POLICY CENTER FOR Maternal Mental Health™

REPORT

The Role of Medicaid in Advancing Obstetric Provider Maternal Mental Health Screening and Treatment

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Top Lines:

- Untreated Maternal Mental Health (MMH) disorders are a leading cause of preterm birth and maternal mortality, and the role of the Obstetric provider is critical.
- In 2023, the American College of Obstetricians and Gynecologists (ACOG) released clinical practice guidelines for screening, diagnosis, and treatment of MMH disorders.
- 40% of births are covered through Medicaid, and nearly 80% of Medicaid enrollees have coverage through Managed Care Organizations (MCOs), which function like health insurance companies.
- State Medicaid agencies can support the implementation of ACOG guidelines by modifying their MCO contracts, reimbursement, and quality improvement programs to prioritize implementation.
- Analysis of 41 state Medicaid agencies' MCO health plan contracts found 9 addressed the role of OBs in providing maternal mental health, by either requiring screening, addressing reimbursement, or reporting of HEDIS® prenatal depression screening measures: AZ, CA, IN, MI, NM, NV, PA, WA, WI
- States with the highest Medicaid HEDIS Maternal Mental Health screening rates are CA, PA, WA, WI

Introduction

This report provides an overview of the Policy Center's examination of state Medicaid agency (SMA) managed care organization (MCO) contracts to understand the extent to which SMAs are addressing the role of obstetric providers such as OB/Gyns ("OBs") in screening and treating Maternal Mental Health (MMH) disorders. Specifically, we assessed health plan contracts to determine if they (1) require OBs to screen, (2) address OB reimbursement for MMH screening, or (3) require MCOs to report HEDIS® perinatal depression screening measures. The report also includes the HEDIS MMH screening rates for the top-performing states in order to investigate whether these three actions may be influencing screening rates.

Background

The prevalence and harms of untreated maternal Mental Health (MMH) disorders are well-documented. In the U.S. MMH disorders are a leading cause of preterm birth and maternal mortality, with suicide accounting for nearly 20% of maternal deaths.[1–3] One in five women will experience an MMH disorder such as prenatal or postpartum depression and anxiety; yet, research estimates that 50-70% of women go undiagnosed, and 75% of those diagnosed go untreated.[1,2]

The role of OBs in maternal mental health screening

As the woman's primary provider during pregnancy and the postpartum period, obstetric providers (OB/Gyns, midwives, and family practice providers who deliver babies), "OBs" are uniquely positioned to provide screening, treatment, and referrals starting at the beginning of pregnancy through the full postpartum year.

Screening to detect these disorders has been recommended by bodies including the American College of Obstetrics and Gynecology (ACOG) in 2015 and the US Preventive Services Task Force in 2016.[4–6] In 2023, ACOG expanded upon its recommendation for OB/Gyns to screen for maternal mental health disorders and released the first *clinical practice guidelines* (CPGs) for screening and treatment of these disorders.[5] The CPGs recommend screening using a standardized questionnaire, beginning at confirmation of pregnancy and continuing at various intervals throughout the perinatal period, followed by diagnosis and treatment. Also in 2023, the Health Resource and Services Administration's (HRSA) Alliance for Innovation in Maternal Health (AIM) released a patient safety bundle recommending perinatal mental health screening at prenatal and postpartum visits.[7]

Though the development of ACOG's maternal mental health CPGs is monumental, research illustrates that care has not been routinely delivered in accordance with any CPGs in the U.S. for an average of 17 years.8 The implementation of CPGs in the U.S. requires substantive efforts by payors, including state Medicaid agencies, to address payment and incentives and measure whether services are being provided in accordance with guidelines.

In 2019, two standardized measures were created by the National Committee for Quality Assurance (NCQA) to track rates of OB screening for MMH disorders: (1) *Prenatal Depression Screening and Follow-Up* (PND-E) and (2) *Postpartum Depression Screening and Follow-Up (PDS-E)* as a part of the Healthcare Effectiveness Data and Information Set (HEDIS).[8]

These measures were adopted by some state Medicaid agencies that required their MCOs to adopt these measures. Pennsylvania and California were among the states that were early adopters. The Centers for Medicare and Medicaid (CMS) reviews measures to designate as mandatory or voluntary in "Core Sets" of measures that SMAs must consider. These measures were first included as voluntary measures in the Adult and Child "Core Set" maintained by the CMS in 2024.[9,10]

The role of Medicaid in implementing ACOG's maternal mental health guidelines

Currently, Medicaid covers nearly 50% of all births in the United States.[11] State Medicaid agencies (SMAs) are, therefore, well-positioned to address the essential and life-saving role that OBs play in identifying and treating MMH disorders.

In 40 states and DC, state Medicaid agencies (SMAs) contract with health insurers known as "managed care organizations" (MCOs) to provide Medicaid enrollees with care. Nearly 80% of all mothers enrolled in Medicaid are enrolled in MCOs, making this the primary way that Medicaid mothers receive their care.[12] These contractual arrangements are the means by which reporting, payment, and incentives can be required.

State Medicaid Agencies and their contracted MCOs primarily reimburse their in-network OBs through a "bundled obstetric payment" for maternity services.[13] Expert bodies such as ACOG have suggested that this bundled payment is insufficient and may disincentivize OB providers from providing MMH screening and follow-up counseling.[14] ACOG's policy statement, *"Payment for OB-GYNs"* specifically supports separate billing and payment for MMH screening and follow-up counseling provided by an OB:

> *"ACOG supports insurer billing policies that include: Separate billing and payment for ancillary and supportive services, including but not limited to the administration and interpretation of screening (eg, depression, health-related social needs, or social determinants of health), counseling services (eg, genetic, vaccine, nutrition), group prenatal care…and other services that were not accounted for in the development of the global maternity codes," as well as "Separate billing and payment for ongoing outpatient management and care coordination for postpartum conditions that require additional care, such as cardiac conditions, mental health conditions…"*[15]

Indeed, when ACOG first issued recommendations to screen for prenatal and postpartum depression, ACOG also shared applicable fee-for-service (FFS) CPT® billing codes (96160, 96161, 96127, or 96146), indicating that insurers may or may not reimburse for these codes in addition to the "bundled obstetric payment."[16]

State Medicaid agencies have several opportunities to implement ACOG's recommendations among their MCOs and the MCO's in-network OB providers. This report examines the extent to which SMAs have been leveraging the following opportunities, to implement ACOG's clinical practice guidelines:

(1) Requiring OBs to provide prenatal and postpartum MMH screening
(2) Separating OB reimbursement for MMH screening and follow-up from a bundled rate
(3) Requiring reporting of HEDIS MMH screening and follow-up measures

Methods

This study included three parts, a review of: 1) Medicaid MCO contracts, 2) Three SMA approaches to reimbursing OBs for MMH screening and treatment, and 3) Medicaid HEDIS MMH screening rates, by state.

The methods used are detailed below.

1) State Medicaid Agency and Medicaid Managed Care Organization Contract Review

In July 2024, the Policy Center identified and downloaded the “boilerplate” MCO contracts for each of the 40 states and DC that take part in Medicaid managed care.

Each contract was searched for the following keywords: “maternal,” “maternity,” “obstetric,” “obstetrician,” “gynecology,” “pregnancy,” “pregnant,” “prenatal,” “perinatal,” “postpartum,” “anxiety,” “depression,” “mental Health,” and “screening.” Contract language with these keywords was documented for analysis. When other documents were linked or referred to in the contract, we searched for this language as well. Thematic analysis was conducted to determine if the MCO contracts reference or require:

(1) OBs provide MMH screening
(2) Medicaid MCO report HEDIS (or HEDIS-like) MMH screening and follow-up measures
(3) OB reimbursement for MMH screening and follow-up separate from a bundled maternity payment

2) OB Reimbursement Case Studies

Our contractual scan only reviewed documents that were directly linked to the state MCO contracts. However, we chose three states to conduct a more comprehensive review of all relevant publicly available documents, including those not linked in the contracts (i.e., provider manuals, state policy guidance, and fee schedules). We chose states that, based on our initial review, appeared to be innovating in MMH screening reimbursement and/or are top-performing states with regard to Medicaid HEDIS maternal depression screening rates: California, North Carolina, Pennsylvania, Washington and Wisconsin, according to a data pull the Policy Center for Maternal Mental Health received from the National Committee for Quality Assurance in January 2024.

We sought to answer the following questions for each state:

- *Are MMH screening billing codes provided? If so, which codes, and where are they found?*
- *What is the reimbursement rate?*
- *Is there a limit on the number of MMH screenings?*
- *Is an evidence-based MMH screening tool required*?
- *Is there a higher reimbursement rate for positive screens (to reimburse the provider for creating a follow-up plan)?*
- *Is there guidance to bill for follow-up and, if so, what are the code(s) and rate?*

3. Medicaid HEDIS Prenatal and Postpartum Depression Screening and Follow-up Rates by State

Finally, we identified the states that were top-performing on the HEDIS MMH screening measures: *Prenatal Depression Screening and Follow-up (PND-E)* and *Postpartum Depression Screening and Follow-up (PDS-E)*. (Note: These HEDIS specifications/data are not limited to screening by obstetric providers.)

To identify these states, we analyzed data from the 2023 Quality Compass dataset, provided by the National Committee for Quality Assurance (NCQA) in January 2024. We identified the “top four” performing states that had reported enough data to NCQA for rates to be reportable.

Findings

Section 1: State Medicaid Agency and Medicaid Managed Care Organization Contract Review

A. OBs required to provide prenatal and/or postpartum MMH screening

Four of the 41 state contracts explicitly require OBs to provide prenatal and/or postpartum MMH screening and treatment: AZ, CA, OR, and VA. (See Figure 1.)

Table 1

State	*OB Prenatal MMH Screening Required*	*OB Postpartum MMH Screening Required*
AZ	X	X
CA	X	X
OR	X	
VA	X	X

Arizona’s MCO contract[17] requires “maternity care providers” to conduct MMH screening among all patients and requires appropriate follow-up for a positive screen:

> *“ 3. Maternity care providers shall ensure that:* ***… j. Perinatal and postpartum depression and anxiety screenings are conducted at least once during the pregnancy and then repeated at the postpartum visit with appropriate counseling and referrals made if a positive screening is obtained….*** *i. Providers shall refer to any norm-referenced validated screening tool to assist the provider in assessing the postpartum needs of members regarding depression and decisions regarding health care services provided by the Primary Care Provider (PCP) or subsequent referral to the plan/entity responsible for the provision of behavioral health services if clinically indicated.”*

CA’s MCO contract[18] requires screening throughout pregnancy and at the postpartum visit as well as providing care in alignment with ACOG standards.

"Contractor must implement a comprehensive risk assessment tool for all pregnant Members that is comparable to the ACOG standard and CPSP standards per 22 CCR section 51348. Contractor must maintain the results of this assessment as part of the Member's obstetrical record, which must include medical/obstetrical, nutritional, psychosocial, and health education needs risk assessment components. The risk assessment tool must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. …Contractor must follow up on all identified risks with appropriate interventions consistent with ACOG standards and CPSP standards and document those interventions in the Member's Medical Record."

Oregon's MCO contract[19] requires providers to conduct MMH screening at an "initial prenatal exam."

"6. Screening Members. Contractor shall do all of the following… e. Require Providers to screen Members and provide prevention, early detection, brief intervention and Referral to Behavioral Health services in any of the following circumstances… (2) At an initial prenatal exam."

Virginia's MCO contract[20] requires providers of "pregnant individuals" to provide MMH screening in accordance with ACOG, and requires appropriate follow-up to a positive screen.

"5.13.1.3 Maternal Mental Health Screenings and Referrals. The Contractor must, through agreements with its providers, make every reasonable effort to screen pregnant individuals (or refer to an appropriate practitioner to screen) for mental health concerns in accordance with the American Congress of Obstetricians and Gynecologists (ACOG) or American Academy of Pediatrics (AAP) standards. The Contractor must have a process to refer individuals who screen positive for mental health concerns to appropriate services including, but not limited to, follow-up screening, monitoring, evaluation, and treatment. All Contractor staff conducting these screenings must be trained in the administration of such screens and must have the necessary training to ensure appropriate Member support and treatment for identified mental health concerns."

B. Reporting of HEDIS MMH Screening and Follow-up Measures

Nine states require reporting of HEDIS MMH screening and follow-up measures

The prenatal and postpartum depression HEDIS measure specifications do not limit screening and follow-up to that performed by OBs. However, the HEDIS measures are important indicators, and certainly can/should capture screening and follow-up by OBs.

Nine states currently require HEDIS MMH screening reporting. Among these nine states (see **Figure 2**), five states include requirements for the HEDIS MMH screening measures in their MCO contracts (IN, MI, NH, NM, and WA), three states include these measures in their annual External Quality Review (EQR) reports (CA, PA, and NV), and one state includes this in their State Medicaid Quality Strategy (WI). (Note: Since some states change performance metrics throughout the contract period, it was also necessary to scan states' EQR and State Medicaid Quality strategy documents for the latest performance measures they require of their MCOs.) New Hampshire limits its focus to postpartum depression screening, and Indiana focuses only on prenatal screening.

Table 2: States requiring reporting of HEDIS MMH screening measures

State	Prenatal HEDIS Reporting Required	Postpartum HEDIS Reporting Required
CA	X	X
IN	X	
MI	X	X
NH		X
NM	X	X
NV	X	X
PA	X	X
WA	X	X
WI	X	X

Examples of state language requiring MCOs to report the HEDIS MMH screening measures

WA's MCO contract[21] lists the measures in the contract's required performance metrics:

> *"Measures Reported Using Electronic Clinical Data Systems (ECDS): …Prenatal Depression Screening and Follow-Up; Postpartum Depression Screening and Follow-Up."*

WI's 2025 state Medicaid Quality strategy[22] also lists the measures in the state's required performance metrics:

> *"Objective 2: Improve healthy birth outcomes by increasing utilization of certain maternity services, by reducing rates of babies with low birth weights, and by reducing rates of C-section utilization, while also reducing racial and ethnic disparities in these measures, by MY 2027. Quality measures include… Prenatal Depression Screening and Follow-Up (PND-E) (HEDIS Measure). The percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received followup care. Baseline available in MY2025…. Postpartum Depression Screening and Followup (PDS-E) (HEDIS Measure) The percentage of deliveries in which members were screened for clinical depression during the postpartum period and received follow-up care within 30 days if screening was positive. Baseline available in MY2025."*

PA's 2023 Medicaid External Quality Review (EQR) report[23] requires MCOs to report all HEDIS measures:

> *"MCOs are required by DHS, as part of their Quality Assessment and Performance Improvement (QAPI) programs, to report the complete set of Medicaid measures, as specified in the HEDIS MY 2022: Volume 2: Technical Specifications.*

Although HEDIS is not referenced specifically, AZ's medical policy manual,[24] (which is referenced in the contract), notes MCOs are required to create:

> "...*a process for monitoring provider compliance for perinatal and postpartum depression and anxiety screenings being conducted at least once during the pregnancy and then repeated at the postpartum visit, with appropriate counseling and referrals made, if a positive screening is obtained."*

Indiana's MCO contract provides a monetary incentive to MCOs based on their performance on the *Prenatal Depression Screening and Follow-Up (PND-E)* measure, in addition to requiring the measure.[25] The monetary incentive *increases* based on the level of performance on this measure. The contract states:

"Prenatal Depression Screening and Follow-Up (PND-E). The percentage of deliveries in which members were screened for clinical depression during pregnancy using a standardized instrument. Amount of Performance Withhold at risk: 15%.

- *If Contractor's 2023 measurement year rate is at or above the 10th percentile of NCQA 2024 Quality Compass, Contractor is eligible to receive an incentive payment equal to fifty percent (50%) of the amount of the Performance Withhold at risk.*
- *If Contractor's 2023 measurement year rate is at or above the 25th percentile of NCQA 2024 Quality Compass, Contractor is eligible to receive an incentive payment equal to seventy-five percent (75%) of the amount of the Performance Withhold at risk.*
- *If Contractor's 2023 measurement rate is at or above the 50th percentile of NCQA 2024 Quality Compass, Contractor is eligible to receive an incentive payment equal to one hundred percent (100%) of the amount of the Performance Withhold at risk.*

C. OB reimbursement for MMH screening and follow-up separate from a bundled rate

Two states' contracts explicitly address reimbursement to OBs for MMH screening and treatment.

Only NC and WI's contracts reference reimbursement to OBs for maternal mental health care, and they refer to external documents with that detail. (See "case studies" on these states below.)

Section 2: OB Reimbursement Case Studies

Our study confirmed that most states include reimbursement details in separate policy documents, not their Medicaid-managed care contracts. These details may be found in provider manuals, state billing guides, fee schedules or other documents.

Therefore, to understand the other methods that states use to document reimbursement expectations, we chose three states to conduct a more comprehensive review of all relevant publicly available documents. California, North Carolina, Pennsylvania, Washington,and Wisconsin were selected, because our initial review found they appeared to be innovating on OB reimbursement for MMH, and because these states with the exception of North Carolina were top-performing HEDIS MMH-screening states for Medicaid. Using all relevant, publicly

available policy documents, we sought to answer several key questions about reimbursement (see **Figure 3**).

Table 3. MMH Reimbursement - Five State Case Study Summary Findings (2024)

State	***MMH screening billing codes provided?***	***Limits on MMH screening frequency?***	***Is Screening with a valid tool required?***	***Screening Reimbursement Rate***	***Higher reimbursement rate for positive screens (to reimburse for follow-up plan)?***	***MCOs are required to report MMH screening performance measures?***
CA	Yes, in Medicaid provider training manual Requires code for positive vs. negative	Yes, once prenatally, once postpartum	Not mentioned, however OBs are required by law to screen and use a validated screening tool	Negative Screen $17.14 Positive Screen w/ Follow-up Plan $37.25	Yes	Yes
NC	Yes, in Medicaid policy document	Yes, no reimbursement for screening in pregnancy. Limited to 3 screens in the postpartum period (combined for all provider types including pediatricians)	Yes	$4.49	No	No

<table>
<tr><td>PA</td><td colspan="6">PA Medicaid (referred to as “Medical Assistance”) requires MCOs to ensure that in-network OB providers conduct a needs assessment among pregnant patients and submit an “Obstetrical Needs Assessment Form” (ONAF).[26] The ONAF includes a check box for screening for prenatal depression. PA Medicaid requires MCOs to reimburse OBs for submission of the ONAF, although it doesn’t prescribe a rate.

MCOs receive an incentive payment of up to 2% of premiums when benchmark percentiles are met for various HEDIS measures (75% and 90%), and a penalty if less than 50%.

Further, PA has adopted a maternity care bundle payment that includes a gainshare program with their MCOs that is voluntary for providers to participate in.
MCOs must contract with the OBs that elect to join the gainshare program. A target price for maternity care is set prospectively. Then, providers are paid on a fee-for-service basis and a retrospective review is conducted to compare FFS payments to the target price. If payments are less than the target price, the difference is added to a shared shavings pool for payout to the OB team.[27]</td></tr>
<tr><td>WA</td><td>Yes, in “Pregnancy Related Services Billing Guide”

Requires code for positive vs negative</td><td>No</td><td>Yes</td><td>$2.85

(of note this rate was increased in 2025 to $11.25)</td><td>No</td><td>No</td></tr>
<tr><td>WI</td><td>Yes, in the Medicaid provider handbook</td><td>No</td><td>Yes</td><td>$35.35</td><td>No</td><td>Yes</td></tr>
</table>

Following are the detailed findings for each state.

California

Are MMH screening billing codes provided? If so, where are they found? Yes. California provides billing codes for MMH screening in their **Medicaid provider training document.**[28] There is no reference to MMH billing and reimbursement in CA’s MCO contract. The provider training document states:

“Providers of prenatal care and postpartum care may submit claims twice a year per pregnant or postpartum individual: once when the individual is pregnant and once when they are postpartum. The combined total claims for screening pregnant or postpartum recipients using HCPCS codes G8431 and/or G8510…Providers must include a pregnancy or postpartum diagnosis code on all claims…Modifier HD is used with G8431 and G8510 when billing for either a positive or negative depression screening...”[29]

Is there a limit on MMH screenings? Yes, providers can submit claims twice a year per pregnant or postpartum individual: once when pregnant and once when they are postpartum.

Is an evidence-based MMH screening tool required? It is not mentioned. (However, there is a state law that requires screening with a validated screening tool.)

Is there a higher reimbursement rate for positive screens to reimburse the provider for creating a follow-up plan? Yes. Documentation of a positive screen and a follow-up plan is reimbursed at $37.25. Documentation of a negative screen (with no needed follow-up plan) is $17.14.[30]

Is there guidance to bill for follow-up? Not mentioned.

North Carolina

Are MMH screening billing codes provided? If so, where are they found? Yes. North Carolina provides billing codes for MMH screening in **NC Medicaid Policy IE-5**.[31] The NC MCO contract provides a reference to NC Medicaid Policy IE-5. The policy states:

" 3.6.1 …Obstetric, family practice, and pediatric providers may be reimbursed for three brief emotional/behavioral assessments, with scoring and documentation, per standardized instrument – during the first year after the delivery date or until the beneficiary eligibility ends, in addition to global obstetrics and postpartum package services. If a problem is identified, the female beneficiary shall be referred to their primary care provider or other appropriate providers. …Note: Refer to Attachment B (C) Postpartum Services for guidance related to postpartum depression screening."

"C. Billing Postpartum Services… Providers performing postpartum depression screening are required to bill diagnosis Z13.32 (encounter for screening for maternal depression) in combination with one of the CPT codes below… CPT Code 96127: Brief emotional/behavioral assessment [e.g., depression inventory, attention-deficit hyperactivity disorder (ADHD) scale], with scoring and documentation, per standardized instrument."

Is there a limit on MMH screenings? Yes. Providers (not limited to Obstetric providers) can bill for up to four MMH screenings postpartum.

Is an evidence-based MMH screening tool required? Yes, providers are required to use a "standardized instrument," but the instruments are not indicated.

Coding and Reimbursement Providers can bill code 96127 and be reimbursed $4.49 per screen.

Is there a higher reimbursement rate for positive screens (to reimburse the provider for creating a follow-up plan)? Not mentioned.

Is there guidance to bill for follow-up? Not mentioned.

Pennsylvania

The questions we were seeking to answer relative to screening and reimbursement codes/rates requirements were not applicable in Pennsylvania (PA). PA requires MCOs to reimburse OBs for the completion of a comprehensive prenatal needs assessment form (ONAF) which includes among other things, screening for maternal depression and a quality improvement program. Contract provisions include:

> *"Commencing on January 1, 2023, reimbursement for submission of the initial ONAF form was made through the 2023 Maternity Quality Enhancement Program (MQEP) year, and subsequently the entire ONAF series for the 2024 program year. This component will be paid out at the current contracted rate to providers during the 4th and final settlement of the program year and will be associated with the EOB code 'ONAF'."*
>
> *"Quality Measures: The PH-MCO shall use the following quality measures to determine its incentive payments: a. Social Determinants of Health Screening: Complete at least one (1) Social Determinants of Health screening using a Nationally recognized tool, during the episode duration with submission of G9919 (positive screening result) or G9920 (negative screening result) Procedure Codes. Claims must include appropriate ICD-10 Z-codes when relevant those determinant areas as defined by Social Determinants of Health. The PH-MCO may use associated Logical Observations Identifier Names (LOINC) codes instead of the G and Z-codes. b. Timeliness of Prenatal Care c. Postpartum Care* ***d. Prenatal Depression Screening Follow Up. e. Postpartum Depression Screening Follow Up*** *f. Prenatal Immunization Status – Combination."*

Quality Measure scoring is based on the following (PH-MCO refers to "Physical Health-MCO" as PA is a carve-out state for behavioral health care):

> "*8. Scoring of Quality Measures: Point totals for each quality measures are listed below. Virtual or telehealth visits should count for calculation of quality scores.*
> *"Prenatal Depression Screening Follow Up i. 1 point for reaching or exceeding the goal of 77.27% e. Postpartum Depression Screening Follow Up i. 1 point for reaching or exceeding the goal of 86.94%"*
>
> *"Quality measures for MY2024/RY2025 that will be reported to DHS by PH-MCOs: This is the list of quality measures that PH-MCOs will report to the Department at the aggregate level for their Maternity Care Bundle population and non-Maternity Care Bundle population. The PH-MCO must track these quality measures for the Maternity Care Bundle population at the Practice level and report to the Department, as requested….*
>
> *c. Prenatal Depression Screening Follow Up- The PH-MCO needs to provide the percentage of deliveries in which members were screened for clinical depression while pregnant and, if screened positive, received follow-up care for their Maternity Care Bundle population and non-Maternity Care Bundle population.*
>
> *d. Postpartum Depression Screening Follow Up- The PH-MCO needs to provide the percentage of deliveries in which members were screened for clinical depression during the postpartum period, and if screened positive, received follow-up care for their Maternity Care Bundle population and nonMaternity Care Bundle population."*

Washington

Are MMH screening billing codes provided? If so, where are they found? Yes. Washington provides billing codes for MMH screening in the October 1, 2024 to December 31, 2024 — Pregnancy-related services billing guide. The guide states:

"HCA covers screening for depression and anxiety during pregnancy and the postpartum period. Providers must screen pregnant and postpartum clients for depression and anxiety using a standardized, validated screening tool. Screening results are not equivalent to a diagnosis. Screening for perinatal depression and anxiety must occur at the initial prenatal/OB visit, at least once during the 2nd or 3rd trimester, and once in the postpartum period per American College of Obstetrics and Gynecology (ACOG) recommendation.

Is there a limit on MMH screenings? Yes, limited to frequency recommended by ACOG, however if more frequent screening is needed, providers may submit a limitation extension request to HCA.

Is an evidence-based MMH screening tool required? Yes. The guide notes "Providers must screen pregnant and postpartum clients for depression and anxiety using a standardized, validated screening tool."

Coding and Reimbursement Provider bill codes 96127 or 96160 with modifiers U1 for a negative screen and U2 for a positive screen. Reimbursement was $2.85 in 2024. Specifically the guide states:

When billing HCA for perinatal depression and anxiety screening, use CPT® code 96127 or 96160. If the provider conducts a depression screening and anxiety screening on the same date of service using two different screening tools, the provider may bill separately for each screening using the appropriate CPT® code. Submit the claim for the screening with the date the screening occurred. Perinatal mental health screening may be billed in addition to bundled or unbundled obstetric codes. If more frequent screening is needed, providers may submit a limitation extension (LE) request to HCA."

Modifier U1 negative screen, Screening score within a normal range

Modifier U2 positive screen, Indicates risk, concern, impairment, or identification of a developmental and/or behavioral disorder.

"When billing for clients age 20 and younger, see HCA's Early and Periodic Screening, Diagnosis, and Treatment Well-Child Program Billing Guide."

Is there a higher reimbursement rate for positive screens to reimburse the provider for creating a follow-up plan? Not mentioned.

Is there guidance to bill for follow-up? Not mentioned.

Additional Relevant Content

"Providers are responsible for having adequate training to administer and interpret screening tools, including determining screening outcome. - Providers may use the Perinatal Psychiatric Consultation Line (PPCL) for recommendations and referrals related to perinatal mental and

behavioral health. Providers may refer the client to Perinatal Support Washington Warmline for telephone support, professional referrals, and information about other resources."

What if a problem is identified as the result of a screening? When a screening indicates a possible problem, the screening provider must ensure the client receives necessary services, including referring the client to an appropriate provider for an assessment where a diagnosis and plan of care are developed. Health care professionals may provide services for clients when services are within their scope of practice. To be reimbursed, providers must indicate the screening outcome by including one of the modifiers listed below. Providers must document in the client's record the name of the screening tool, the score, and what referrals were made."

Wisconsin

Are MMH screening billing codes provided? If so, where are they found? Yes. Wisconsin provides billing codes for MMH screening and follow-up counseling in their **Medicaid provider handbook** but only for care provided by obstetric providers during pregnancy, and not in the postpartum.[32] The Wisconsin MCO contract[33] provides a reference to the section of the provider handbook where MMH screening details and billing codes can be found. The contract states:

"Wisconsin Medicaid and BadgerCare Plus covers a separate mental health and substance abuse screening benefit for all pregnant members (see ForwardHealth online handbook Topic #4442). The purpose of this benefit is to identify and assist pregnant members at risk for mental health or substance abuse problems during pregnancy. The benefit has two components: a. Screening for mental health (e.g., depression and/or trauma) and/or substance abuse problems. b. Brief preventive mental health counseling and/or substance abuse intervention for pregnant members identified as being at risk for experiencing mental health or substance abuse disorders."

The provider handbook provides the following codes:

- *H0002: Mental Health and Substance Abuse Screening*
- *H0004: Preventive Mental Health Counseling and Substance Abuse Intervention*

Is there a limit on MMH screenings? No. The screening code (H0002) can be billed during pregnancy and up to 60 days postpartum, and the number of screenings is not limited. CPT code Z369.9 (antenatal screening unspecified) must be used. For the mental health counseling code (H0004), there is a limit of 16 units per member, and only four units are allowed per date of service.

***Is an evidence-based MMH screening tool required*?** Yes, providers are required to use an evidence-based screening tool, with several examples included in the provider handbook.

Coding and Reimbursement: Medicaid reimburses $35.35 per screening using code H0002 with modifier HE (mental health) or HF (substance use).

Is there a higher reimbursement rate for positive screens to reimburse the provider for creating a follow-up plan? Not mentioned.

Is there guidance to bill for follow-up? Yes, Medicaid reimburses OBs for follow-up mental health counseling using code H0004. This code reimburses $16.41 per unit (15 minutes per unit) and is limited to four units (1 hour) for each visit, and 16 units (four hours) per pregnancy.

Section 3. Medicaid HEDIS Prenatal and Postpartum Screening and Follow-up Rates by State

Our team analyzed the HEDIS MMH screening rates received by the National Committee for Quality Assurance's 2023 Quality Compass dataset. Among the states with enough data being reported, we identified four states as "top-performing:" PA, CA, WI, and WA.

Table 4. HEDIS Top 4 Performing States Among Medicaid Enrollees for Screening[1]

State	PND-E Medicaid Prenatal Depression Screening Rate	PDS-E Medicaid Postpartum Depression Screening Rate
Pennsylvania	28.7	26.9
California	19.1	14.7
Wisconsin	13.4	11.1
Washington	2.2	0.3

Although these rates were not limited to screening by OB providers, it is likely that state Medicaid agencies with high rates, particularly for the prenatal measure (PND-E), have taken some action to address screening among OBs with their MCOs. In fact, our research in Section

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two of this report found that one state includes these measures in their MCO contracts (WA), two states include these measures in their annual External Quality Review (EQR)[34] reports (CA, PA), and one state includes this in its State Medicaid Quality Strategy (WI).[35]

Discussion

We found that of the states we analyzed that took one of these three actions (requiring screening in contracts, reimbursement for MMH screening and follow-up, and/or addressing reporting of HEDIS measures), two states didn't address *OB/prenatal screening*: NC only addresses reimbursement for postpartum depression, and NH requires HEDIS measure reporting for postpartum depression, not prenatal depression. This is unfortunate, given the ACOG clinical practice guidelines and prior screening recommendations address the importance of screening starting in pregnancy.

Further, our analysis illustrated that most state Medicaid agencies are not leveraging opportunities to address OB screening, billing, and reimbursement for MMH services, with only 9 states taking action contractually in MCO contracts: AZ, CA, IN, MI, NV, OR, PA, VA, and WA. Specifically, we found:

1) *Four states (AZ, CA, OR, VA) require obstetric prenatal or postpartum maternal mental health screening within MCO contracts.*

2) *Our case studies focused on five states that are taking steps to reimburse OBs for MMH screening separate from a maternity care bundle rate: CA, NC, PA, WA, and WI.*

   Our reimbursement case study focused on five states that are taking steps to reimburse OBs for MMH screening separate from a maternity care bundle rate: CA, NC, PA WA, and WI. While NC and WA provide a low reimbursement rate, not likely to incentivize OBs to screen, CA and WI reimburse screening at a rate of over $30. CA reimburses positive screens at over $30 (to compensate OBs for the creation of a treatment and follow-up plan)[30], and PA addresses compensation and reporting of screening by requiring MCO and OB reporting of an "Obstetric Needs Assessment Form" (ONAF) and associated quality improvement programs.

3) *Nine states require their Medicaid MCOs to report HEDIS or HEDIS-like screening and follow-up data: AZ, CA, IN, MI, NH, NM, NV, PA, WA, WI. (Note: NH only requires reporting of the postpartum depression screening and follow-up measure, not the prenatal depression screening measure).*

   Though the HEDIS MMH screening and follow-up measurement specifications are not unique to OBs, requiring MCOs to report these measures may still influence OB screening and follow-up rates. This may be particularly true regarding the prenatal MMH screening measure, given OB providers are the primary providers of prenatal care.

   Nine states require their Medicaid MCOs to report HEDIS or HEDIS-like prenatal depression screening and follow-up data: AZ, CA, IN, MI, NM, NV, PA, WA, WI. Our

analysis found that CA, PA, WA, and WI have highest Medicaid prenatal and postpartum HEDIS screening rates. Each of these states require reporting of HEDIS measures and address reimbursement to OBs for their efforts in some way.

As illustrated by the states with the best performance for Medicaid HEDIS perinatal depression screening rates, it's not enough to require screening by OBs nor reimbursement to OBs for screening through fee-for-service billing code(s). States must also *require* reporting of screening rates, through HEDIS or HEDIS-like reporting and reimburse OB providers a substantive rate for screening and follow-up care.

Limitations

This study was intended to be a preliminary review of state Medicaid agency contracts in the 40 states and DC that work with Managed Care Organization (MCOs) health plans, to glean insights into how states are addressing MMH through these Medicaid contracts.

Future studies could include a 50-state review of payment mechanisms for maternal mental health, including fee-for-service states. Further, claims data could be reviewed to determine how often OBs are submitting claims for these services.

Finally, this study found that states with high Medicaid HEDIS screening rates are associated with state requirements that MCOs report these measures. Further, we suspect, as is the case with quality improvement initiatives, that the longer a state has required reporting, the better the results. However, it is still possible that states that haven't required reporting of these measures could also have high screening rates that simply aren't being measured/reported. For example, New Jersey, a state that has required providers to screen for maternal depression for nearly two decades, reported that roughly a third of women indicate that they have been screened through the Pregnancy Risk Assessment Monitoring System (PRAMS) survey.[36] A future study could examine this by comparing states' HEDIS rates and patient self-reported screening data as reported through PRAMS.

Recommendations

State Medicaid agencies should adopt the following strategies to improve maternal mental health detection and follow-up:

1. **Require health plans/insurers to track and report HEDIS MMH performance measures** to determine the frequency and utilization of screening and follow-up care and incentivise plans/insurers to implement quality improvement plans. Doing so through the state quality programs yields the highest results. Medicaid agencies should also require that screenings align with ACOG guidelines, including, at a minimum, following ACOG recommended frequency. ACOG guidelines currently recommend that "screening for perinatal depression and anxiety occur at the initial prenatal visit, later in pregnancy, and at postpartum visits." HEDIS also requires a follow-up on a positive screen, so at least one follow-up encounter should be required.

2. **Reimburse at an adequate rate for screening and follow-up.** States with high screening rates, incentivize screening through adequate reimbursement. For example, Wisconsin reimburses screening at a rate of over $30. California reimburses negative and positive MMH screenings differently, with positive screens being reimbursed at over $30, to compensate OBs for the creation of a treatment and follow-up plan.[30]
3. **Code and reimburse for MMH screening and follow-up on a fee-for-service basis.** ACOG released CPT® FFS billing codes (96160, 96161, 96127 or 96146), for reimbursement in addition to any "bundled obstetric payment."[16] Billing codes can also include, for example, behavioral health integration (BHI) codes (such as 99484) and collaborative care codes (CoCM) (such as 99492, 99493, and 99494), which align with broader trends to support integrated mental health care. Further, screening billing and coding should differentiate positive and negative screens so claims data can be utilized for HEDIS measurement and reporting.

Closing

Maternal mental health is a critical issue that has a significant and direct impact on maternal and infant health outcomes, as well as the high maternal morbidity and mortality rates in the United States. State Medicaid agencies (SMAs) and their managed care organization (MCO) health plans play a powerful role in the implementation of screening practices among OB providers, a first step to intervention, diagnosis, and treatment. This analysis shines a light on the actions SMAs and MCOs can take to influence the successful implementation of the screening and treatment clinical practice guidelines developed by the American College of Obstetricians and Gynecologists (ACOG). By doing so, SMAs can make a significant impact in improving the well-being of their enrolled pregnant and postpartum women and families.

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Contributors:

Conceptualization, Lead Investigation: Joy Burkhard, MBA, Caitlin Murphy, MPP, DrPH(c)

Initial Investigation: Madison Scott, JD

Supervision: Joy Burkhard, MBA

Original Draft Writing: Caitlin Murphy, MPP, DrPH(c)

Copy Editors: Cindy Herrick, MA, PMH-C, CPSS and Kate Rope