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

Current Landscape, Innovations, and Next Steps

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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.[1] 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.[2] 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[3], 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.

<u>For the states</u>:

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.

<u>For philanthropy</u>:

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.