Peripartum depression (PPD) is a serious depressive mood disorder that affects mothers during pregnancy and up to a year following childbirth\(^1^,\)\(^2\). Women with PPD may experience feelings of extreme sadness, anxiety, and exhaustion that make it difficult to take care of themselves and others\(^3\). Across the U.S., an estimated 10-25% of women suffer from PPD\(^4^,\)\(^5\). Although PPD is a treatable disorder, it is often under-diagnosed and under-treated.

In the U.S., depression is the leading cause of disability for adults ages 18 - 45 and is twice as common in women\(^6^,\)\(^7\). In 2010, major depressive disorder cost the U.S. an estimated $210.5 billion, with $96.8 billion in direct costs (inpatient and outpatient medical services), $103.1 billion in work-place costs (missed days and reduced productivity), and $10.5 billion in suicide-related costs\(^8\). Depression also increases the likelihood of developing additional disabling chronic illnesses, like heart disease, diabetes, stroke, and Alzheimer’s disease\(^9\).

Caring for a newborn can be challenging; caring for a newborn while struggling with depression can feel impossible. Depression during and after pregnancy is especially concerning given documented adverse effects of maternal depression on child health outcomes. Maternal depression is associated with significant complications at birth, including pre-term birth, low birth weight, and increased length of stay in the neonatal intensive care unit\(^10\). Maternal depression also compromises the mother-child bond, which negatively affects the child’s social, motor, and cognitive development and increases the child’s own risk of developing depression and other mental disorders\(^11\).

Well-established treatment options for peripartum depression exist, including psychotherapy and pharmaceutical treatment\(^12\). Treating a mother’s depression is associated with improvement of maternal depressive symptoms and other disorders in her child\(^13\). However, failure to treat underlying maternal depression may cause the infant’s developmental issues to become less responsive to treatment over time\(^13\).

The Situation in Texas

In 2014, Medicaid covered 54% of all Texas births\(^14\). A comprehensive report from the 84th Texas Legislative Session highlighted that PPD is significantly underreported among Medicaid patients\(^15\). In 2014, only 1.7% of peripartum women enrolled in Medicaid were diagnosed with PPD (3,533 of 212,809). However, the Texas Pregnancy Risk Assessment Monitoring System (PRAMS) reported an estimated rate of 16.9% that year\(^5\). This suggests that 32,347 new mothers with Texas Medicaid may have gone without needed PPD care in 2014.

In Texas, Medicaid for Pregnant Women (MPW) is specifically for uninsured pregnant women whose income is too high to normally qualify for Medicaid\(^16\). Coverage exists during pregnancy and for the 60 days after childbirth. Once MPW coverage ends, women are auto-enrolled into Healthy Texas Women (HTW), a new program that covers women’s health and family planning services for low-income women who are not pregnant\(^17\). This program was recently launched on July 1, 2016, and many Texas providers are not enrolled or familiar with the program\(^18\).

Policy Recommendations

1. **Increase funding for Federally Qualified Health Centers (FQHCs) to specifically provide PPD education and community outreach.**

   Many mothers find it difficult to determine if their levels of sadness and anxiety are normal or could be considered depression for which they can seek treatment\(^19\). Educating families and supportive community members, like community faith leaders, can increase awareness and symptom recognition. Community Health Workers could be used to provide PPD education and treatment referrals to the local FQCH. FQHCs are uniquely poised to provide PPD treatment to vulnerable patients since they provide comprehensive services on a sliding fee scale, often at clinic locations within the mother’s own community\(^20\).
2. Extend MPW coverage to one year after childbirth while HTW becomes more established among Texas providers.

While the administrative dust settles on HTW, continuity of care would be best facilitated by an extension of MPW coverage for the year following childbirth. This gives HTW time to establish strong relationships with Texas providers through greater provider education about HTW, incentives for providers to enroll in HTW, and development of clear HTW guidelines for PPD screening and treatment.

3. Broaden coverage within HTW to provide comprehensive care for peripartum mood disorders.

The majority (64%) of patients affected by major depressive disorder have comorbid behavioral health diagnoses, and 89.5% of patients report experiencing moderate, severe, or very severe depressive symptoms. Currently, only uncomplicated, mild postpartum depression is covered by the HTW program. We estimate that these narrow coverage restrictions leave 17,948 - 31,754 women enrolled in HTW without the care they need. We recommend expanding HTW coverage of peripartum mood disorders to better help women who may need more intensive treatment.

References: