



Case Study: How Minnesota Uses Medicaid Levers to Address Maternal Depression and Improve Healthy Child Development

Tina Kartika



Despite evidence that maternal depression is quite common and can negatively impact the development of young children, it is often undiagnosed and untreated; however, states can use policy levers to increase maternal depression screening and treatment. Since the rate of maternal depression is disproportionately higher in low-income women,¹ Medicaid can play a leading role in identifying at-risk mothers and connecting them to treatment.² Minnesota has administered a [Quality Improvement Project \(QIP\)](#) that focuses on addressing postpartum depression and through the project has developed tools that may be useful to other states.

Background

While children with depressed mothers have increased risks of behavior problems,³ delayed language development,⁴ and poorer infant cognitive outcomes⁵ among a host of other problems, an intervention to reduce maternal depression symptoms has been shown to improve early childhood problem behavior.⁶ For this reason, maternal depression screening is recommended by the U.S. Preventive Services Task Force,⁷

the American Academy of Family Physicians,⁸ the American College of Obstetricians and Gynecologists (ACOG),⁹ and the American Academy of Pediatrics (AAP),¹⁰ with the most recent AAP *Bright Futures Guidelines* recommending postpartum depression screening from the one-month through the six-month well-child visit.¹¹

State Medicaid agencies may allow providers to bill for maternal depression screening under the mother's Medicaid coverage and/or as part of the child's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.¹² Maternal depression screening is covered under the child's Medicaid coverage in 11 states and the District of Columbia according to a 2016 survey.¹³ Covering maternal depression screening under the child's Medicaid coverage enables new mothers who may not be eligible for Medicaid to be screened.

Minnesota's Quality Improvement Project

According to 2009-2011 Minnesota Pregnancy Risk Assessment Monitoring System (PRAMS) data, an average of 9.2 percent of mothers reported experiencing postpartum depression symptoms. Postpartum depression is even more prevalent among low-income mothers: 1 in 5 low-income mothers in the state is diagnosed with postpartum depression, but only 1 in 10 receives treatment.¹⁴

Minnesota's involvement in the [Assuring Better Child Health Development \(ABCD\)](#) Program from 2003 to 2012 paved the way for the state's work on maternal depression screening.¹⁵ To show the state's commitment in addressing this issue, Minnesota approved billing for up to three postpartum depression screens during well-child checks in the first 12 months¹⁶ and added maternal depression screening to the recommendations for EPSDT screenings (known as Child and Teen Checkups (C&TC) in the state).¹⁷

Another opportunity to address postpartum depression opened up when the Minnesota Department of Human Services (DHS, Medicaid Agency) received an [Adult Medicaid Quality \(AMQ\) grant](#) from the Centers for Medicare and Medicaid Services (CMS). As part of this grant, DHS contracted with the Minnesota Department of Health (MDH) to facilitate two cohorts of a QIP on postpartum depression screening. DHS provided MDH with the number of mothers on Medicaid who had a code related to depression and the number of postpartum depression screens in well-child visits that were billed. The QIP started in February 2015, with the goal of supporting improved universal screening and referral for postpartum depression during well-child visits. Minnesota focused on addressing screening implementation issues during well-child checks because more mothers attend a two-month well-child visit (92 percent in Minnesota's Medicaid population in 2012¹⁸) compared to postpartum visits. The first cohort ran for 12 months and the second ran for 10 months, and the two cohorts were implemented at 20 pediatric and family practice clinics across the state.¹⁹

Even though the AMQ grant has concluded, Minnesota continues to run the postpartum depression QIP. Minnesota launched its [third cohort](#) in July 2016, which includes similar project activities as those in the pilot group but without the financial incentive offered in the first two cohorts. In addition to pediatricians and family practitioners, the third cohort is open to obstetricians and other organizations that serve women but do not perform well-child visits. Including these providers expands the scope of the QIP to support universal screening both during pregnancy and postpartum. Identifying mothers with mental health challenges during pregnancy and ensuring they get the treatment they need could lead to better outcomes than addressing the issues only postpartum.

State Policy Levers Minnesota Uses to Address Maternal Depression

- *Medicaid Reimbursement:* As noted earlier, Minnesota Medicaid reimburses maternal depression screening. As a result of this QIP, Minnesota changed the cap on the number of maternal depression screenings in well-child checks from three to six maximum billable visits in the first year of the child's life.²⁰ Screening helps to identify where treatment is needed. Minnesota Medicaid reimburses postpartum depression treatment for mothers eligible for Medicaid. Some mothers who qualify for Medicaid coverage with no cost sharing find their coverage requires cost sharing once their pregnancy eligibility status ends 60 days postpartum. For some mothers, this cost is prohibitive, and they end coverage. However, they can still be screened after their coverage ends because screening is billed under the child's Medicaid.
- *Other Funding Streams:* Since the end of the AMQ grant, Minnesota has been using a variety of funding streams to provide QI and staffing support for the QIP, including state maternal depression dollars.
- *Quality Improvement Infrastructure:* Minnesota organizes learning collaborative sessions and provides technical assistance to support primary care providers and clinic care coordinators participating in the QIP.²¹ MDH provides participating primary care clinics with contacts for the early childhood mental health providers and county mental health clinics that provide treatment on a sliding scale; MDH also provides education about free mental health services. In addition, the state analyzes the data that providers submit monthly and provides run charts back to the providers for rapid-cycle improvements supporting universal screening and referral to treatment.²²
- *Incentives:* In the pilot, Minnesota gave a \$3,000 stipend to participating clinics that implemented universal screening and referral to treatment,²³ which was effective in keeping the clinics engaged. Other incentives the state still offers to participating providers include maintenance of certification (MOC) for pediatrics and family medicine practitioners and continuing medical education (CME) credits for all participants.²⁴ Obstetricians and gynecologists are eligible for MOC through ACOG.

Using lessons learned from the QIP, Minnesota has published [Clinical Guidelines](#) to implement postpartum depression screening in pediatric settings, which may be useful to other states. The Clinical Guidelines include an ideal **screening workflow** from parent and child arrival at the clinic to referral and potential interventions. Other information in the Clinical Guidelines includes **ways to document and chart** for postpartum depression in well-child checks, sample **scripts** for clinic staff to use in screening and referral, **considerations around choosing at which well-child visits to screen and which validated tool to use**, as well as **billing information**. For providers who can only conduct one screening, Minnesota recommends screening at the two-month well-child visit because it is past the initial adjustment period of having a baby while still very early in the child's development. Symptoms of "maternity blues" or "baby blues" that affect 50 to 80 percent of new mothers should subside within two weeks after having a baby,²⁵ so screening at two months would distinguish the lingering postpartum depression from ephemeral baby blues. Additionally, the Clinical Guidelines recommend that if the parent screens positive, the providers monitor the well-being of the child and siblings and provide possible childcare plans the clinic can arrange while the parent receives care. Minnesota has also provided links to the screening tools that are approved for billing available in many languages on the [MDH website](#).

Besides developing useful tools for providers to implement screening, Minnesota has developed [information sheets and a maternal well-being plan](#) for clinicians to make available to clients in seven languages, demonstrating the state's commitment to increasing awareness about postpartum depression.

As of December 2015, providers participating in the project had completed 2,885 screens, with 203 out of the 341 positive screens referred.²⁶ There was a decrease in the rate of referrals in the second cohort (52 percent) compared to that in the first cohort (67 percent) because the second cohort had more family medicine practitioners who were more comfortable treating postpartum depression and did not refer mothers with positive results to other providers but rather managed it themselves.²⁷ The state followed up with clinic teams that participated in the first two cohorts 12 months later, and more than half of the teams still conducted universal screening.²⁸ Among barriers to continued universal screening are difficulty with documentation and lack of staff.²⁹ From the state perspective, tracking for postpartum depression screening can be difficult, but training providers to screen is essential because providers apply their training to all patients instead of only to those who are eligible for Medicaid.³⁰

Linking Mothers to Treatment

Connecting mothers to effective treatments can be challenging. History of mental health problems is a major risk factor for maternal depression—a study of 104 women with postpartum depression in Finland found that 82 percent of them had a history of depression.³¹ However, partly due to conflicting recommendations from providers, many mothers quit medication when they get pregnant, leading to problems postpartum. Therefore, referrals often mean encouraging mothers to reconnect with an existing mental health provider and treatment plan or helping mothers find a new mental health provider. Counseling therapy is the first line of treatment, but inconvenient appointment schedules and lack of transportation may pose barriers to access. Additionally, there are therapists that do not allow mothers to bring their infants to appointments. Medication might be easier to access through a primary care practitioner, but many providers are reluctant to prescribe medication to pregnant or breastfeeding mothers, so mothers often have to wait for a psychiatry appointment to obtain medication as part of their care plans. To address this issue, Minnesota has encouraged primary care providers to consider consulting with a postpartum depression expert psychiatrist in creating treatment plans rather than wait for an open psychiatry appointment.

Minnesota's efforts to address maternal depression provide lessons and tools for other states considering strategies to improve maternal and child well-being. To improve accessibility to information, states can make resources for maternal depression available in multiple languages. Developing a screening workflow can be challenging,³² but having standardized guidance documents providers can refer to helps them to implement screening. State Medicaid agencies could also consider disseminating guidelines and implementing expectations for postpartum depression to be screened during postpartum visits. Allowing Medicaid reimbursement for perinatal and postpartum depression screening is an important first step, but positive diagnosis must be followed by appropriate referrals, follow-ups, and treatment before it can improve health outcomes. According to a 2016 national study, 30.8 percent of women with postpartum depression are identified within clinical settings, 6.3 percent of women with postpartum depression receive adequate treatment, and 3.2 percent of women with postpartum depression achieve remission.³³ Minnesota assists providers participating in the QIP to strengthen their referral practices, which may include connecting mothers to peer or community support programs (e.g., group, hotline, other agencies), family home visiting, psychotherapy, and/or medication.³⁴ Since postpartum depression can have pernicious effects on child development, states can also consider encouraging providers to conduct social-emotional screening for children. From encouraging and reimbursing screening to linking mothers to treatment, there are many ways Medicaid can address maternal depression in states.

Endnotes

1. Samantha B. Berkule et al., "Reducing Maternal Depressive Symptoms Through Promotion of Parenting in Pediatric Primary Care," *Clinical Pediatrics* 53, no. 5 (2014): 460–469, accessed March 15, 2017, doi: 10.1177/0009922814528033.
2. Vikki Wachino, "Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children," *CMS Informational Bulletin*, May 11, 2016, <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>.
3. Dante Cicchetti, Fred A. Rogosch, and Sheree L. Toth, "Maternal Depressive Disorder and Contextual Risk: Contributions to the Development of Attachment Insecurity and Behavior Problems in Toddlerhood," *Development and Psychopathology* 10 (1998):283–300, accessed March 15, 2017, doi: 10.1017/S0954579498001618.
4. A. D. Cox et al., "The Impact of Maternal Depression in Young Children," *Journal of Child Psychology and Psychiatry* 28 (1987): 917–928, accessed March 15, 2017, doi:10.1111/j.1469-7610.1987.tb00679.x.
5. Lynne Murray et al., "The Impact of Postnatal Depression and Associated Adversity on Early Mother-Infant Interactions and Later Infant Outcome," *Child Development* 67 (1996): 2512–2526. doi:10.1111/j.1467-8624.1996.tb01871.x.
6. Daniel S. Shaw et al., "Improvements in Maternal Depression as a Mediator of Intervention Effects on Early Childhood Problem Behavior," *Development and Psychopathology*, 21 (2009): 417–439, accessed March 15, 2017, doi: 10.1017/S0954579409000236.
7. U.S. Preventive Services Task Force, "Final Update Summary: Depression in Adults: Screening," January 2016, <https://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/depression-in-adults-screening1?ds=1&s=depression>.
8. American Academy of Family Physicians, "Postpartum Depression Toolkit," accessed March 24, 2017, <http://www.aafp.org/patient-care/nrn/studies/all/trippd/ppd-toolkit.html>.
9. American College of Obstetricians and Gynecologists, "Optimizing Postpartum Care," June 2016, <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Obstetric-Practice/Optimizing-Postpartum-Care>.
10. Marian F. Earls, "Incorporating Recognition and Management of Perinatal and Postpartum Depression Into Pediatric Practice," *Pediatrics* 126 (2010): e1105, reaffirmed in 2015, <http://pediatrics.aappublications.org/content/126/5/1032.full>.
11. Alyson Sulaski Wyckoff, "Bright Futures: 4th Edition Includes Focus on Social Determinants of Health," *AAP News*, February 17, 2017, <http://www.aappublications.org/news/2017/02/17/brightfutures021717>.
12. Wachino, "Maternal Depression Screening."
13. Sheila Smith et al., *Using Medicaid to Help Young Children and Parents Access Mental Health Services*, National Center for Children in Poverty, updated March 2017, http://www.nccp.org/publications/pdf/text_1164.pdf.
14. Minnesota Department of Health, "Minnesota and Perinatal Mood and Anxiety Disorders," accessed March 15, 2017, <http://www.health.state.mn.us/divs/cfh/topic/pmad/mnfacts.cfm>.
15. "Assuring Better Child Health & Development (ABCD) in Minnesota: 2003-2012," October 17, 2012, http://nashp.org/sites/default/files/abcd/ABCDresources.org/abcd.mn_confpres.102012.pdf.
16. Minnesota Department of Health, "Improving Child, Youth and Maternal Mental Health Screening in Well Child Visits" (presentation, Association of Maternal and Child Health Programs Conference, Kansas City, MO, March 5, 2017).
17. Tessa Wetjen, "Implementing Post Partum Depression Screening in Well Child Checks" (presentation, 2015 CMS Quality Conference: Improving Postpartum Visit Rates and Quality of Care, December 1, 2015).

18. Ibid.
19. Ibid.
20. MDH, "Improving Maternal Mental Health Screening."
21. Minnesota Department of Health, "Perinatal Depression and Anxiety Screening – Cohort 3 Learning Collaborative Quality Improvement Project," accessed March 15, 2017, <http://www.health.state.mn.us/divs/cfh/topic/pmad/content/document/pdf/qjpcohort3.pdf>.
22. Ibid.
23. Wetjen, "Implementing Screening."
24. Ibid.
25. Earls, "Incorporating Recognition of Perinatal Depression."
26. Wetjen, "Implementing Screening."
27. MDH, "Improving Maternal Mental Health Screening."
28. Ibid.
29. Ibid.
30. Ibid.
31. Pirjo Kettunen, Eeva Koistinen, and Jukka Hintikka, "Is Postpartum Depression a Homogeneous Disorder: Time of Onset, Severity, Symptoms and Hopelessness in Relation to the Course of Depression," *BMC Pregnancy and Childbirth* 14 (2014): 402, accessed March 22, 2017, doi: 10.1186/s12884-014-0402-2.
32. Wetjen, "Implementing Screening."
33. Elizabeth Q. Cox et al., "The Perinatal Depression Treatment Cascade: Baby Steps Toward Improving Outcomes," *The Journal of Clinical Psychiatry* 77, no. 9 (September 2016): 1189-1200, accessed March 17, 2017, doi: 10.4088/JCP.15r10174.
34. Tessa Wetjen, "Pregnancy and Postpartum Mental Wellbeing," YouTube video, 43:21, from a webinar presentation, posted by "WellShare International," August 3, 2016, <https://www.youtube.com/watch?v=9GIWJlc54e0>.

About the National Academy for State Health Policy:

The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, nonpartisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

Acknowledgements:

Any information not cited in this case study was kindly provided by Tessa Wetjen, Perinatal Depression Planner from the Minnesota Department of Health. The author thanks Ms. Wetjen, Susan Castellano, and Carrie Hanlon for their helpful comments and contribution to this case study. This case study was made possible by support from the David and Lucile Packard Foundation.