is highly variable and regulated at the state level.

For telemedicine to be universally accessible to patients and providers, financial barriers must be addressed. Reimbursement processes can better incentivize health systems and providers to adopt telemedicine into their practice, including coverage for the overhead costs required for the implementation and maintenance of appropriate technology and infrastructure and coverage for telemedicine-enabled interpreter services when appropriate. Telemedicine

coverage should be expanded across all payers with parity in reimbursement to in-person care. To facilitate home monitoring, this coverage should also include both the necessary durable medical equipment and the time required to interpret remote monitoring of patient-level data, such as blood pressure and blood glucose.[41]

In addition to adequate reimbursement, policies should also prioritize high-quality telemedicine-based care. Of note, one aspect of quality care in this context is technology adequate for video services, which includes cellular telephone and broadband access. As 2-way audiovisual telemedicine appointments demand a certain degree of digital literacy, equitable access requires telemedicine applications to be user-friendly for patients with limited health literacy and minimal technological proficiency. The Federal Communications Commission reports that nearly 6% of all Americans and a quarter of those in rural areas lack access to fixed broadband services.[42] Equitable telemedicine policy should incentivize access to affordable broadband and support initiatives to improve digital literacy in vulnerable populations. Until then, reimbursement for audio-only visits should be on par with video visits for patients who do not have access to video-equipped devices or the Internet.

Finally, variations in state policies can limit the equitable delivery of telemedicine. Access to telemedicine across state lines is limited by state-based licensure and credentialing policies that determine which services can be provided and which services can be reimbursed.[43] Restriction of telemedicine care across state lines introduces obstacles to accessing care, particularly for patients with limited local options. Interstate licensure compacts are 1 potential solution to alleviate this challenge and increase access for patients. In addition, several states have restricted reproductive health services; policies that limit specific telemedicine services (eg, medication abortion) may have unforeseen consequences that result in limiting all types of reproductive healthcare.

On a professional society level, it is essential to develop and uphold standards of care for telemedicine practitioners, facilities that support telemedicine care, and technological platforms. Formal competencies for telemedicine care have been developed by the Association of American Medical Colleges.[44] Program evaluation and outcome surveillance are important parts of implementing a new model of care; the Model for Assessment of Telemedicine Applications is one option for systematic evaluation of telemedicine programs that focuses on 8 components: the health problem of interest; safety; clinical effectiveness; cost-effectiveness; patient perspectives; and sociocultural, legal, and ethical attributes.[45] It is essential that as telemedicine is upscaled to increase access, the quality of care remains high and subject to the same standards as other types of healthcare, with MFM-specific competencies, evaluation protocols, and quality improvement efforts.

MFM clinicians can play a key role in advocating for policies at the local, state, and federal levels, with suggestions enumerated in Table 2. Health policy initiatives designed to improve access, eliminate inequities, and reduce maternal morbidity and mortality must include strategies that address the implementation of telemedicine. Although the pandemic has introduced unprecedented barriers to ambulatory practice, we now have the opportunity to leverage the investments that have been made to create sustainable MFM telemedicine models that also address the crucial needs of the patients we serve.

TABLE 2
Advocacy options for clinicians

Get involved with your state chapter of the American College of Obstetricians and Gynecologists
Get involved with your state medical society
Write an opinion piece or letter to your newspaper
Write a letter or meet with your local lawmakers
Meet with your federal lawmakers when they return to their local offices
Get involved with the Society for Maternal-Fetal Medicine State Legislative Network and sign up for action alerts

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SMFM recognizes that obstetrical patients have diverse gender identities and is striving to use gender-inclusive language in all of its publications. SMFM will be using terms such as "pregnant person" and "pregnant individual" instead of "pregnant woman" and will use the singular pronoun "they." When describing study populations used in research, SMFM will use the gender terminology reported by the study investigators.

Reprints will not be available.

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