

## Depression during pregnancy and the postpartum period: State-level screening policies are the first step

Perinatal depression is one of the most common complications of pregnancy. While estimated rates of perinatal depression vary depending on how depression is measured and the population studied, federal researchers have estimated that between 8.5 and 11 percent experience depression during pregnancy and between 6.5 percent and 13 percent experience depression during the first year postpartum.<sup>1</sup> Diagnosed rates of depression alone have increased seven-fold between 2000 and 2015.<sup>2</sup>

Over the past several years through early in the COVID-19 pandemic, rates of perinatal depression have substantially increased. Based on responses from the Pregnancy Risk Assessment Monitoring System (PRAMS) from 2017-2020 – a survey of individuals who have given birth in the past year – rates of depression are substantially higher than rates previously estimated.<sup>3</sup> Overall rates of self-reported perinatal depression have increased from 23 percent in 2017 to 26 percent in 2020, largely driven by increases in depression during pregnancy (Figure 1).

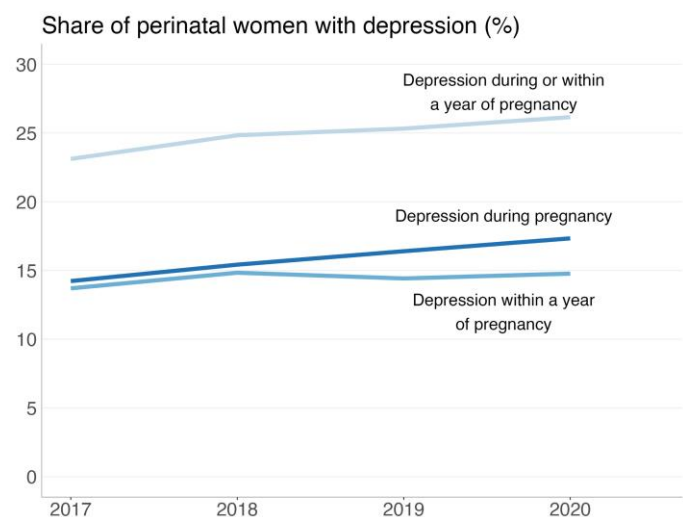
Untreated depression during pregnancy is one of the greatest risk factors for both postpartum and chronic depression.<sup>4,5</sup> Further, perinatal depression can increase the risk of other pregnancy complications, including suicide, and can create a financial burden on individuals, their families, and society.<sup>6</sup>

### Rates of perinatal depression by population

According to 2017-2020 PRAMS responses, baseline rates and increases in perinatal depression vary by population. In 2017, around 28 percent of Black, American Indian, and Alaskan Native postpartum individuals reported experiencing perinatal depression – far higher than the 21.5 percent of white individuals in 2017. In 2020, the first year of the COVID-19 pandemic, perinatal depression rates among American Indian and Alaskan Native populations increased seven percentage points to 35 percent (Figure 2).

Rates of perinatal depression are also substantially greater in younger individuals, with the greatest baseline rates seen in women under 25, ranging from 29 percent among 20–24-year-olds

**Figure 1. Depression during pregnancy drives increases in rates of perinatal depression**



Source: CDC PRAMS, 2017-2020

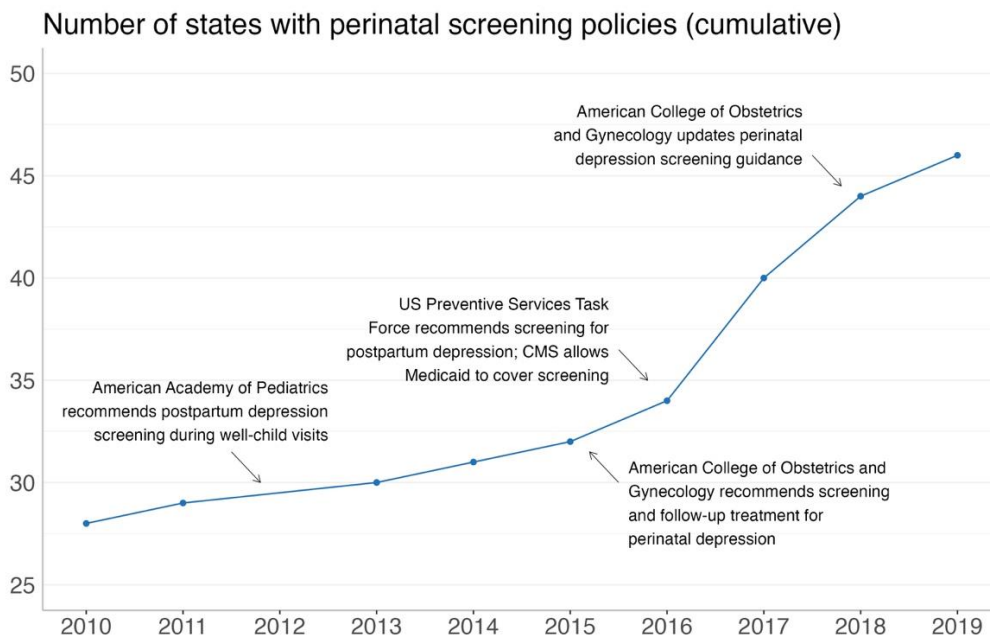


## Policies that address perinatal depression

Cox et al.'s "Perinatal Depression Treatment Cascade" describes the gaps in diagnosis, initiation of treatment, adequacy of treatment, and treatment response among women with perinatal depression.<sup>7</sup> Each of these inflection points are opportunities for policy or programmatic intervention to increase rates of diagnosis and treatment, and ultimately reduce the number of women with untreated depression during and after pregnancy.

Despite the increases in rates of perinatal depression, over the past decade several associations and government agencies have issued recommendations for states to enact screening and treatment policies, for insurers to cover depression screening and treatment, and for clinicians to adopt new guidelines. As these groups issued recommendations, more states adopted screening policies (Figure 4). According to data from The Commonwealth Fund, around half of states (28 states) had already implemented screening policies by 2010, including recommendations or requirements for clinicians to screen patients during prenatal, postpartum, or well-child visits.<sup>8</sup> In 2012, the American Academy of Pediatrics recommended that clinicians screen for depression during well-child visits, and states slowly began adopting policies requiring insurers to cover screening during one or more well-child visits.<sup>9</sup> In 2016, the US Preventive Services Task Force issued guidance recommending screening for postpartum depression, and at the same time, the Centers for Medicare and Medicaid Services (CMS) clarified its guidance allowing states to reimburse for postpartum depression screening during well-child visits.<sup>10,11</sup> Within the following three years, 12 additional states implemented policies recommending, requiring, or reimbursing for postpartum depression screenings.

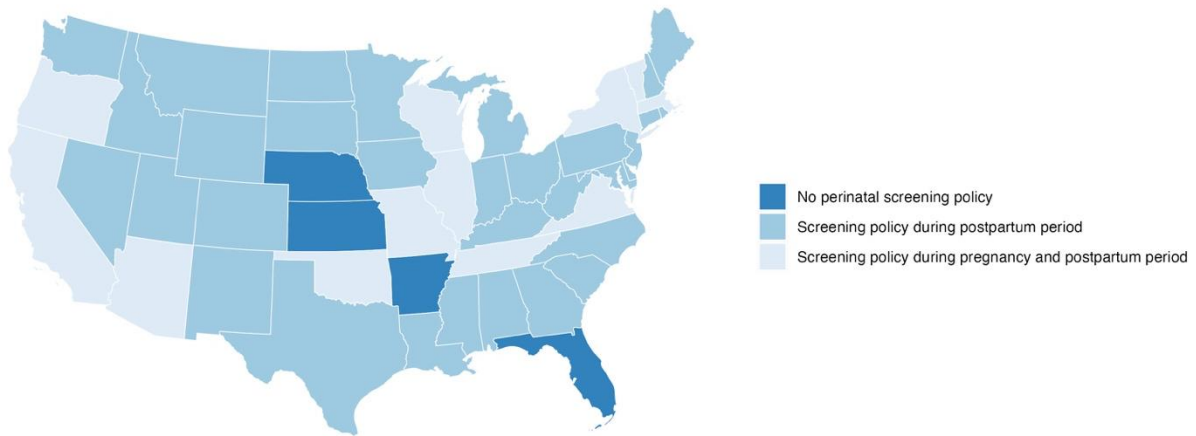
**Figure 4. More states started screening after recommendations from the US Preventive Services Task Force and guidance from CMS**



Source: The Commonwealth Fund, State Policies to Improve Maternal Health Outcomes (2020)

Although states were quick to respond to updated screening guidance, states largely focused on postpartum depression screenings rather than screenings during prenatal visits. By 2020, only 12 states recommended screening during prenatal visits, while all but five states recommended screening during the postpartum period. Most recommend or require screening during well-child visits only – not during the comprehensive postpartum visit endorsed by the American College of Obstetrics and Gynecologists (ACOG) (Figure 5). Although ACOG has been recommending screening during pregnancy as well as the postpartum period since 2015, states have been more responsive to the Medicaid allowances for screening during well-child visits.<sup>12</sup>

**Figure 5. Most states only recommend or require screening during the postpartum period**

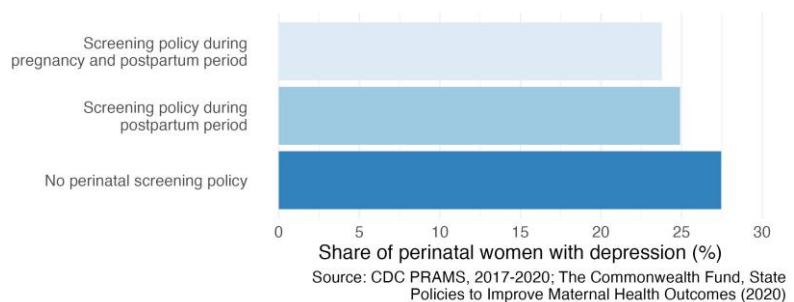


Source: The Commonwealth Fund, State Policies to Improve Maternal Health Outcomes (2020)

Averaging self-reported rates from 2017-2020, states that enacted screening policies by 2020 have lower rates of perinatal depression (Figure 6). States with screening policies during pregnancy and postpartum have an average rate of around 24 percent, states with screening policies only postpartum have a rate of around 25 percent, and the five states without screening policies have a higher average rate of 27.5 percent. While these differences demonstrate an association, rather than causation – that is, screening policies do not necessarily lead to lower rates of perinatal depression – the states without policies and higher rates may benefit from increased screening as the first step in identifying and treating perinatal women with depression.

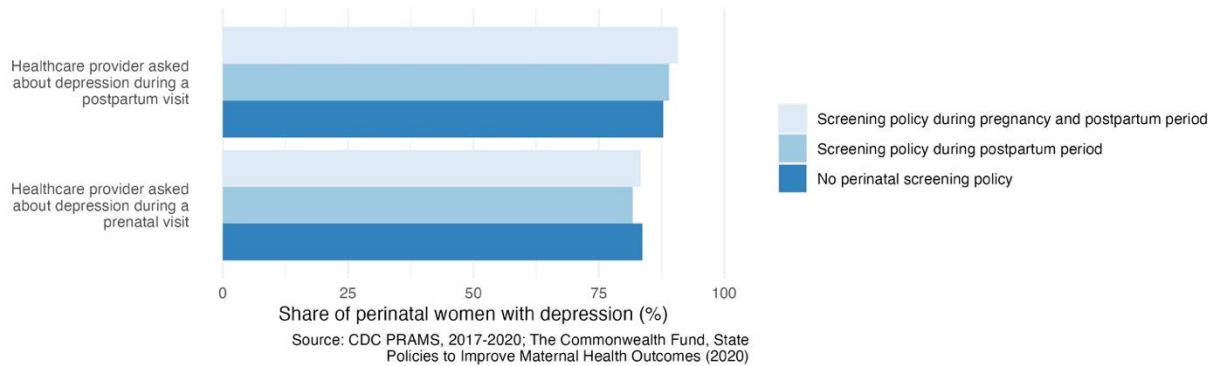
Although less than a third of states have implemented policies recommending screening for depression during pregnancy, the share of women responding that their provider asked about depression during a prenatal visit from 2017-2020 did not substantially vary by state policy. Around 83.5 percent of respondents in states with no screening policy and

**Figure 6. Perinatal depression rates are higher in states without screening policies**



states with a screening policy during pregnancy responded that they were asked about depression during a prenatal visit. Although a slightly smaller share of women in states with only postpartum screening policies responded that they were asked about depression during pregnancy, self-reported screening rates still appear to be high. The share of women who responded that they were asked about postpartum depression is even higher, reaching over 90 percent in states that have screening policies during pregnancy and postpartum.

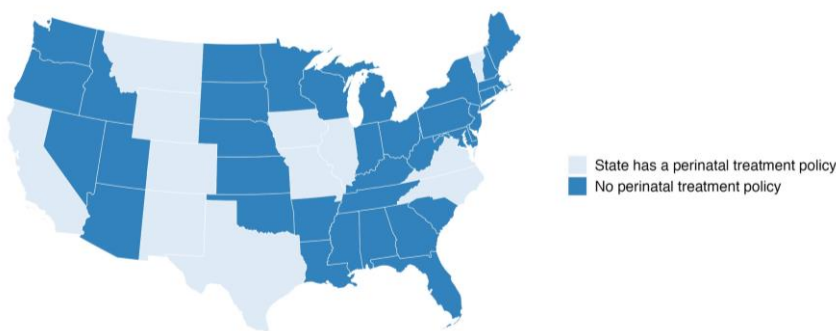
**Figure 7. Women were asked about depression during postpartum visits more often than during prenatal visits**



Although PRAMS respondents largely reported that providers asked about depression, providers may not be using an evidence-based screening tool like the Edinburgh Postnatal Depression Scale and the Patient Health Questionnaire-9.<sup>12</sup> Further, screening for depression alone only has a marginal effect on the risk of continued depression during and after pregnancy.<sup>13</sup> Screening combined with treatment is needed to reduce rates of untreated perinatal depression, demonstrated by ACOG’s 2015 recommendation for screening and follow-up treatment.<sup>12</sup> Treatment rates vary by population studied, but researchers have estimated that only 13.6 percent of women with depression during pregnancy and 15.8 percent of women with postpartum depression are treated.<sup>7</sup>

Only 12 states have implemented policies related to treatment of perinatal depression as of 2020 (Figure 8).<sup>8,12</sup> States have appeared to respond more strongly not to the recommendations issued by ACOG or the US Preventive Service Task Force, which both recommended screening and

**Figure 8. Fewer states have perinatal treatment policies**



Source: The Commonwealth Fund, State Policies to Improve Maternal Health Outcomes (2020)

treatment during pregnancy and postpartum, but instead mainly to the CMS guidance allowing screening during well-child visits as part of the Early and Periodic Screening, Diagnostic, and Treatment Medicaid benefit.<sup>10</sup> The federal government covers between 50 percent and

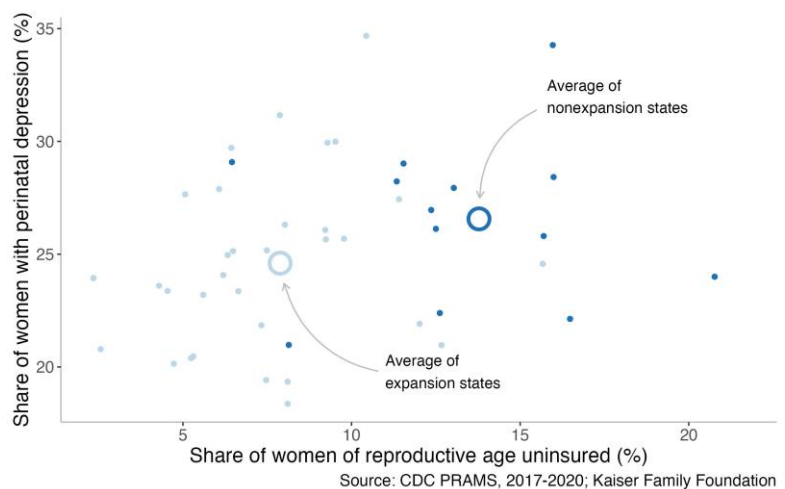
77 percent of Medicaid costs, depending on the state.<sup>14</sup> When the federal government shoulders most of the screening costs, coupled with the already low cost of screening, states are more inclined to adopt policies to improve the mental health of new mothers.

### Medicaid coverage as a policy solution

Enacting state-level screening and treatment policies is only marginally associated with lower rates of depression and a higher likelihood of being asked by a provider about depression. Other mechanisms combined with state-level screening and treatment policies may more effectively reduce rates of untreated perinatal depression. Medicaid covered about 42 percent of all deliveries and 35 percent of children in 2020.<sup>15,16</sup> Pregnant women under an income threshold are categorically eligible for Medicaid coverage, and many – especially those in states that did not expand Medicaid to all low-income adults – are previously uninsured. Without coverage, women are less likely to attend primary care visits before they become pregnant where they could be screened for depression, and are less likely to receive adequate treatment, including medication and psychotherapy.<sup>17,18</sup>

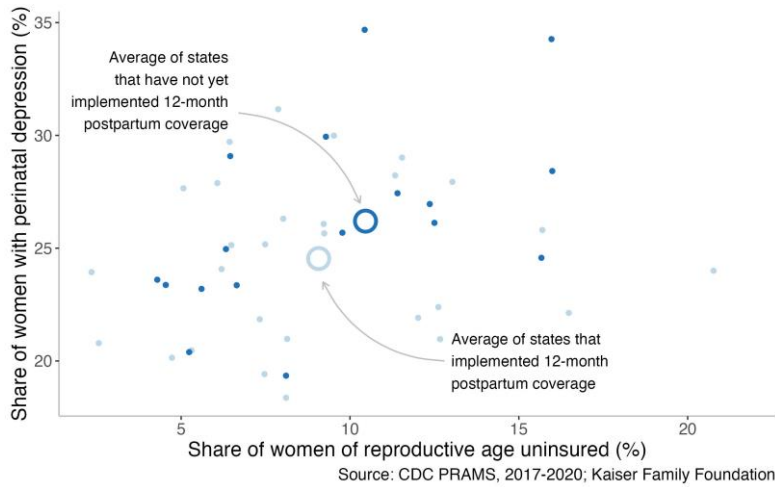
As of 2020, 15 states had not expanded Medicaid to all low-income adults.<sup>19</sup> While the number has declined to 10 states as of 2023, large states like Texas and Florida have still not expanded, leaving thousands of women uninsured before they become pregnant. Researchers have recently shown that Medicaid expansion was associated with declines in pre-pregnancy depression, one of the biggest risk factors for subsequent depression during and after pregnancy.<sup>18,20</sup> Based on 2017-2020 PRAMS data, the share of women with perinatal depression and the share of women uninsured are lower, on average, in expansion states compared with nonexpansion states (Figure 9). Expanding Medicaid to all low-income adults in the remaining states could help identify more women with depression early on and reduce rates of untreated perinatal depression.

**Figure 9. States with Medicaid expansion have lower rates of perinatal depression and uninsurance**



By default, pregnant individuals lose Medicaid coverage 60 days after giving birth unless they qualify some other way, such as low income or disability. Starting in April 2022, CMS has made it easier for states to extend Medicaid eligibility from 60 days to one year postpartum through a

**Figure 10. States that have not extended Medicaid postpartum coverage as of 2023 had higher rates of perinatal depression and uninsurance**



state plan amendment.<sup>21</sup> 31 states opted to extend Medicaid postpartum coverage as of early 2023.<sup>22</sup> Although the PRAMS data on depression rates only capture 2017-2020, it is clear that states that already had lower rates of perinatal depression, on average, opted to implement this policy (Figure 10). Like the states that have not yet expanded Medicaid to all low-income adults, states could address perinatal depression by extending Medicaid to one year postpartum, which can provide additional opportunities for screening and follow-up treatment coverage.

### Integration of screening and treatment

Screening policies can help identify women with perinatal depression, but screening alone is not enough to reduce depressive symptoms. As states consider expanding Medicaid to all low-income adults and to pregnant women through one year postpartum, states as well as providers at the local level can address untreated perinatal depression through integrating mental health treatment into the OB/GYN or primary care setting. Several states have implemented perinatal psychiatry access programs, where psychiatrists with expertise in perinatal mental health consult with primary care providers as needed to discuss treatment options for their patients who screen positive for depression.<sup>23,24</sup> Other states have implemented collaborative care models that combine screening, treatment initiation, and follow-up within the same practice, which can improve care transitions and quality of treatment.<sup>25,26</sup> To address perinatal depression, states will need to implement screening and treatment policies, improve health insurance coverage, and work with clinicians to better integrate mental health screening and treatment in the OB/GYN and primary care setting.

## References

1. Gaynes BN, Gavin N, Meltzer-Brody S, et al. *Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes*. Agency for Healthcare Research and Quality (US); 2005.
2. Haight SC, Byatt N, Moore Simas TA, Robbins CL, Ko JY. Recorded Diagnoses of Depression During United States Delivery Hospitalizations, 2000–2015. *Obstet Gynecol*. 2019;133(6):1216-1223. doi:10.1097/AOG.0000000000003291
3. CDC. Pregnancy Risk Assessment Monitoring System. Published March 29, 2023. Accessed April 25, 2023. <https://www.cdc.gov/prams/index.htm>
4. Milgrom J, Gemmill AW, Bilszta JL, et al. Antenatal risk factors for postnatal depression: a large prospective study. *J Affect Disord*. 2008;108(1-2):147-157. doi:10.1016/j.jad.2007.10.014
5. Woolhouse H, Gartland D, Mensah F, Brown SJ. Maternal depression from early pregnancy to 4 years postpartum in a prospective pregnancy cohort study: implications for primary health care. *BJOG*. 2015;122(3):312-321. doi:10.1111/1471-0528.12837
6. Luca DL, Margiotta C, Staatz C, Garlow E, Christensen A, Zivin K. Financial Toll of Untreated Perinatal Mood and Anxiety Disorders Among 2017 Births in the United States. *Am J Public Health*. 2020;110(6):888-896. doi:10.2105/AJPH.2020.305619
7. Cox EQ, Sowa NA, Meltzer-Brody SE, Gaynes BN. The Perinatal Depression Treatment Cascade: Baby Steps Toward Improving Outcomes. *J Clin Psychiatry*. 2016;77(9):1189-1200. doi:10.4088/JCP.15r10174
8. State Policies to Improve Maternal Health Outcomes. The Commonwealth Fund. Published November 19, 2020. Accessed April 25, 2023. <https://www.commonwealthfund.org/publications/maps-and-interactives/2020/nov/state-policies-improve-maternal-health-outcomes>
9. Earls MF, Yogman MW, Mattson G, et al. Incorporating Recognition and Management of Perinatal Depression Into Pediatric Practice. *Pediatrics*. 2019;143(1):e20183259. doi:10.1542/peds.2018-3259
10. CMS. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children. Published online May 11, 2016. Accessed April 25, 2023. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib051116.pdf>
11. United States Preventive Services Taskforce. Evidence Summary (Pregnant and Postpartum Women): Screening for Depression in Adults. Published online January 26, 2016. Accessed April 25, 2023. <https://www.uspreventiveservicestaskforce.org/uspstf/document/evidence-summary-primary-care-screening-for-and-treatment-of/depression-in-adults-screening>
12. ACOG. *Screening for Perinatal Depression*.; 2018. Accessed April 26, 2023. <https://www.acog.org/en/clinical/clinical-guidance/committee-opinion/articles/2018/11/screening-for-perinatal-depression>



13. O'Connor E, Rossom RC, Henninger M, Groom HC, Burda BU. Primary Care Screening for and Treatment of Depression in Pregnant and Postpartum Women: Evidence Report and Systematic Review for the US Preventive Services Task Force. *JAMA*. 2016;315(4):388-406. doi:10.1001/jama.2015.18948
14. Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier. KFF. Published March 31, 2023. Accessed April 26, 2023. <https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/>
15. Keisler-Starkey K, Bunch LN. Health Insurance Coverage in the United States: 2020. *Current Population Reports*. Published online September 14, 2021:40.
16. Births Financed by Medicaid. KFF. Published December 17, 2021. Accessed October 23, 2022. <https://www.kff.org/medicaid/state-indicator/births-financed-by-medicaid/>
17. Harman JS, Edlund MJ, Fortney JC. Disparities in the Adequacy of Depression Treatment in the United States. *PS*. 2004;55(12):1379-1385. doi:10.1176/appi.ps.55.12.1379
18. Margerison CE, Hettinger K, Kaestner R, Goldman-Mellor S, Gartner D. Medicaid Expansion Associated With Some Improvements In Perinatal Mental Health. *Health Affairs*. 2021;40(10):1605-1611. doi:10.1377/hlthaff.2021.00776
19. Status of State Medicaid Expansion Decisions: Interactive Map. KFF. Published November 19, 2021. Accessed December 3, 2021. <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>
20. Míguez MC, Vázquez MB. Risk factors for antenatal depression: A review. *World J Psychiatry*. 2021;11(7):325-336. doi:10.5498/wjp.v11.i7.325
21. CMS. Improving Maternal Health and Extending Postpartum Coverage in Medicaid and the Children's Health Insurance Program (CHIP). Published online December 7, 2021. Accessed April 27, 2023. <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21007.pdf>
22. Medicaid Postpartum Coverage Extension Tracker. KFF. Published November 19, 2021. Accessed November 30, 2021. <https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/>
23. Byatt N, Biebel K, Moore Simas TA, et al. Improving perinatal depression care: the Massachusetts Child Psychiatry Access Project for Moms. *General Hospital Psychiatry*. 2016;40:12-17. doi:10.1016/j.genhosppsych.2016.03.002
24. Vermont Department of Health. Support Delivered: Perinatal Mood and Anxiety Info & Resources. Vermont Department of Health. Published July 18, 2016. Accessed December 4, 2022. <https://www.healthvermont.gov/family/pregnancy/PMADs>
25. Gjerdingen D, Crow S, McGovern P, Miner M, Center B. Stepped care treatment of postpartum depression: impact on treatment, health, and work outcomes. *J Am Board Fam Med*. 2009;22(5):473-482. doi:10.3122/jabfm.2009.05.080192
26. Melville JL, Reed SD, Russo J, et al. Improving care for depression in obstetrics and gynecology: a randomized controlled trial. *Obstet Gynecol*. 2014;123(6):1237-1246. doi:10.1097/AOG.0000000000000231