



# State Strategies to Measure and Incentivize Adolescent Depression Screening and Treatment in Medicaid

*Kate Honsberger and Alexandra King*

State Medicaid programs are interested in strategies to increase rates of adolescents being screened for depression and better linking them to treatment. These strategies help to improve quality of care and control costs associated with undiagnosed and untreated depression. This case study highlights how Minnesota and Oregon have implemented quality measures or incentives for adolescent depression screening and follow-up treatment to improve performance of Medicaid providers and health plans in this crucial service area.

A significant number of children and youth experience mental health issues; many of these children are enrolled in Medicaid. According to research, half of all lifetime cases of mental illness begin by age 14<sup>1</sup> and depression is the second most prevalent behavioral health disorder among Medicaid enrolled children.<sup>2</sup> Rates of adolescent depression have also increased nationally over the past several years.<sup>3</sup> Early identification, diagnosis, and treatment of mental health conditions can be an important step in helping to reduce future health problems and is critical to the health outcomes of children and youth.<sup>4</sup> Mental illnesses can also have an impact on the physical health of children and adults. The connection between physical and behavioral health is also reflected in recent state efforts to integrate behavioral and physical health in service delivery systems.<sup>5</sup> Efforts to increase screening and treatment of depression in adolescents can also have an impact on costs related to undiagnosed or untreated mental illnesses in adults. According to a recent Medicaid and CHIP Payment and Access Commission (MACPAC) report, almost half of all Medicaid spending is for services, not just mental health services, for Medicaid enrollees who have a behavioral health diagnosis.<sup>6</sup>

Early identification of depression is critical to an adolescent's development. A large number of national child health and preventive service guidelines support and recommend annual depression screening in adolescents, including The Bright Futures Guidelines.<sup>7</sup> These guidelines are a comprehensive set of recommended health screenings and preventive services for children, developed by the American Academy of Pediatrics and supported by the Health Resources and Services Administration.<sup>8</sup> The Bright Futures Guidelines specifically recommend that adolescents receive depression screenings at well-child visits starting at age 12 through age 21.<sup>9</sup> The Guidelines also provide a list of recommended screening tools<sup>10</sup> for providers to use when screening for depression in adolescents during a well-child visit.

Once an adolescent has been screened for depression and identified as being at risk for the condition, the next step in the system of care is to refer that individual to a provider for follow-up care and any necessary treatment.<sup>11</sup> An adolescent's system of care will track individuals who were referred to treatment and determine that they receive the recommended follow-up care. This task can be difficult as it requires states to use a system-wide mechanism to track referral follow-ups.<sup>12</sup> This case study features Minnesota and Oregon, which are using innovative measures at the provider and health plan level to track rates of adolescent depression screening and to measure and incentivize follow-up treatment for those who screen positive for adolescent depression.

## Minnesota: Adolescent Depression Screening Statewide Clinical Quality Measure

In 2008, the Minnesota Health Reform law tasked the Minnesota Department of Health with establishing a statewide system of clinical quality measures for providers. The goal of this quality system was to create a standardized approach to measuring quality across coverage types and demographics. As a result, the [Minnesota Statewide Quality Reporting and Measurement System](#) became the sole authority in the state to establish quality reporting requirements for all providers in the state. All physician practices and health centers in Minnesota, including those who serve Medicaid enrollees, are required to participate in the Statewide Quality Reporting and Measurement System. The work to create statewide clinical measures was done in partnership with [MN Community Measurement](#), a non-profit that creates measures and publishes



health care data in Minnesota with the goal of improving quality of health care. To oversee development of the statewide measures, Minnesota relied on MN Community Measurement's Measurement and Reporting Committee,<sup>13</sup> or MARC, which includes providers, health plans, and a consumer representative. This committee makes recommendations on measure development, approves measures and reporting policies and analyzes data collection issues.

The Statewide Quality Reporting and Measurement System developed a measure to determine the rate of adolescents being screened for depression in a clinical setting. The development of the adolescent depression screening measure consists of establishing which individuals are included in the measure. In this case, Minnesota looks at adolescents between the ages of 12 and 17 who receive a well visit. The measure identifies the number of these patients who were screened using one of 11 mental health or depression screening tools (see text box) and who had their score on this tool documented in their medical records.<sup>14</sup>

The depression screening tools that Minnesota has designated as valid for the purposes of the adolescent depression screening measure are:

- Patient Health Questionnaire – 9 item version (PHQ-9)
- PHQ-9M Modified for Teens and Adolescents
- Kutcher Depression Scale (KADS)
- Beck Depression Inventory II (BDI-II)
- Beck Depression Inventory Fast Screen (BDI-FS)
- Child Depression Inventory (CDI)
- Child Depression Inventory II (CDI-2)
- Patient Health Questionnaire – 2 item version (PHQ-2)
- Pediatric Symptom Checklist – 17 item version (PSC-17) - parent version
- Pediatric Symptom Checklist – 35 item (PSC-35) - parent version
- Pediatric Symptom Checklist – 35 item Youth Self-Report (PSC Y-SR)
- Global Appraisal of Individual Needs screens for mental health and substance abuse (GAIN-SS)

To ensure accuracy, the measure excludes adolescents who already have a diagnosis of depression, bipolar disorder, a personality disorder, schizophrenia, or a specified intellectual disability. Provider specialties eligible to submit data on this measure include family and internal medicine and pediatric/adolescent providers.

To support providers in meeting the measurement reporting requirements, MN Community Measurement provides informational webinars and data submission guides, and hosts a monthly technical assistance call. In addition, the Minnesota Department of Health Early and Periodic Screening, Diagnostic and Treatment (EPSDT) staff provide training to clinics and providers around the state and information about mental health screening and referral resources.

After a pilot in 2013 to test the data collection process and validate the data, the Statewide Quality Reporting and Measurement Systems launched the statewide measure and collected data from providers for the 2014 measurement year in January of 2015. Minnesota posts the data for all of their clinical quality measures publically and by individual practices.<sup>15</sup> The results of the first year of data showed that “of the nearly 109,000 12-to 17-year-olds that had well child exams in 2014, only 45 percent (43,300 patients) were screened for mental health and/or depression conditions. Of those screened, 9.7 percent (4,300 patients) had results that indicated they may have a mental health condition.”<sup>16</sup> The statewide rate of screening for this measure in 2016 went up to 70 percent, a 25 percent improvement over 2015.<sup>17</sup> While the Minnesota measure includes adolescents with different sources of insurance coverage, the 2016 adolescent depression screening rate is an encouraging sign that adolescents are increasingly receiving well-care visits. The national screening rates for adolescents in Medicaid for a well-care visit is 44 percent.<sup>18</sup>

The measure is also being used to help determine quality in specific aspects of the Medicaid delivery system. The Minnesota Health Homes program currently utilizes the adolescent and pediatric depression screening measure for performance measurement and evaluation of certified health care homes in the state.<sup>19</sup> Minnesota also publically posts measure results for individual clinics on their website to encourage improvement.<sup>20</sup>

In Minnesota, by having one statewide committee designated to develop and establish quality measures and reporting requirements for providers, the state is better able to streamline data reporting requests which can improve reporting rates for providers. The public posting of quality data for the various measures also incentivizes providers to participate and to improve their performance.

## Oregon: Coordinated Care Organization Incentive Metric for Depression Screening and Follow-Up

The Oregon Health Authority (OHA), which administers the state's Medicaid program, uses quality health metrics to demonstrate and track how [Coordinated Care Organizations \(CCOs\)](#) are improving care, making quality care accessible, eliminating health disparities, and curbing the rising cost of care. As directed by the state Legislature, these measures are developed and scored annually by a designated [Metrics and Scoring Committee](#).<sup>21</sup> Based on their annual performance of these incentive measures, funds from a quality pool are then awarded to eligible CCOs.<sup>22</sup>



OHA has included an incentive metric on depression screening and follow up for adults since 2013; however, beginning in 2015, OHA adjusted the metric to include adolescents aged 12 and older.<sup>23</sup> This change was influenced by the growing prevalence of both depression and drug and alcohol misuse in adolescents in Oregon, and the short and long-term impact of undetected and untreated mental and substance use issues for this population.

Oregon uses the Depression Screening and Follow-Up incentive metric, a standardized quality outcome metric that uses Electronic Health Records to measure whether a screen was conducted and follow-up was provided.<sup>24, 25</sup> Providers must administer, score, and interpret an age-appropriate standardized screening tool, and if positive, document a follow-up plan on the date of the positive screen. For those identified at risk, a follow up plan must include the proposed outline of treatment to be conducted and one of more of the following: “an additional evaluation, a suicide risk assessment, a referral to a practitioner who is qualified to diagnose and treat depression, pharmacological intervention, or other intervention or follow up for the diagnosis or treatment of depression.”<sup>26</sup>

Use of the adolescent depression metric has highlighted both successes and areas for improvement in the system of care. Including adolescents in this metric has assisted in the identification of patients that would have otherwise not been noted to be experiencing depression. In addition, through the identification of a need and provision of care for more adolescents, it has brought to light the challenges of meaningful follow up in the context of the adolescent settings and resources.<sup>27</sup> Due to unique health care needs and barriers to care, adolescents are often less likely to connect with appropriate care resources.<sup>28</sup>

To address this issue, OHA, in coordination with the Oregon Pediatric Improvement Partnership (OPIP) and CCOs, has looked at potential partnership opportunities with school-based health centers and other entities to address teen barriers to accessing services. This metric has also highlighted challenges of transitioning from pediatric to adult care as well as the unique aspects of adolescent health. CCOs have learned that adolescent depression screening is not adult depression screening for adolescents; adolescents require different screening methods and follow-up. Therefore, the most recent version of the CCO incentive metric includes new depression screening mechanisms and follow up options that can be tailored for the adolescent population (the Patient Health Questionnaire (PHQ-9) and Pediatric Symptom Checklist (PSC-17)).<sup>29</sup>

With the benefits already clear to OHA, this CCO incentive metric has been included in the approved list of CCO incentive metrics every year since 2015, resulting in improved CCO performance statewide. Statewide depression screening and follow up for those individuals aged 12 and older increased by 34 percent, 13 COOs illustrated overall improvement on the measure scores, and 15 CCOs achieved the 2015 benchmark measure score (25 percent) or their improvement targets.<sup>30</sup> Due to these improvements, in 2017 the benchmark was increased to 52.9 percent.<sup>31</sup>

## Recommendations

States interested in promoting the identification of adolescent depression and follow-up care can consider the following steps:

- Tailor existing adult measures to include younger ages and screening tools for adolescents
- Publish practice-level performance to encourage reporting and improvements
- Establish a measure advisory board that regularly reviews measures and monitors issues with data reporting
- Review potential partnership opportunities to improve follow up for adolescents (such as school-based health centers, hospital-based adolescent out-patient programs, or other entities involved in adolescent health care)
- Create explicit processes to transition the adolescent into being the primary patient, including messaging on rights related to confidential care

To help states learn more about state-specific Medicaid or CHIP performance improvement projects, measures, or incentives promoting children's preventive services, NASHP has created a 50-state chart and map set on child and adolescent preventive services including behavioral health screenings; weight assessment; lead screening; immunizations; preventive oral health services; and well visits. [View the resources here.](#)

## Endnotes

1. Kessler RC, Chiu WT, Demler O, Merikangas KR, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Arch Gen Psychiatry*. 2005 Jun; 62(6):617-27.
2. The Medicaid and CHIP Payment and Access Commission (MACPAC). "Table 4-1: Percentage of non-Dually Eligible Medicaid Enrollees under Age 65 with a Behavioral Health Diagnosis by Basis of Eligibility, 2011." *In Report to Congress on Medicaid and CHIP*. June 2015. <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%9494People-Use-and-Expenditures.pdf>
3. U.S. Office of Disease Prevention and Health Promotion. Healthy People 2020. "Mental Health and Mental Disorders." <https://www.healthypeople.gov/2020/topics-objectives/topic/mental-health-and-mental-disorders/objectives>
4. Duncan, Greg, et al., "A Science-Based Framework for Early Childhood Policy: Using Evidence to Improve Outcomes in Learning, Behavior, and Health for Vulnerable Children," *Center on the Developing Child at Harvard University* (2007), accessed April 4, 2017. <http://developingchild.harvard.edu>.
5. Stanek, M. "Promoting Physical and Behavioral Health Integration: Considerations for Aligning Federal and State Health Policy." *The National Academy for State Health Policy*. November 13, 2014. <http://www.nashp.org/promoting-physical-behavioral-health-integration-considerations-aligning-federal-state-policy/>
6. The Medicaid and CHIP Payment and Access Commission (MACPAC) "Chapter 4: Behavioral Health in the Medicaid Program- People, Use, and Expenditures." *In Report to Congress on Medicaid and CHIP*. June 2015. <https://www.macpac.gov/wp-content/uploads/2015/06/Behavioral-Health-in-the-Medicaid-Program%E2%80%9494People-Use-and-Expenditures.pdf>
7. Multiple guidelines recommended annual screening in adolescents including: Bright Futures Recommendations, Society of Adolescent Medicine, maternal and Child Health Bureau, American Academy of Pediatrics, Substance Abuse and Mental Health Services Administration, and the US Preventive Services Task Force.
8. The American Academy of Pediatrics. "About Bright Futures." Accessed March 29, 2017. <https://brightfutures.aap.org/about/Pages/About.aspx>
9. "Recommendations for Preventive Pediatric Health Care." *The American Academy of Pediatrics and Bright Futures*. February 2017. [https://www.aap.org/en-us/Documents/periodicity\\_schedule.pdf](https://www.aap.org/en-us/Documents/periodicity_schedule.pdf)
10. "Mental Health Screening and Assessment Tools for Primary Care." *The American Academy of Pediatrics*. January 2012. [https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH\\_ScreeningChart.pdf](https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Mental-Health/Documents/MH_ScreeningChart.pdf)



11. Stroul, B., Pires, S., Boyce, S., Krivelyova, A., & Walrath, C. (2015). Issue Brief: Return on investment in systems of care for children with behavioral health challenges. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
12. For example, Colorado asks providers to use a Medicaid billing code when billing for an adolescent depression screen that allows for positive and negative screening to be tracked and followed.
13. MN Community Measurement. "The Measurement and Reporting Committee (MARC)." Accessed March 29, 2017. <http://mncm.org/about-us/leadership/marc/>
14. "Pediatric Preventive Care: Adolescent Mental Health and/or Depression Screening Specifications - 2017 Report Year." MN Community Measurement. 2016. <http://www.health.state.mn.us/healthreform/measurement/measures/fnl13pmd.pdf>
15. MN Community Measurement. "Minnesota Health Scores." Accessed March 29, 2017. <http://www.mnhealthscores.org>.
16. Smith, S. and Ghare, E. "Fact Sheet: Pediatric Preventive Care Measures." *Minnesota Department of Health*. October 29, 2015. [http://mncm.org/wp-content/uploads/2015/10/Ped-Prev-Care\\_fact-sheet\\_FINAL1.pdf](http://mncm.org/wp-content/uploads/2015/10/Ped-Prev-Care_fact-sheet_FINAL1.pdf)
17. Source: Minnesota Statewide Quality Reporting and Measurement System, Minnesota Department of Health
18. Annual EPSDT Participation Report, Form CMS-416 (National), Fiscal Year: 2015. Total Eligibles Receiving at least One Initial or Periodic Screen, Ages 15-18.
19. Minnesota Department of Health. "Health Care Homes Performance Measurement and Evaluation" Accessed March 29, 2017. <http://www.health.state.mn.us/healthreform/homes/outcomes/datasub.html>
20. To view individual clinic results visit: <http://www.mnhealthscores.org/clinic-measure-detail/mental-health-screening-teens#/results>
21. In 2012, the Metrics and Scoring Committee was established by Senate Bill 1580 to recommend outcomes and quality measures for Coordinated Care Organizations (CCOs). The committee is made up of nine members that are appointed by the Director of the Oregon Health Authority and serve two-year terms. Members include: Three members at large; three individuals with expertise in health outcomes measures; and three representatives of coordinated care organizations. Read more about the Metrics and Scoring Committee and the measure selection criteria here: <http://www.oregon.gov/oha/analytics/Pages/Metrics-Scoring-Committee.aspx>
22. Oregon Office of Health Analytics. "Technical Specifications and Guidance Documents for CCO Incentive Measures." Accessed March 29, 2017. <http://www.oregon.gov/oha/analytics/Pages/CCO-Baseline-Data.aspx>
23. There are some exclusions and exemptions within the depression screening & follow-up metric. Exclusions include those individuals with an active diagnosis of depression, or bipolar disorder. Exemptions include situations when a patient refuses to participate; or patient is in an urgent or emergent situation where time is of the essence and to delay treatment would jeopardize the patient's health status.
24. Reuland C, Gillespie RJ, and Thorne E. "Depression Screening and SBIRT for Adolescents: Practical Considerations for Implementing the CCO Incentive Metrics." Webinar Presentation, Patient Centered Primary Care Institute, June 16, 2015. [http://www.pccpi.org/sites/default/files/webinar-related/6\\_16\\_15%20AWV\\_6\\_9\\_Slides\\_FINAL\\_2\\_1.pdf](http://www.pccpi.org/sites/default/files/webinar-related/6_16_15%20AWV_6_9_Slides_FINAL_2_1.pdf)
25. There are various options to consider in terms of billing for screening (\*9627 currently pays less than 99420) (Source below):
  - Option 1: CPT 96127 – specific for emotional/behavioral screening tools (theoretically can be used for either PHQ-2 or PHQ-9) \*
  - Option 2: CPT 99420 – nonspecific screening tool (for internal tracking you need to be able to distinguish between different kinds of screening tools).

Reuland C and Gillespie RJ. "Depression Screening: Levers, Models and Learnings from Oregon." Webinar Presentation. National Academy for State Health Policy. December 2015.
26. Reuland C and Gillespie RJ. "Depression Screening: Levers, Models and Learnings from Oregon." Webinar Presentation. National Academy for State Health Policy. December 2015.
27. Reuland C and Gillespie RJ. "Depression Screening: Levers, Models and Learnings from Oregon." Webinar Presentation. National Academy for State Health Policy. December 2015.
28. Committee on Adolescence. Achieving Quality Health Services for Adolescents. *Pediatrics* 2008;121;1263
29. "CCO Incentive Measure Specification Sheet for 2017 Measurement Year: Screening for Clinical Depression and Follow-Up Plan." *Oregon Health Authority*. February 10, 2017. [http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202017%20\(revised%20Feb%202017\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202017%20(revised%20Feb%202017).pdf)
30. "Oregon's Health System Transformation Report: CCO Metrics 2015 Final Report." *Oregon Health Authority*. June 2016. 87-88. [http://www.oregon.gov/oha/Metrics/Documents/2015\\_performance\\_report.pdf](http://www.oregon.gov/oha/Metrics/Documents/2015_performance_report.pdf)
31. "CCO Incentive Measure Specification Sheet for 2017 Measurement Year: Screening for Clinical Depression and Follow-Up Plan." *Oregon Health Authority*. February 10, 2017. [http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202017%20\(revised%20Feb%202017\).pdf](http://www.oregon.gov/oha/analytics/CCOData/Depression%20Screening%20-%202017%20(revised%20Feb%202017).pdf)

### 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](http://www.nashp.org).

### Acknowledgements:

This case study was written by Kate Honsberger and Alexandra King of NASHP. The authors would like to thank Colleen Reuland of the Oregon Pediatric Improvement Partnership (OPIP) and Katy Schalla Lesiak from the Minnesota Department of Health for their input and review of this document. In addition, the authors would like to thank Carrie Hanlon of NASHP for her guidance and support in the development of this document.

This case study is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UC4MC28037 Alliance for Innovation on Maternal and Child Health (\$349,975). The information or content and conclusions are those of the researchers and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.