



TO: Texas Health and Human Services Commission
Sent via email: HDISPublicComments@hhsc.state.tx.us

FROM: Texas Medical Association
American College of Obstetricians and Gynecologists District XI (Texas)
Texas Association of Obstetricians and Gynecologists
Texas Academy of Family Physicians
Texas Pediatric Society

RE: Comments on Draft Postpartum Depression Plan

DATE: July 23, 2020

On behalf of the above-named organizations, thank you for the opportunity to comment on the Texas Health and Human Services Commission’s (HHSC’s) Draft Postpartum Depression Plan as required by House Bill 253 (86th regular session). As noted in the plan’s introduction, an estimated 14% of postpartum women in Texas suffer from the disorder each year compared with an estimated one in eight nationally.¹ However, across states and populations, the rates vary considerably, ranging from 9.7% in Illinois to 23.5% in Mississippi.² While Texas’ rate is closer to the national average, there is clearly room for improvement by adopting a comprehensive, proactive, and deliberate postpartum depression (PPD) reduction plan.

As drafted, the plan provides state policymakers, physicians, providers, and advocates a very helpful compendium of current and future programs and services where women can obtain PPD screening, referrals, treatment, and management. Importantly, our members were pleased regarding:

- Forthcoming enhancements to the Healthy Texas Women’s (HTW’s) PPD benefits, particularly the addition of counseling services;
- Support to increase use of group prenatal visits;
- The 2021 launch of the Department of State Health Services’ (DSHS’) updated Grand Rounds series related to PPD; and
- Efforts to decrease stigma related to postpartum depression.

However, as a *strategic* plan, we believe the document could be improved by providing more specificity regarding the state’s anticipated milestones and metrics for improving access to PPD screening, referral, treatment, and support services over the next five years. As such, we recommend the following general and specific revisions.

¹ [Vital Signs: Postpartum Depressive Symptoms and Provider Discussions About Perinatal Depression — United States, 2018](#), Centers for Disease Control and Prevention, *Weekly* / May 15, 2020 / 69(19);575–581.

² *Ibid.*

Thank you for continued efforts to improve maternal health and your timely consideration.

General

We recommend restructuring the document, moving the comprehensive compendium of programs and services to an appendix, and starting instead with an overview of PPD; its incidence in Texas compared with other states; the impact the disorder has on women, children, and families; and how health care disparities contribute to PPD. **As a strategic plan, it also is important that HHSC provide a vision statement telegraphing where it would like Texas to be in five years, including milestones to measure progress and programmatic and policy options Texas will need to implement to achieve its vision (recognizing the plan will evolve over time).** We encourage HHSC to incorporate in the plan regular review of data regarding service utilization and health outcomes. As an example, we point you to the [Texas Statewide Behavioral Health Strategic Plan](#) for 2017-21.

We also recommend highlighting within the executive summary key new initiatives that will be implemented within the year so stakeholders can quickly reference them, along with adding an appendix with a list of all the new initiatives that are expected to be added within the next year.

Lastly, as elaborated in our comments below, we ask that HHSC strongly consider incorporating recommendations that our organizations believe will meaningfully improve PPD screening and treatment. If HHSC does not feel it can address programmatic and/or statutory reforms within this document, then it should clearly specify a timeframe for doing so as well as the process HHSC will use to systematically engage stakeholders over the next five years to identify and implement programmatic changes.

Specific

- Page 6: The quote on the bottom of the page does not accurately portray physicians' perspective on mental health. Physicians *absolutely* value mental health. While physicians might be unaware of the benefits and services within programs such as Healthy Texas Women, an issue on which we will comment later, or be unaware of the PPD resources within their community, particularly because there is not a central repository of this information, this quote misconstrues physicians' perspective. We recommend that the quote be removed.

~~“I see that often OBs don't have the training or don't know where to refer...perhaps they don't value the mental health component as much as the physical component. When OBs find out about resources, trainings, and regional support coordinators that can help them, they are more interested in screening and referring.”~~

- Pages 8 and 22: Healthy Texas Women. On pages 8 and 22, the draft plan states that adult women who lose pregnancy-related Medicaid are automatically enrolled in HTW. However, under the terms of the state's Medicaid 1115 Women's Health Waiver, this policy no longer applies. Unfortunately, the loss of auto enrollment will severely compromise continuity of care for women. We urge HHSC to collaborate with stakeholders to identify mechanisms to streamline eligibility in order to minimize potential gaps in care.
- Page 16: Pregnancy medical home. Our organizations strongly support expansion of the pregnancy medical home model, a model we have collectively long championed. We support including mental health screening as a key component of each pilot. However, the language within the draft states that “HHSC plans to ensure that pilot providers are implementing routine mental health screening” without confirming whether Medicaid will pay for such services. As outlined within our recommendations (below), we urge HHSC to extend payment for PPD screening exams to additional services and physician/provider exams.

- Page 17: Healthy Texas Women Plus. We strongly support the addition of enhanced PPD benefits within HTW, including counseling services. We have concerns about launching the new benefit within six weeks, which will provide a very short timeframe to recruit participating providers and educate women about the new services. Additionally, the draft specifies that the enhanced benefits under HTW+ will “raise awareness of PPD and treatment options among HTW providers in addition to increasing access to care.” However, the document doesn’t elaborate what these new benefits will be, including whether there will be physician and provider educational events. The new benefits will take effect September 2020, yet our organizations have not had opportunity for input, including the opportunity to review the underlying data used by the agency to develop the proposed enhanced benefit.
- Page 23: Substance use disorder. There is a strong link between PPD and substance use. Thus, we recommend that the plan elaborate on that connection, outline opportunities to enhance education and training on the co-occurrence of PPD and substance use, and articulate the need for additional treatment facilities capable of providing treatment to women with co-occurring PPD and substance use.
- Pages 24-25: PPD Treatment Network. At the bottom of page 24, the draft notes that HHSC is assessing opportunities to connect women with pregnancy-related Medicaid to HTW physicians and providers who could serve as the mother’s “primary care provider” after her Medicaid coverage ends two months postpartum. We commend HHSC’s efforts to promote continuity of care between the programs. However, not all HTW providers are qualified or able to provide primary care. Many are clinics focused on women’s health care services only. Moreover, it is important to be clear that even with the enhancement of HTW benefits in September 2021, HTW benefits will remain limited, meaning that physicians’ ability to meet HTW enrollee’s primary care needs also will be constrained. Expectations must be clearly set regarding what HTW+ will provide and what it will not.

We also recommend amending the language on page 25 as follows:

- Revise Medicaid provider directories to identify HTW providers qualified to provide primary care services.
- Add information to Medicaid managed care enrollment packets to encourage women to select qualified HTW providers as primary care providers.
- Encourage qualified HTW providers to serve as Medicaid and CHIP primary care providers.
- Page 24: To increase PPD screening within primary care physician practices and clinics, the draft states that HHSC intends to “work with providers, Medicaid and CHIP health plans, *and the HHSC Office of Inspector General* (emphasis added) on guidance to providers.” The strategic plan is unclear on the extent that the OIG will be involved on developing guidance. Any guidance from the OIG should be to help providers with the administrative burden associated with billing and documentation requirements, as recognized on page 21 of the Strategic Plan. It should not extend to clinical guidelines, which should be based on evidence-informed clinical criteria.
- Page 24: The draft references HHSC’s research regarding maternal mood disorders developed by other state Medicaid programs, nonprofits, advocacy groups, and universities in the U.S. It would be helpful for HHSC to share this research with stakeholders, since the agency used it to inform its decision-making regarding implementation of Senate Bill 750.
- Page 36: The draft includes a quote from an unnamed psychologist stating he or she has heard that pediatricians do not know how to have the conversation with parents about maternal depression

screenings. Including unsourced off-hand remarks about other healthcare providers seems inconsistent with the collaborative and evidence-based goals of the Strategic Plan. We recommend that the quote be removed.

~~*“I hear that pediatricians don’t know they can get reimbursement for maternal depression screenings, they don’t know how to have the conversation with parents, and they don’t know where to send the person.”*~~

- Nurse Family Partnership (NFP) and home visiting programs. We recommend adding the NFP and other home visiting programs as another key resource in the state’s efforts to improve early identification and referral of women with potential PPD. Nurses within the program establish strong relationships with new mothers during the critical months before delivery and two years following, making them ideal to connect women in need to appropriate services.

Programmatic Transformation

We strongly encourage HHSC to amend the PPD Strategic Plan to incorporate regulatory and/or legislative recommendations that are needed to meaningfully advance the state’s PPD screening and treatment improvement plan.

Of highest importance to our organizations is extending Medicaid postpartum benefits for a full 12 months. While coverage itself will not solve every access-to-care problem for women at risk of or experiencing postpartum depression, it is an essential key that women need to successfully access medically necessary mental and physical health care services. Postpartum depression often manifests itself well after pregnancy-related Medicaid ends 60 days postpartum. While enhancing HTW mental health benefits will most certainly help, postpartum women need comprehensive care for a full year following delivery to care for all their behavioral and mental health needs.

Additionally, we offer the following:

1. Collaborate with the Texas Child Mental Health Care Consortium to explore implementation of a Postpartum Depression Access Network akin to the Child Psychiatric Access Network ([CPAN](#)), which Texas launched this year. CPAN offers a network of mental health specialists to train and provide virtual consultations to primary care physicians to expand capacity to treat and manage child and adolescent behavioral health disorders. Massachusetts implemented such a program – Massachusetts CPAN for Moms Program ([MCPAP](#)) – focused on postpartum depression.
2. Expand the types of settings and physician specialties for which postpartum depression screening exams are payable under Texas Medicaid in order to improve early identification of PPD, including:
 - Increasing from one to four the number of PPD screening exams provided during a newborn’s well-child visits, which would align Texas Medicaid policy with the American Academy of Pediatrics’ recommendations to conduct screening exams during the 1-, 2-, 4-, and 6-month well-baby checks.
 - Extend Medicaid/CHIP coverage for PPD screening exams for mothers with newborns admitted to the neonatal intensive care unit for an extended stay. Mothers of infants in the NICU are more likely to experience maternal mental health challenges, and research shows the benefits of screenings in NICUs as a critical part of every family assessment; and
 - Pay obstetrical care physicians and providers for conducting PPD screening in accordance with guidance from the American College of Obstetricians and Gynecologists, which recommends at least one screening exam be provided prenatally or within six weeks postpartum.

3. Maintain Medicaid audio-only telemedicine and telehealth services as well as new telemedicine and telehealth flexibilities extended to the HTW and Family Planning Program. Access to virtual care is critical to improving the availability of PPD screening and treatment for women who lack transportation or face other barriers accessing in-person or traditional telemedicine.
4. Collaborate with stakeholders to identify strategies to seamlessly transition women from pregnancy-related Medicaid to HTW+ in order to maintain continuity of care.
5. Establish a mechanism for physicians and providers to quickly refer women with moderate to severe PPD to local mental health authorities (LMHAs). At a minimum, each LMHA should explain on its website how to make such a referral and establish a point of connection for physicians to call. Furthermore, it is important for the state to collect data on whether LMHAs themselves have capacity to diagnose and treat women with PPD. Many physicians report their LMHA lacks the capacity or expertise to do so. Each LMHA should report on the number of women referred for PPD treatment compared with those the center could serve. Likewise, we request that HHSC establish a similar process to simplify referrals to substance use disorder treatment facilities. There is a strong link between PPD and substance use, thus women with co-occurring conditions need timely treatment for both.
6. Establish a reference tool on the HTW+ website for physicians to quickly identify covered benefits. A common complaint among physicians about HTW is that it is difficult to determine what the HTW benefit package covers.
7. Increase awareness of the Postpartum Depression Tool Kit. Several physicians commented they were unaware of the tool kit but found it to be informative. We recommend that HHSC work with our organizations as well as the Medicaid managed care organizations (MCOs) to promote the kit to physicians who participate in Medicaid and HTW.
8. Provide a centralized, regularly updated electronic portal where patients and physicians can quickly search to identify regional resources, building on requirements of [Resource Guide Provided to Parents of Newborn Children](#) (Section 161.501 of Health and Safety Code) as found on the DSHS website.
9. Collaborate with state physician societies, faith-based organizations, hospitals, and advocacy groups, among others, to develop a coordinated outreach and educational campaign to educate mothers and families about PPD and reduce stigma associated with treatment.
10. Incorporate into PPD educational materials and resources information about the interconnection between untreated PPD and substance use disorders and suicide. Additionally, as HHSC develops the PPD referral network as required by SB 750, it will be important that the state work with the MCOs and physicians/providers to ensure a holistic network that can connect women with PPD to an array of services to address co-occurring behavioral health needs rather than focusing on a single disorder.
11. Add language within the Strategic Plan describing how health care disparities, including lack of health insurance and transportation, have an impact on PPD screening, referral, treatment, and management.