



# Seizing New Policy Opportunities to Help Low-Income Mothers with Depression:

*Current Landscape, Innovations, and Next Steps*

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June 2016 | Stephanie Schmit and Christina Walker

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# Executive Summary

## Background

If the nation could get better at identifying and treating maternal depression among low-income women, particularly women with young children, it would be an extraordinary public health opportunity, as the National Research Council (NRC) and Institute of Medicine (IOM) pointed out in their comprehensive 2009 report on depression in parents.<sup>1</sup> One reason is that depression is widespread among low-income mothers—for example, one in nine babies in poverty has a mother suffering from severe depression, and half have a mother experiencing depression at some level of severity.<sup>2</sup> The second reason is the harm untreated depression presents to both mother and child. It hinders a mother's capacity to help her young child develop, places children's safety and cognitive and emotional development at risk, and stymies her own efforts to escape poverty. Unfortunately, even though research shows that effective treatments for depression address these challenges<sup>3</sup>, low-income mothers of young children have very high rates of untreated depression.

This paper details information gathered through a scan of federal, state, and local efforts to seize this public health opportunity at a large scale, building on new policy provisions available through the Patient Protection and Affordable Care Act (ACA), recent federal decisions and guidance, and local and state innovations. This brief drew upon interviews of child care and early education, health, and mental health stakeholders. Because the stakes for young children's development are so high, it is important for stakeholders from these particular sectors to understand whether and how advocates and policymakers in the child care and early childhood sector could seize these new levers for change.

Two broad lessons emerged from the work. First, while the provisions of the ACA offer important new routes to finance, expand, and systematize maternal depression identification and treatment, major efforts to take advantage of these positive policy changes are still very rare. The reasons include historical barriers between the health, mental health, and child care and early education systems; the difficulty of understanding and influencing complex policies—particularly in Medicaid; and the lack of national strategy or targeted technical assistance that could help cut through this complexity. Second, many innovative ideas for improving identification and treatment of maternal depression are surfacing from the local and state levels. These include policy initiatives—such as identifying new Medicaid reimbursement strategies to support evidence-based depression treatment, expanding reimbursement for outreach activities, or seeking to reduce gaps in coverage after the perinatal period—as well as initiatives that focus on the structures that make better policy possible—for example, creating new opportunities for stakeholders to collaborate or improving measures and accountability. This suggests that the moment is ripe to learn from and spread these early innovations.

In order to understand multiple stakeholder perspectives in a variety of contexts, the scan included in-depth interviews in four states: Connecticut, Minnesota, Ohio, and Virginia. In addition to more than three dozen interviews, the paper also drew upon a literature and document review as well as insight, advice, and guidance from an expert advisory committee of seven people representing child care and early education, mental health, and Medicaid.

## The Landscape

The interviews identified that no state had yet created an effective and comprehensive state-wide approach. Interviewees across the health, mental health, and child care and early education sectors suggested that it is difficult to make systems-level changes when systems are siloed and when each has an approach to serving individuals from either the child or the adult’s perspective. In addition, while many stakeholders outside the Medicaid sectors did not report knowledge of or engagement with Medicaid, others were able to identify specific challenges in their state’s Medicaid policies that they felt held back progress on depression screening and treatment for low-income mothers with young children.

At the same time, the scan also highlighted a striking level of emerging innovation. In every state, at least one stakeholder could identify a local or state initiative to address maternal depression. Some examples include:

- In New Haven, CT, the Mental Health Outreach for Mothers (MOMS) Partnership—a collaborative of agencies working to improve the wellbeing of mothers and children—supports local mothers serving as Community Mental Health Ambassadors to deliver screening, brief intervention, and referral/linkage to clinical treatment. The Partnership is currently exploring Medicaid reimbursement for this new outreach model with the state of Connecticut.
- In Ohio, an evidence-based maternal depression treatment for mothers who are participating in home visiting programs is provided by mental health clinicians working in partnership with home visitors. The model has expanded to home visiting programs in ten states. In four of those states (South Carolina, Kentucky, West Virginia, and Massachusetts), Medicaid is paying for the program.
- In Minnesota, advocates are exploring strategies to extend Medicaid coverage for mothers to two years postpartum. Because Minnesota covers pregnant women under Medicaid to a higher income level than after they give birth, stakeholders are concerned that a woman whose income falls just over the Medicaid standard could have to shift her insurance coverage to the health exchange right in the midst of depression treatment, potentially requiring co-payments that would discourage her continued participation and/or forcing her to change providers.
- In Virginia, child care and early education and mental health advocates are working with the state’s Medicaid office to explore ways to seek Medicaid coverage for maternal depression treatment for a mother and child together (referred to as “dyadic” treatment) when only the child has Medicaid eligibility, making it possible to help more families.
- In all states, stakeholders had ideas and possible solutions to help create the conditions for policy reform. These included bringing stakeholders together to design or implement better approaches to addressing maternal depression, improving cross-training, better integrating primary and behavioral health care, collecting data to understand the state’s needs, and exploring quality and outcome measures related to maternal depression.

Additionally, in 2016, the federal government took three significant steps that could galvanize additional state and local activity.

- On January 26, 2016, the U.S. Preventive Services Task Force (USPSTF) determined that

screening for depression in all adults is a preventive service that is well-supported by evidence. This recommendation specifically includes pregnant and postpartum women, and – in a separate opinion - adolescents ages 12-18. This decision means that state Medicaid programs have the opportunity to get an incentive payment if they cover this screening and other preventive services with no cost-sharing to the beneficiary.

- On March 2, 2016, the U.S. Centers for Medicare and Medicaid Services, or CMS (which oversees Medicaid at the federal level), and the Health Resources and Services Administration (which oversees home visiting, among other things) issued a joint guidance letter to help states understand how to appropriately draw on Medicaid funding to support home visiting. The guidance could be helpful for maternal depression initiatives, which may include home visiting components; it also provides a model that CMS could follow for other topics related to maternal depression.
- On May 11, 2016, CMS issued its first guidance directly related to maternal depression treatment, explaining how states can fund maternal depression screening and mother-child dyadic treatment using a child’s Medicaid eligibility. Based on our interviews, this guidance directly addresses one of the issues a number of states are considering, and it could offer an excellent opportunity for bringing child care and early education, mental health, health, and other stakeholders together to address maternal depression policies more broadly. In addition, it provides a model that CMS could follow for other policy topics.

## Next Steps

To build from the individual innovations identified above and move to a future of systemic success in identifying and treating maternal depression will require new and powerful connections across levels of government and across sectors. At minimum, these sectors must include stakeholders from the health, mental health, and child care and early education sectors. Others who are engaged in improving the lives of low-income families and families of color, such as child welfare, should also be considered as partners in this important work. The recommendations below propose a path forward that combines immediate steps for early successes, the development of infrastructure to sustain the effort, and the creation of a clear policy framework to make it far easier for states to do this work in the future without reinventing the wheel.

### For the states:

1. Seize the opportunity of the USPSTF recommendations and the two federal guidance documents (on home visiting and depression screening/dyadic treatment) as catalysts for:
  - a. outreach and technical assistance from national experts to state leaders and advocates; and
  - b. state convenings that bring together stakeholders from all three sectors to learn about the opportunities and consider next steps.
2. Identify and implement high-priority improvements in Medicaid and related policies to support maternal depression identification and treatment among low-income mothers of young children.

### For philanthropy:

3. Bring together leading state and local innovators along with national experts and federal staff from all relevant sectors in an intensive experience such as through a roundtable or convening. The goals should be to broaden the conversation about the most promising next steps—building on the findings of this brief, the new federal opportunities, and the innovations emerging from ground-level—and recruit core partners for the ongoing work needed to better address maternal depression.
4. Support an ongoing learning community of state and local innovation partners that would conduct regular calls, webinars, and potentially in-person meetings.
5. Support the development of a working list of high-priority areas for federal action, including a short list for completion during the Obama Administration and a longer list to be incorporated into transition documents and briefings. This list would likely include specific areas of Medicaid policy that need clarification or policy guidance.
6. Support work towards an overarching state policy framework to improve maternal depression identification and treatment, based on the information gathered from the steps listed above. This policy framework should be developed in partnership with the early adopter states in the learning community and would be a tool other states could use to reform their systems.

For federal agencies:

7. Issue guidance jointly across federal agencies in the high-priority areas identified by states and national partners. For example, just as HRSA and CMS jointly issued the home visiting guidance, the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), CMS, and other agencies as needed could jointly issue other guidance letters—building on the dyadic treatment letter—that address additional policy questions that come up in using Medicaid to support evidence-based maternal depression treatment.
8. Provide ongoing technical assistance jointly supported by the relevant federal agencies. For example, identify a lead agency with a permanent technical assistance center (such as SAMHSA) to convene other relevant agencies to collaborate and provide the necessary technical assistance to the states.
9. Explore, in collaboration with states, the implications for improved maternal depression policies whenever new regulations or decisions affecting the broader Medicaid context for children and families are implemented. For example, as states implement new Medicaid managed care rules, federal agencies should provide assistance to help states identify opportunities for improving maternal depression treatment.

Identifying and treating low-income mothers with depression is an important opportunity to take on a major challenge that faces low-income families, promoting children’s learning and successful development and families’ economic stability. Now is the time, given the reforms to essential state systems—particularly Medicaid and mental health—afforded by the ACA.



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### **Introduction**

Untreated maternal depression, particularly in mothers of young children, is a major public health problem that can interfere with a parent's capacity to help a child develop, place children's safety and cognitive and emotional development at risk, and stymie families' efforts to escape poverty. Even though research shows that effective treatments for depression address these challenges<sup>4</sup>, low-income mothers of young children have very high rates of untreated depression—for reasons that include lack of insurance coverage for mental health care. For these reasons, the National Research Council (NRC) and Institute of Medicine (IOM) concluded in 2009 that fixing the system to support rather than hinder identification and treatment of maternal depression among low-income women is an extraordinary public health opportunity.<sup>5</sup>

Yet very little is known nationally about how well states are doing at seizing this opportunity. On the one hand, the Patient Protection and Affordable Care Act (ACA) and recent federal decisions and guidance, explained in more detail below, offer important new routes to finance and systematize maternal depression identification and treatment. On the other hand, as we entered this project, we heard from many people that major efforts to take advantage of these positive policy changes were not yet being mounted, for many reasons. These include historical barriers between the health, mental health, and child care and early education systems and the difficulty of understanding and influencing complex policies—particularly in Medicaid. Thus, the impetus for this brief was to understand better what opportunities and challenges exist in the states today and to start laying out a framework for action. Throughout this brief there are referrals to "three sectors": the child care and early education sector, the mental health sector, and the Medicaid sector.

To identify the opportunities, challenges, and action opportunities, the brief draws on a detailed look at initiatives in four states (Connecticut, Minnesota, Ohio, and Virginia), which we have placed in a national context through research, interviews with more than three dozen stakeholders, and the expertise of a national advisory board. The goal of the brief is to help state policymakers, advocates, stakeholders, and community practitioners in the health, mental health, and child care and early education sectors by providing them with a road map to identify the systemic barriers and offer early and emerging insights about how to overcome them. As a result, we hope that policymakers and advocates who care about early childhood and families in poverty can join forces with Medicaid and mental health experts to understand and seize the opportunities available through the ACA and related health initiatives to reform state-level

policies and funding mechanisms, and to make large-scale progress on identifying and treating mothers with depression.

## Why This Is the Moment to Address Maternal Depression

### What Is Known about Maternal Depression & Treatment

Depression is widespread among poor and low-income mothers, including mothers with young children. One in nine poor infants lives with a mother experiencing severe depression and more than half live with a mother experiencing some level of depressive symptoms. Low-income mothers, compared to their higher-income counterparts, experience more severe depression that impacts their everyday life.<sup>6</sup> Moreover, depression is not only linked to the postpartum period. One study showed that 9 percent of low-income mothers with children birth to age 5 had at least one major depressive episode within the previous year.<sup>7</sup> While depression is highly treatable,<sup>8</sup> many low-income mothers do not receive treatment—even for very severe levels of depression. Indeed, one-third of mothers with major depressive disorder get no treatment at all.<sup>9</sup> Additionally, while some people only experience one instance of depression, many others (30-50 percent) experience chronic or recurrent depression requiring the need for long-term support or treatment.<sup>10</sup>

Unfortunately, untreated maternal depression is damaging to children, particularly young children, placing at risk their safety and cognitive and behavioral development. Strong and consistent evidence indicates that a mother's untreated depression undercuts young children's development, including risks to learning, success in school, and adult success. The effects can be life-long, including “lasting effects on [children's] brain architecture and persistent disruptions of their stress response systems.”<sup>11</sup> A thorough review of this research by the NRC and IOM finds that maternal depression endangers young children's cognitive, socio-emotional, and behavioral development, as well as their learning and physical and mental health over the long term.<sup>12</sup>

Furthermore, depression can affect a mother's ability to participate fully in society. For example, depression has been linked to making it difficult to get and keep a job, lower income over time, more unemployment, lower productivity at work, and an increased number of absent days from work.<sup>13</sup> A study of mothers participating in Early Head Start programs found that depressed mothers did not increase their participation in education, job training, and employment, while their non-depressed peers did.<sup>14</sup> Depression is also found to occur in patients suffering from a range of other physical, mental, or behavioral health disorders, including heart disease, diabetes, stroke, eating disorders and substance abuse.<sup>15</sup> Research has shown that treatment for the depression can lead to improvements in co-occurring condition as well as overall quality of life.<sup>16</sup>

Many policy and system barriers have contributed to the low treatment rates of maternal depression. However, recent changes offer the opportunity to design and implement reforms that would increase the number of mothers who receive effective treatment. There is evidence that suggests, in addition to benefiting mothers' wellbeing, these reforms could improve children's outcomes—helping families across the country rise out of poverty.



## New Policy Opportunities

The enactment of the ACA in 2010 created a set of new policy opportunities for states to address maternal depression. Key changes include increased access to health insurance, strengthened mental health benefits, increased support for preventive services, and improved attention to integration of primary care and mental health. Early evidence hints at the potential for these interlinked changes to improve low-income people's access to mental health treatment. A recent Government Accountability Office (GAO) report found that behavioral health officials in states that have expanded access to Medicaid under the ACA identified increases in the quality and availability of treatment options to low-income people. In contrast, the report found that officials in non-expansion states were still focused on targeting services specifically to those low-income people diagnosed with the most serious and persistent mental illnesses.<sup>17</sup>

One of the challenges that people who are not health policy experts experience in understanding how to seize these policy opportunities is that the specifics differ a great deal depending on state policy choices and depending on whether an individual or family gets health insurance from a state Medicaid program or from a private health insurance provider through the public marketplace. However, this paper is focused on Medicaid, which provides health coverage to almost all poor children and many poor parents, depending on state choices. A sampling of the main opportunities afforded through state Medicaid policy choices are described below (additional detail on the four states included in this brief can be found in Table 1 on page 11; additional details on state choices more generally are included in Appendix I).

The most relevant ACA provisions and regulations include the following:

- *Medicaid Expansion*: The ACA gave states a strong financial incentive to improve access to health insurance through Medicaid for low-income adults, but not all states have taken advantage of that option. Specifically, the ACA supports states by providing financial incentives to expand Medicaid coverage for low-income adults up to 138 percent of the federal poverty level (FPL). To date, 32 states (including the District of Columbia) have expanded Medicaid.<sup>18</sup>
- *Strengthened Mental Health Benefits*: Whether or not states choose to expand Medicaid, the ACA requires strengthening the mental health benefit package for Medicaid-eligible adults. All plans, including Medicaid, must cover behavioral health treatment, mental health inpatient services, and substance abuse treatment. However, specific behavioral health benefits will be dependent upon the state and the particular health plan.<sup>19</sup> In addition, CMS recently finalized long-awaited rules for mental and behavioral health parity in Medicaid, marking a significant milestone for access to mental health care.
- *Preventive Services*: The ACA requires that all insurers cover, at no cost to the beneficiary, preventive services that are identified by the U.S. Preventative Services Task Force (USPSTF), as well as by the Advisory Committee on Immunization Practices, the Health Resources and Services Administration's (HRSA's) Bright Futures Project, and HRSA and the Institute of Medicine (IOM) committee on women's clinical preventive services.<sup>20</sup> State Medicaid programs that choose to cover all the most highly recommended preventive services with no cost-sharing to beneficiaries are eligible for a federal incentive payment.<sup>21</sup> In January 2016, the USPSTF identified depression screening in adults including pregnant and postpartum women as a high-priority preventive service (See Emerging Innovations).

- *Integrated Primary and Behavioral Health Homes:* Health homes coordinate care to individuals with multiple chronic health conditions. An opportunity identified in the ACA is to integrate primary and behavioral care into one collaborative care model, which would support primary care and mental health care providers in coordinating patients' care and monitor patients' improvements. Evidence has shown that integrated primary and behavioral health homes are beneficial to the patients receiving care along with being cost-effective.<sup>22</sup>
- *New Managed Care Organization Regulations:* Many states provide health care to children and families on Medicaid through Managed Care Organizations (MCOs), which contract with the state to provide a package of care, rather than through a typical fee-for-service Medicaid model where the state directly reimburses individual providers for services provided. The state's contracts with the MCOs include an emphasis on quality and accountability standards and can focus attention on issues of particular interest, which could potentially include maternal depression. In April 2016, CMS issued its first update in many years of regulations governing these organizations, potentially providing additional opportunities for states to better address maternal depression.

### Seizing these Policy Opportunities through Collaboration across Sectors

This paper was motivated by the belief that engaging child care and early education—as well as health and mental health—stakeholders in decisions about Medicaid and mental health policy could potentially be a catalyst for improvements in the identification and treatment of maternal depression, given that the stakes for young children's development are so high. While later sections of this paper explain what was gathered about the current landscape, this section explains briefly what each group of stakeholders might gain from a collaborative approach to policy reform.

Medicaid, health, and mental health experts stand to gain in a number of ways by including child care, early education, and family services representatives in the design of maternal depression policies. Child care and early education experts and practitioners - who are often interacting with families on a daily basis - already know a great deal about the circumstances of low-income children and families, potentially serving as a crucial source of insights, information, and questions to be addressed through data collection. Child care and early education practitioners may also have a front-line view of the limits of the state's current policies, and they may be able to tell stories and otherwise contribute in communicating to the public and policymakers about the importance of addressing the mental health needs of both children and their parents and the potential negative effects of untreated maternal depression on young children's development and education.

In addition, depending on the state and the specific goals of the initiative, child care and early education practitioners can potentially support health policy goals by playing a role in delivering services, using a variety of funding streams including Medicaid reimbursement—for example, through outreach to mothers or case management services that build on existing relationships. Early childhood providers may be especially successful at engaging mothers, particularly when they provide information to them about the implications for their children.

There are also important reasons for child care and early education providers and stakeholders to collaborate with Medicaid and mental health stakeholders in driving change, even if the Medicaid system

initially seems too complex. Most crucially, by working on a system-wide redesign, child care and early education stakeholders have the opportunity to dismantle barriers they currently face in trying to get mental health treatment for mothers—eventually reducing workload and making the system more responsive to local programs as well as to families. In addition, if a redesigned system genuinely works for mothers, it will lead to real improvements in young children’s wellbeing and behavior in early education programs. As the child care and early education sector knows particularly well, mental health concerns in a young child will manifest in disruptive and problematic behaviors by the children while in care, and these mental health concerns can usually be linked back to difficult aspects of the child’s life at home.<sup>23</sup> So for example, once a mother has been treated for depression, children show improvements in their development as well as behavior and mental health problems.<sup>24</sup>

A successful redesign that truly improved access to treatment could also help child care and early education providers who themselves experience depression. Very often as low-income working mothers themselves, child care and early education staff are also at risk of experiencing untreated depression.<sup>25</sup> One study found that 7 in 10 of the early childhood teaching staff worried about paying for routine health care costs for both themselves and their family members.<sup>26</sup>

Depending on a specific state’s circumstances and the design of its initiative, child care and early education stakeholders could also identify funding through Medicaid for certain aspects of what they do now or would like to do. For example, in recent guidance (See Emerging Innovations), CMS identified that Medicaid funding authorities could reimburse for home visiting activities conducted by those who are not physicians or for preventative services recommended by a licensed professional but furnished by non-licensed professionals.<sup>27</sup>

## Methodology & State Context

Our goal in this paper was to provide an updated and rich picture of the current state landscape, reflecting the perspectives of stakeholders in the health, mental health, and child care and early education sectors internal and external to state government. Because understanding multiple stakeholder perspectives was key, we chose to go in-depth in four states (Connecticut, Minnesota, Ohio, and Virginia). We conducted more than three dozen interviews, ranging from 7 in Virginia to 12 in Ohio (See Appendix I). To provide a broader context for these detailed interviews, we drew on a literature and document review (including, for example, federal guidance and policy papers) and on insight, advice, and guidance from an expert advisory committee representing child care and early education, mental health, and Medicaid (See Appendix III).

In choosing the states, we looked for at least some states that were already interested in the issue of maternal depression and that were known for early innovations in the sector, so that we could identify emerging ideas for consideration elsewhere. At the same time, we sought geographic and political diversity and wanted to include at least one state that had not yet expanded Medicaid, to increase the relevance of our findings to varied state circumstances. Table 1 (see next page) gives additional context on the four states chosen, highlighting some of their similarities and differences.

Table I. State Policy and Infrastructure

	Connecticut	Minnesota	Ohio	Virginia
<b>Number of Children under 6<sup>28</sup></b>	235,257	419,682	849,992	616,467
<b>Poverty Rate of Children Under 6<sup>29</sup></b>	16.7%	16.9%	26.9%	17.3%
<b>Medicaid Expansion<sup>30</sup></b>	Yes - Effective January 2014	Yes - Effective January 2014	Yes - Effective January 2014	No - As of April 2016; up for discussion in FY2017 budget proposal
<b>Medicaid Eligibility Household Income Level for Parents of dependent children (based on FPL)<sup>31</sup></b>	Up to 196% FPL	Up to 200% FPL	Up to 138% FPL	Up to 49% FPL
<b>Medicaid Eligibility Level for Pregnant Women(based on FPL)<sup>32</sup></b>	Up to 258% FPL	Up to 278% FPL	Up to 200% FPL	Up to 143%
<b>Past Medicaid Eligibility Levels prior to Medicaid Expansion</b>	Parents with dependent children were eligible up to 185% of poverty and pregnant women were eligible up to 250% of poverty.	Parents with dependent children were eligible up to 100% of poverty.	Parents at or below 90% of the poverty level were eligible.	Up to 49% FPL (No Medicaid expansion)
<b>Lead Early Childhood Education and Care Agencies</b>	<p>The child care subsidy program</p> <ul style="list-style-type: none"> <li>CT Care 4 Kids— sponsored by Office of Early Childhood</li> <li>Child care licensing</li> <li>Office of Early Childhood</li> <li>Home visiting</li> <li>Office of Early Childhood</li> <li>Publicly funded pre-k</li> <li>Office of Early Childhood</li> <li>Head Start</li> <li>Department of Education</li> <li>Early Intervention</li> <li>Part C services</li> <li>Office of Early Childhood</li> </ul>	<p>The child care subsidy program</p> <ul style="list-style-type: none"> <li>Department of Human Services</li> <li>Child care licensing</li> <li>Department of Human Services</li> <li>Home visiting</li> <li>Department of Human Services</li> <li>Head Start</li> <li>Department of Education</li> <li>Head Start State Collaboration Office</li> <li>Early Intervention</li> <li>Part C services</li> <li>Department of Health</li> </ul>	<p>The child care subsidy program</p> <ul style="list-style-type: none"> <li>Department of Jobs and Family Services</li> <li>Child care licensing</li> <li>Department of Jobs and Family Services</li> <li>Home visiting</li> <li>Department of Health</li> <li>Publicly funded pre-k</li> <li>Department of Education</li> <li>Department of Jobs and Family Services</li> <li>Head Start</li> <li>Head Start Association</li> <li>Early Intervention Part C services</li> <li>Department of Health</li> </ul>	<p>The child care subsidy program</p> <ul style="list-style-type: none"> <li>Department of Social Services</li> <li>Child care licensing</li> <li>Department of Social Services</li> <li>Home visiting</li> <li>Home Visiting Consortium</li> <li>Department of Health</li> <li>Publicly funded pre-k</li> <li>Department of Education</li> <li>Head Start</li> <li>Department of Social Services</li> <li>Head Start State Collaboration Project</li> <li>Head Start Association</li> <li>Early Intervention Part C services</li> <li>Department of Behavioral Health and Developmental Services</li> <li>Infant and Toddler Connection of VA</li> </ul>
<b>Medicaid Agency</b>	Department of Social Services	Department of Human Services	Department of Medicaid	Department of Medical Assistance Services

## The Current Landscape: Barriers

The in-depth interviews illustrated the complexity of the current landscape, highlighting two powerful themes. On the one hand, even those stakeholders who were familiar with the opportunities in the ACA to improve mental health care and services for low-income mothers with depression still recognized many barriers to achieving that goal, and no one—even in the states identified as more advanced—believed their state had created an effective and comprehensive state-wide approach. And because each system is so complex and so separate from the others, no single person we interviewed in any state had a comprehensive view of the policy opportunities or challenges. On the other hand, many new initiatives were emerging from the local and state levels, along with new federal actions and guidance that provides new opportunities. Thus, in the in-depth interviews, at least one stakeholder in every state could identify a local or state initiative to address maternal depression. This section highlights the first of those threads, the challenges; the next section below highlights the striking opportunities.

**Fragmentation of policies, systems, and expertise hinders progress.** Interviewees across the health, mental health, and child care and early education sectors suggested that it is difficult to make systems-level changes when systems are siloed and when each has an approach to serving individuals from either the child’s or the adult’s perspective. Furthermore, the funding streams dedicated to paying for services for families are extremely different and administered separately among the Medicaid, mental health, and child care and early education sectors.

Interviewees found that departments and programs were administered independently and disjointedly, which led to a lack of knowledge, intentionality, and communication between the sectors. Interviewees also stated that when relationships did exist that helped work across systems, these collaborations were tied so distinctly to those personal relationships that personnel turnover could easily derail the work occurring across departments.

An Ohio stakeholder said that “...systems are not set up to make it easy. When there is already a connection between the mental health and early childhood worlds, then it can work well... In other places, [they] can be two very different entities, and are not working together already.”

A Connecticut stakeholder said that “the [child care and early education sector] would need to know that [addressing maternal depression] is even an opportunity that they need to be thinking of. It is so bifurcated in Connecticut, even though they are trying to get rid of the silos.”

Child care and early education stakeholders face particular obstacles in engaging with Medicaid experts and other health and mental health policymakers to identify system changes that could help in addressing maternal depression. With the child care and early education sector stretched so thin already due to policy developments in the sector, as well as being traditionally underpaid and under-resourced, it may be challenging for them to take on policy battles in other sectors, or for their counterparts in the health and mental health sectors to see them as partners in this important work. As a result, interviewees stated that there is a lack of clarity about

the child care and early education sector’s role in addressing maternal depression. Some suggested that the health and mental health sectors may also not view their child care and early education counterparts as

partners in this important work.

In addition, interviewees recognized that the early care and education sector is often poorly tied to child health and other service providers within the community. For example, in Connecticut, an evaluation on child care and early education services found that while some child care and early education providers conduct maternal depression screenings, they struggle with connecting the families to the services they need. This could be a reason why child care and early education providers would benefit greatly from a more coherent system that would not require them to work so hard to find services. Yet it is also an obstacle to viewing their engagement with health and mental health policy as beneficial, given they may see the cumbersome system but not the opportunities for them if it worked better. One interviewee from the child care and early education sector also suggested that providers may not see their role in addressing maternal depression, as they are experts in child development and may feel that they do not understand the needs of the parents or how to best connect them to the necessary services. Child care and early education providers often have limited or no training in identifying or screening for maternal depression.

**Medicaid and other health policies can be barriers and opportunities.** Medicaid policies are clearly central to whether low-income mothers with young children can gain access to depression screening and treatment. While some aspects of the Medicaid policy framework are national, many are state choices—including whether to expand coverage, what specific benefits to cover (within a context of federal rules that expand mental health parity and preventive services), what providers to authorize (such as licensed health professionals at various levels and/or social services professionals or paraprofessionals), whether to provide coverage through MCOs or fee-for-service payments to individual providers, and what reimbursement payments to provide for what services. Particularly when it comes to eligible populations not previously served (such as low-income adults in many states prior to the ACA expansion) or issues not previously highlighted as a priority (such as maternal depression), the sheer complexity of thinking about all these different policy levers together can create a major barrier in itself—as can the enormous variation by state in the details of what is required, allowed, and reimbursed (See Appendix III). Interviewees confirmed that understanding all of the state Medicaid policies can be difficult, particularly for those not from the Medicaid sector. In many states, MCOs are predominantly the delivery system for the Medicaid population, so stakeholders should recognize that partnering with the MCOs is an important step in making progress on addressing maternal depression.

While developing a full list of policy challenges and opportunities is far beyond the scope of this brief, those interviewed identified a number of current Medicaid policies that often pose particular obstacles to a coherent strategy for tackling depression:

- ***Restrictive Medicaid billing and reimbursement practices.*** Interviewees thought that restrictive billing and reimbursement practices by Medicaid agencies in several states posed a challenge to successful services, particularly because of a system divided between services to the adult and to the child. For instance, pediatricians may be screening mothers for depression at well-child visits, but in some instances, are unable to bill for providing this service and are therefore not getting reimbursed for their time to screen moms. This inability to get paid for their time may deter pediatricians from providing screenings, creating a missed opportunity in identifying additional

mothers with depressive symptoms. And while pediatric office visits were routinely identified as a clear opportunity to identify mothers with mental health concerns, interviewees stated that health insurers, particularly Medicaid in most states, may not reimburse for a screening as a result of issues such as where the mother's medical record exists and what billing code should be used. A forthcoming study by the National Center for Children in Poverty (NCCP), found that nine states allow billing for maternal/caregiver depression screening under the child's Medicaid in pediatrician or family medicine visits, typically multiple times a year.<sup>33</sup>

- ***Focus on screening and not on treatment.*** Interviewees also suggested that, despite these obstacles, there has been more attention focused on how to reimburse for screening than how to promote the follow-up needed after a positive screen for getting the mother connected with a treatment provider. It is important for the system to incentivize providers to connect mothers to services and treatment once depression is identified.
- ***Additional billing and reimbursement issues.*** Other reimbursement issues included the desire to have a package of services for mothers with depression or bundled payments for each period of depression. Interviewees in Minnesota and Connecticut perceived the Medicaid fee schedule in their state as too inflexible and hindering a provider's ability to stratify services and appropriate payments to best meet the needs of the patient. Interviewees recognized that not all patients need the highest level of care intensity—such as what is needed for people suffering from severe and persistent mental illness (SPMI)—and that not all mothers with depression will require the same services. Additional issues were raised related to the type of provider and setting that can be reimbursed. For particular services only a certain level or type of professional is allowed to be reimbursed for services, although this varies by state. For example, one interviewee in Ohio told us that only masters' level clinicians, and not other professionals, providing maternal depression treatment can bill using psychotherapy codes. Additional barriers were raised related to the ability to bill for services provided outside of a medical setting, as many systems are not set up to allow this.
- ***Medicaid eligibility levels and duration of eligibility.*** Even in states that have implemented the Medicaid expansion, Medicaid eligibility remained an issue, particularly for women with income just above the eligibility level. This was particularly an issue because pregnant women in all three expansion states we studied were eligible for Medicaid coverage during pregnancy and for the several weeks immediately following the pregnancy up to a higher income level than for parents in general (See Table 1). After that time period, however, the income level for eligibility drops, causing many women to lose Medicaid coverage at a time when they may still be depressed. For example, in Minnesota, eligibility levels drop for women just 60 days after the birth of their child from 278 percent FPL to 200 percent FPL. While these women who lose Medicaid coverage are able to purchase health insurance through the private health care exchange, and may also qualify for a subsidy to assist with their monthly payments, the transition from Medicaid to another health care insurer can create additional barriers to accessing care and treatment. For instance, several interviewees noted that the new health care plan may require co-payments for each treatment visit, which low-income women may be unable to afford. Further, different providers are often covered on different health insurance plans; therefore the provider a beneficiary was eligible to see through Medicaid may no longer be able to treat her under the mother's new plan. The loss of Medicaid coverage during a demanding time period when women are often still recovering both physically

and emotionally from the birth and arrival of their new child can disrupt a woman's continuity of care or make treatment unaffordable.

- **Lack of Medicaid expansion.** In the one state we studied that has not implemented Medicaid expansion, Virginia, interviewees repeatedly mentioned the lack of expansion as the major policy challenge. Because the income eligibility level for Medicaid is so low and because premium tax credits established by the ACA to help purchase insurance in the private health insurance marketplaces are only available to individuals with income between 100 and 400 percent FPL, many parents in the 19 non-expansion states are not eligible for Medicaid or premium tax credits if their incomes exceed the current Medicaid eligibility threshold but remain below 100 percent of the poverty level (\$20,160 annual income for a family of three). Therefore, many of the women who need access to and could benefit greatly from Medicaid services do not receive any assistance.

**Other direct barriers to accessing treatment.** Even when a woman with high levels of depressive symptoms has access to Medicaid or other health coverage, our interviewees highlighted other common access issues. For instance, mental illness still carries with it a lot of stigma and fear, which could hinder people from seeking the treatment they need. In fact, the stigma of seeking mental health treatment has been found to be one of the most common concerns among low-income women and may account for underutilization of mental health treatment, particularly for women of color and for immigrants.<sup>34</sup> These women may also lack a medical home or primary care provider, which means they often show up in urgent care centers and emergency rooms for their health care. Low-income mothers also face many logistical difficulties in getting to a care provider, such as finding quality child care, available appointments, or safe, reliable transportation. Furthermore, most states identified that they have “provider deserts,” particularly in rural areas, which would make the process of finding an appropriate provider and transportation to the provider’s office even more difficult for most low-income women.

Moreover, even when a provider can be found, the quality of the care may be poor. Interviewees stated the need for more attention to mothers with depression at different stages of the pregnancy and for a time period longer than the postpartum period. Moreover, this attention on the illness should be reflected in better provider trainings and ensuring that mothers with depression are getting connected to evidence-based treatment. All of these issues could be addressed in the context of a state’s overall strategy, and many of them suggest specific Medicaid policy and reimbursement solutions—such as investing in case management and outreach to mothers as part of a plan.

## The Current Landscape: Emerging Innovations

Despite these considerable barriers, many opportunities emerged from our interviews to take advantage of this federal landscape and change state policies systematically. These included local and state innovations that, while not comprehensive in the view of those we interviewed, pointed towards bigger next steps; promising ideas suggested by interviewees that are not yet implemented on the ground; and new federal decisions and guidance that require or clarify state actions to address maternal depression.

### State and Local Innovations and Emerging Ideas

Some state and local innovations focused directly on policy or practice change, while others sought to



create the conditions for ongoing change—for example, tackling the fragmentation of systems by bringing health, mental health, early childhood, and other stakeholders together in new ways.

**Collaboration Among Key Stakeholders.** Several state and local initiatives have taken on fragmentation directly. Often, these start with direct service connections, but they offer the opportunity to build to policy and system collaborations. As an Ohio stakeholder said, “when [early childhood and health stakeholders] come together to work...they learn a lot about each other.” For example, in Connecticut, providers who treat mothers with maternal depression can use the 2-1-1 centralized resource hotline that helps connect people to mental health services. Within the 2-1-1 system, providers who self-identify as having an expertise in treatment of maternal mood disorders are flagged, so that clients can be referred to the most appropriate provider.

Another example, from Ohio, is the Cleveland Regional Perinatal Network (CRPN)’s Perinatal Depression Project, which was created through grant funding to address the gaps and barriers families faced in accessing maternal depression screening and treatment. The project was started in response to the recognition that mothers were not being consistently screened and identified for maternal depression, and if diagnosed, there was no one to refer them to for treatment. All healthcare institutions in the Cleveland area as well as several home-visiting and social service agencies have incorporated a key element of the project, the CarePath—a step-by-step process developed by the project to help providers screen for maternal depression—and currently screen and refer for depression during and after pregnancy. While the training has not yet happened in a child care or preschool setting, the tools are certainly able to be used in these settings. The CRPN Project also formed the Cuyahoga Perinatal Depression Task force in 2007 and since 2010 has developed a data tracking system to measure outcomes. In 2015 there were 11,531 depression screens completed and 1,021 women referred for treatment. The project is currently grant funded through the Ohio Department of Health’s Child and Family Health Services Block Grant and Maternal and Child Health grants, and City of Cleveland MomsFirst Project/HRSA. The CRPN Perinatal Depression Project has reached far beyond Cleveland and has been duplicated in other parts of Ohio. While the model is grant funded, many of the recipients of the services provided under the model are Medicaid patients.

Another example of collaboration through direct services is a Minnesota initiative proposed by the governor’s Children’s Cabinet team to provide mental health consultation grants for on-site consultation to child care and early education programs, addressing mental health issues for both generations together. When there is a potential mental health issue identified, these mental health consultants would offer services and referrals for needed treatment to both the children and their parents.

Interviewees in several states offered additional suggestions for establishing more formal communication between stakeholders. For instance, a Minnesota interviewee recommended creating a working group specifically focused on addressing maternal depression and its importance to the child care and early education sector. Bringing people from separate agencies and departments together in a formal setting can provide them with the space to create recommendations on how services can be integrated and how resources can be more accessible for families. Others suggested that more coordinated provider training, that spans across sectors, would ensure all providers know about maternal depression, why it is important

to address, and how to make referrals. Still others suggested that states could incentivize collaboration through grant funding initiatives to ensure all of the relevant stakeholders are working together to address maternal depression—a strategy similar to the Ohio and Minnesota initiatives already cited.

## Policy Changes in the States

State agencies, advocates, and local innovators also are working to improve Medicaid and related policies to support maternal depression identification and treatment.

**Collaboration to Improve Billing Procedures for Dyadic Therapy.** In Virginia, stakeholders from the mental health and child care and early education sectors held a meeting with the state’s Medicaid office to discuss the possibility of creating billing procedures and the appropriate codes for dyadic therapy—or therapy that includes both the child and the parent(s). Dyadic therapy would allow mothers identified with depression to work on their relationship with their child, since parent-child attachment is so important to the healthy development of a young child. This is an ongoing process in Virginia.

A recent CMS memorandum regarding maternal depression screening and treatment specifically supports the delivery of dyadic therapy through Medicaid and provided guidance to help state Medicaid agencies implement this policy change. Therefore, states wanting to seize this opportunity now have a path for moving this policy forward.

**Finding a Way to Extend PostPartum Medicaid Coverage to Provide Continuity of Care.** In Minnesota, new mothers were previously covered by Medicaid for a full year postpartum. Over time, this benefit has been reduced, and now, the state only covers mothers for the minimum 60-day postpartum period established through the ACA. A goal among advocates is to extend coverage for these mothers for two years postpartum—while also extending Medicaid coverage to their child for two years—to meet both the mother and child’s mental and physical health needs during such a critical time.<sup>35</sup>

**Integrating Behavioral and Physical Health Care to Improve Mental Health.** Ohio’s Medicaid department is in the process of redesigning its community behavioral health benefit to better align services to a person’s level of need. Behavioral health care in Ohio is transitioning into the Medicaid MCOs that are currently administering the state’s physical health care plans. This transition, which should be complete by the beginning of 2018, will promote stronger coordination, lower cost, and better overall health outcomes. The state is defining what will be covered in a new menu of behavioral health services through Medicaid managed care. There is debate in the health and mental health sectors over whether integrating behavioral and physical health care within MCOs is best. Those operating behavioral health plans often argue that traditional physical health managed care organizations do not have the expertise necessary to better serve patients with mental illness, and proponents of integration believe that the separation of service provision can create barriers to care coordination and information-sharing.<sup>36</sup> Interviewees in Ohio were optimistic about the opportunity the integration afforded the state, and they want to focus on better serving their most vulnerable customers through this change, particularly mothers and children with more intensive care needs, such as cross-systems care needs, and trauma-informed patient care.

**Solving Licensing and Reimbursement Barriers.** Moving Beyond Depression™ (MBD)<sup>37</sup> is a comprehensive, evidence-based and integrated approach to identifying and treating depression in mothers participating in home visiting programs. It provides a two-generation approach to treating depression in a non-clinical, non-traditional setting. MBD is a systemic program incorporating screening, identification, treatment, and follow-up. It emphasizes collaboration between mental health clinicians and home visitors to optimize both clinical and home visiting outcomes. The key element of MBD is In-Home Cognitive Behavioral Therapy (IH-CBT) developed by Every Child Succeeds® and Cincinnati Children’s Hospital Medical Center. It is the only evidence-based treatment program specifically for mothers in home visiting and has been adopted by programs operating in 10 states, including Ohio. MBD has been evaluated and has a proven track record of decreasing depressive symptoms in mothers participating in treatment. Research has found that, after completing IH-CBT, 70 percent of mothers no longer met criteria for major depressive disorder.

Currently, South Carolina, Kentucky, West Virginia, and Massachusetts, are using Medicaid to fund MBD treatment through home visiting programs that contract with or are part of organizations that are already set up to bill Medicaid. Because Medicaid policy varies from state to state, it is more difficult for some states to use Medicaid as a reimbursement mechanism given the nature of the service delivery. Moreover, additional funds are needed to cover the full cost of the program. It is anticipated that MBD will be appealing to MCOs seeking to address maternal depression in high-risk families because of its demonstrated cost-effectiveness, its broad impacts, and the ability for states to leverage of investments made in early childhood home visiting.

**Potential Medicaid Support for New Outreach Models.** The New Haven Mental Health Outreach for Mothers (MOMS) Partnership is a collaboration of agencies across New Haven, CT, that works to improve the wellbeing of mothers and children. The model includes mothers from the community serving as Community Mental Health Ambassadors who deliver screening, brief intervention, referral, and clinical treatment with clinicians. This has increased utilization and adherence to mental health services dramatically. Medicaid reimbursement for these positions is currently being explored in partnership with Connecticut Department of Social Services. The New Haven MOMS Partnership surveys the mothers to determine what services are needed. In 2015, a survey found that 58 percent reported moderate to high levels of depressive symptoms.<sup>38</sup> Mental health services for maternal depression are provided in non-clinical, de-stigmatizing settings such as in grocery stores and in fully licensed settings that are billable through Medicaid.<sup>39</sup>

**Gathering Background Data To Target Services.** Minnesota is one of 40 states currently implementing the Pregnancy Risk Assessment Monitoring System (PRAMS) survey tool, through a joint project between the state’s Department of Health and the U.S. Centers for Disease Control and Prevention (CDC). In Minnesota, a sample of mothers who have recently given birth to a child, are sent a survey that asks them questions about experiences before, during, and after birth to determine maternal health and behaviors, in addition to infant health. The state samples about 220-250 mothers each month and has chosen to include questions in the survey about maternal depression, anxiety, stressors, and mental health—including treatment, education, or support the mother has received. Results show that 95-97 percent of moms are getting education about maternal depression in the state. Furthermore, Minnesota

uses Medicaid billing data, the PRAMS survey data, and WIC and home visiting data to better understand the prevalence of depression and anxiety. State administrators determined a list of Medicaid billing codes to use in monitoring and reviewing all instances of maternal depression. States could create similar lists for their own analyses, which could inform decision making on issues like screening, treatment availability, and reimbursements.

**Federal Innovations to Inform State Policy.** In 2016, the federal government took three significant steps that could galvanize additional state and local activity.

The first one, which affects both Medicaid and private health insurers, is the decision by the U.S. Preventive Services Task Force (USPSTF) that screening for depression in all adults is a preventive service that is well-supported by evidence. This recommendation specifically includes pregnant and postpartum women, and (in a separate opinion) adolescents ages 12-18. When the USPSTF determines that a service has a priority level of A or B (as in this case), insurers are required to cover it free. State Medicaid programs that choose to cover all the A and B level preventative services with no cost-sharing to beneficiaries are eligible for an incentive payment that increases their federal reimbursement level by 1 percent for these services.<sup>40</sup> Currently, 11 states choose to cover all of the A and B services, receiving the incentive payment: California, Colorado, Delaware, Hawaii, Kentucky, New Hampshire, New Jersey, New York, Nevada, Ohio, and Wisconsin. The recommendation highlights the need for effective referral and treatment systems. This is particularly important since there are known effective treatments available. When effectively implemented, this recommendation could result in many fewer women suffering from untreated depression. Since our interviews occurred before this USPSTF decision, we cannot report yet on its impact, but we anticipate it will substantially increase state interest in depression screening and treatment.

The second is a federal policy guidance letter on financing state home visiting initiatives, jointly issued by HRSA—which oversees the other major federal funding stream for home visiting—CMS—which oversees Medicaid. In 2010, the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program created the first nationwide home visiting program. MIECHV has supported high-risk families in communities across the country through intensive home visiting services. It supports evidence-based programs that connect families with trained professionals—often nurses, social workers, or parent educators—who help parents acquire the skills they need to promote their children’s development. This guidance letter provides states with a step-by-step approach to aligning their Medicaid state plan and their home visiting approach, to draw on Medicaid funding in an appropriate way and achieve their home visiting goals. For example, it suggests approaches to funding case management services as well as direct clinical services offered by home visitors and indicates which federal waiver authorities might be useful. Because home visiting could be a key part of a state’s maternal depression plan—to provide screening and referral, treatment, or both—this letter is directly useful to a maternal depression strategy.<sup>41</sup> It also provides a model for future guidance that could help states develop a comprehensive approach to maternal depression. States can consider which of these components may be possible or what state plan changes may be needed to achieve them to best meet the needs of the families in their state.

And finally, CMS issued its first guidance directly related to maternal depression treatment, explaining

how states can fund maternal depression screening and mother-child dyadic treatment based on a child's Medicaid eligibility. The guidance clarifies that states can allow maternal depression screenings to be claimed as a service for the child under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit, because the scientific evidence indicates that maternal depression is a risk factor for the child and that screening for it in a well-child visit is a best practice. Once a state makes that choice, providers such as pediatricians can be reimbursed for conducting the screening. After diagnosis, the guidance also clarifies that treatment services provided to the mother and child together—for example, family or dyadic therapy (but not separate treatment for the mother alone)—can also be claimed as direct services for the child.<sup>42</sup> For mothers who are not eligible for Medicaid themselves and are uninsured, the ability to receive reimbursable treatment when provided jointly with their child opens up new possibilities for treating maternal depression for low-income women.

## Next Steps

To build from the individual innovations identified above and move to a future of systemic success in identifying and treating maternal depression will require new and powerful connections across levels of government and across sectors. At minimum, the sectors must include stakeholders from the health, mental health, and child care and early education sectors, but others who are engaged in improving the lives of low-income families and families of color, such as child welfare, should also be considered as partners in this important work. The recommendations below, which draw from both the scan itself and the deliberations of the project's expert advisory board, propose a path forward that combines immediate steps for early successes, the development of infrastructure to sustain the effort, and the creation of a clear policy framework to make it far easier for states to do this work in the future without reinventing the wheel.

### For the states:

1. Seize the opportunity of the USPSTF recommendations and the two federal guidance documents (on home visiting and depression screening/ dyadic treatment) as a catalyst for:
  - a. outreach and technical assistance from national experts to state leaders and advocates; and
  - b. state convenings that bring together stakeholders from all three sectors to learn about the opportunities and consider next steps. These meetings could be ad hoc, or states could invite additional members to join existing entities—such as child care and early education members and local innovators attending a regular Medicaid/ mental health meeting, or Medicaid and mental health state staff going to the early childhood coordinating council.
2. Identify and implement high-priority improvements in Medicaid and related policies to support maternal depression identification and treatment among low-income mothers of young children. The convening just described, along with technical assistance provided with philanthropic support as described below, would likely be very helpful in supporting state leaders, local innovators, and policy advocates in this work.

### For philanthropy:

3. Bring together leading state and local innovators along with national experts and federal staff from all the relevant sectors in an intensive experience such as through a roundtable or convening. The goals

should be to broaden the conversation about the most promising next steps—building on the findings of this brief, the new federal opportunities, and the innovations emerging from ground-level—and recruit core partners for the ongoing work needed to better address maternal depression.

4. Support an ongoing learning community that would support regular calls, webinars, and potentially in-person meetings, through support from federal officials and/or philanthropy. The information gathered through this scan suggested substantial interest among states and local jurisdictions, including policymakers and external stakeholders, in such a learning community, to help participants more effectively seize this opportune moment to get started and learn from others engaging in this work.
5. Support the development of a working list of high-priority areas for federal action, including a short list for completion during this administration and a longer list to be incorporated into transition documents and briefings. See inset for examples.

Creating a list of high priorities for federal action would likely include specific areas of Medicaid policy that need clarification or policy guidance:

- How to reimburse pediatric providers for screening and dyadic treatment through a child's Medicaid coverage;
- How to incentivize and track effective referral and follow-up for a mother's treatment (that is, going beyond screening);
- Potential strategies for designing and reimbursing effective benefit packages for maternal depression;
- Strategies for supporting community outreach and home-based treatment, where appropriate to a state's plans;
- Strategies for supporting the involvement of non-medical professionals, community health workers, and paraprofessionals (such as early education or home visiting staff) in appropriate roles;
- Removing obstacles to mental health services in primary care;
- Promoting quality and accountability in maternal depression treatment, including in managed care contracts;
- Ensuring smooth integration between Medicaid and the private health care exchanges; and
- Potential strategies for addressing postpartum coverage gaps under a state's Medicaid plan.

6. Support work towards an overarching state policy framework to improve maternal depression identification and treatment, based on the information gathered from the steps listed above. This policy framework would be developed in partnership with the early adopter states in the learning community and would be a tool other states could use to reform their systems.

For federal agencies:

7. Issue guidance jointly across federal agencies in the high-priority areas identified by states and national partners, building on a number of excellent models. For example, just as HRSA and CMS jointly issued the home visiting guidance, the Administration for Children and Families (ACF), the Substance Abuse and Mental Health Services Administration (SAMHSA), and CMS and other agencies as needed could jointly issue other guidance letters—building on the dyadic treatment letter—that address additional policy questions that come up in using Medicaid to support evidence-based maternal depression treatment.

8. Provide ongoing technical assistance jointly supported by the relevant federal agencies. For example, identify a lead agency with a permanent technical assistance center (such as SAMHSA) to convene other relevant agencies to collaborate and provide the necessary technical assistance to the states.
9. Explore, in collaboration with states, the implications for improved maternal depression policies whenever new regulations or decisions affecting the broader Medicaid context for children and families are implemented. For example, as states implement the new Medicaid managed care rules, they should have access to help thinking through the potential opportunities for improving maternal depression treatment.

Identifying and treating low-income mothers with depression is an important opportunity to take on a major challenge that faces low-income families: promoting children's learning and successful development and families' economic stability. Now is the time, given the reforms to essential state systems—particularly Medicaid and mental health—afforded by the ACA.

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The findings and conclusions of this report are those of the authors alone, and do not necessarily reflect the opinions of our funders.



# Appendix I

## List of Interviewees, by State

### Connecticut

Merrill Gay, Executive Director, Early Childhood Alliance

Lisa Honigfeld, Vice President for Health Initiatives, Child Health and Development Institute of Connecticut

Myra Jones-Taylor, Commissioner, Connecticut Office of Early Childhood

Kimberly Karanda, Regional Manager, Mental Health and Addiction Services

Kate McEvoy, State Medicaid Director, Connecticut Department of Social Services

Judith Meyers, President and CEO, Child Health and Development Institute of Connecticut

Nydia Rios-Benitez, Behavioral Health Clinic Manager, Connecticut Mental Health and Addiction Services

Jessica Sager, Executive Director, All Our Kin

Megan Smith, Assistant Professor of Psychiatry, in the Child Study Center and of Epidemiology (Chronic Diseases); Director, New Haven Mental Health Outreach for MotherS (MOMS) Partnership

Elaine Zimmerman, Executive Director, Connecticut Commission on Children

### Minnesota

Mary Jo Banken, Department of Health

Melvin Carter, Executive Director, Minnesota Children's Cabinet

Jennifer DeCubellis, Assistant Commissioner, Minnesota Department of Human Services

Sarah Drake, Pharmacy Program Manager, Minnesota Department of Human Services

Stephanie Hogenson, Research and Policy Director, Children's Defense Fund

Julie Marquardt, Director, Purchasing and Service Delivery, Minnesota Department of Human Services

Julie Pearson, Medicaid Services Policy Supervisor, Minnesota Department of Human Services

Clare Sanford, Director of Government and Community Relations, New Horizon Academy

Tessa Wetjen, Principal Planner of Maternal Depression Screening Program, Minnesota Department of Health

Catherine Wright, Early Childhood Mental Health Coordinator, Minnesota Department of Human Services

Barbara Yates, Executive Director, Resources for Child Caring

### Ohio

Avril Albaugh, Project Director, Cleveland Regional Perinatal Network

Robert Ammerman, Scientific Director, Every Child Succeeds

Rebecca Baum, Developmental Behavioral Pediatrician, Nationwide Children's Hospital

Maureen Corcoran, President, Vorys Health Care Advisors

Rebekah Dorman, Director, Invest in Children of Cuyahoga County

Marcia Egbert, Senior Program Officer, The Gund Foundation

Kellee Gauthier, Program Manager, Ohio Chapter, American Academy of Pediatrics

Wendy Grove, Director, Ohio Office of Early Childhood

Sarah Hallsky Lee, Health Promotion Coordinator, Ohio Child Care Resource and Referral Association

Eric Koralak, Executive Director, Action for Children, Ohio  
Sandy Oxley, Executive Director, Voices for Ohio's Children  
Samuel Rossi, Director of Communications, Ohio Department of Medicaid

## **Virginia**

Suzanne Gore, Deputy Director for Administration, Department of Medical Assistance Services  
Jill Hanken, Staff Attorney, Virginia Poverty Law Center  
Karen Kimsey, Deputy Director for Complex Care Services, Department of Medical Assistance Services  
Tammy Mann, President and CEO, Campagna Center  
Saba Masho, Professor, Virginia Commonwealth University Department of Family Medicine and  
Population Health  
Margaret Nimmo-Crowe, Director, Voices for Virginia's Children  
Cheryl Roberts, Deputy Director for Programs, Department of Medical Assistance Services

## Appendix II

### List of Advisory Committee members

- Joan Alker, Executive Director, Georgetown University Center for Children and Families and Research;  
Associate Professor, Georgetown University Health Policy Institute
- Lark Huang, Director, Office of Behavioral Health Equity, Substance Abuse and Mental Health Services  
Administration
- Tammy Mann, President and CEO, The Campagna Center
- Jeanne Miranda, Professor, Department of Psychiatry and Biobehavioral Sciences, University of  
California Los Angeles
- Donna Cohen Ross, Principal, Health Management Associates (and former Senior Policy  
Advisor/Director of Enrollment Initiatives, Center for Medicaid and CHIP Services)
- Megan V. Smith, Assistant Professor of Psychiatry, in the Child Study Center and of Epidemiology  
(Chronic Diseases); Director, New Haven Mental Health Outreach for MotherS (MOMS)  
Partnership
- Sheila Smith, Director, Early Childhood, National Center for Children in Poverty



## Appendix III

### Selected State Medicaid Policy Choices

Federal requirements create basic rules for state Medicaid programs, but states still have flexibility in the design of their Medicaid programs around eligibility, enrollment procedures, and benefits. This list is not inclusive of all state options but includes key options with the potential to increase access to and improve the quality of care for pregnant women and young mothers seeking mental health care.

Eligibility Options	
<b>Income eligibility for pregnant women</b>	States have the flexibility to set their Medicaid income eligibility for pregnancy coverage above the federal minimum of 133% FPL. Most states have set their income eligibility at 185% or higher. The higher the income eligibility limit, more pregnant women can benefit from affordable pregnancy-related care.
<b>Income eligibility for adults</b>	<p>The ACA set the minimum Medicaid eligibility for adults at 133% FPL, but this has effectively become a state option due to the Supreme Court’s 2012 decision. As a result, adults in non-expansion states may have very limited access to Medicaid and, as a result, fall into the “coverage gap”.</p> <p>In non-expansion states eligibility for adults with dependent children varies, but is 67% FPL or lower in 17 states, with two states as low as 18% FPL. In these states, adults who earn more than their state’s eligibility limit but less than 100% FPL fall into the coverage gap because they have no affordable health insurance option – they make too much money to qualify for Medicaid but not enough money to receive advanced premium tax credits (APTCs) to purchase insurance through the Marketplace.</p> <p>Adults in non-expansion states without dependent children have even more limited access to Medicaid. Only one state provides Medicaid coverage to these adults. In 18 states, adults without dependent children have zero eligibility for Medicaid. Adults under 100% FPL are therefore not eligible for Medicaid or affordable coverage through the Marketplace, placing them in the coverage gap.</p> <p>Implementing Medicaid expansion is beneficial to maternal and infant health because in expansion states more women have access to affordable health care prior to and after their pregnancy.</p>
<b>Presumptive eligibility for pregnant women</b>	States have an option to adopt presumptive eligibility for pregnant women. Under this option, pregnant women who appear eligible for Medicaid are enrolled immediately while their full application is pending an eligibility determination. This option allows pregnant women to access Medicaid coverage as soon as possible after applying.

<b>Benefits Options</b>	
<b>Pregnancy Coverage</b>	States have the option to provide pregnant women their full Medicaid coverage or only pregnancy-related coverage. When pregnant women receive the full Medicaid benefit package, they have access to mental health services.
<b>Prescription Coverage</b>	All states choose to include prescription coverage in their Medicaid program. However, states can set parameters around brand name versus generic drugs or levels of cost-sharing, potentially impacting the accessibility of certain mental health medications.

<b>Access to Care</b>	
<b>MCO Provider Networks</b>	The majority of states use Managed Care Organizations (MCOs) to provide coverage rather than a fee-for-service model. When negotiating with MCOs, states can set requirements for their provider networks within federal guidelines which have just been updated. Ensuring a robust network across all areas of the state (rural, urban and suburban) will increase access to mental health services.
<b>Reimbursement Rates</b>	States have flexibility to set reimbursement rates for providers. Reimbursement rates can affect the number of providers, including mental health providers, who accept Medicaid.
<b>Cost-Sharing</b>	States have the option to charge premiums to pregnant women over 150% FPL and cost-sharing for non-pregnancy related expenses (such as mental health care). Minimizing cost sharing reduces financial barriers to care.



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<sup>29</sup> CLASP calculations of American Community Survey data, Table B17024, <http://www.census.gov/acs>.

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<https://www.medicaid.gov/medicaid-chip-program-information/by-state/connecticut.html>; Minnesota:

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<https://www.medicaid.gov/medicaid-chip-program-information/by-state/virginia.html>.

<sup>32</sup> Medicaid income eligibility levels can be found on each state's Medicaid homepage: Connecticut:

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