SENATE COMMITTEE ON HEALTH
Senator Dr. Richard Pan, Chair

BILL NO: AB 798
AUTHOR: Cervantes
VERSION: April 9, 2019
HEARING DATE: June 12, 2019
CONSULTANT: Melanie Moreno

SUBJECT: Maternal mental health

SUMMARY: Creates a pilot program, to be privately funded, in counties that elect to participate, including the County of Riverside, to increase the capacity of health care providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions.

Existing law:
1) Requires Department of Public Health (DPH) to maintain a program of maternal and child health, referred to as the Maternal, Child and Adolescent Health Division (MCAH). Permits MCAH to include the provision of educational, preventative, diagnostic and treatment services, including medical care, hospitalization and other institutional care and aftercare, appliances and facilitating services directed toward reducing infant mortality and improving the health of mothers and children. Permits DPH to make grants or contracts or advance funds from any funds that are made available for the purposes of the Maternal and Child Health Program Act. [HSC §123225, 123235]

2) Requires DPH to investigate and apply for federal funding opportunities to support maternal mental health (MMH), as specified. Requires DPH to notify the Legislature of its efforts to secure and utilize federal funds it receives. [HSC § 123611]

This bill:
1) Creates a pilot program in counties that elect to participate, including the County of Riverside, to increase the capacity of health care providers that serve pregnant and postpartum women up to one year after delivery to effectively prevent, identify, and manage postpartum depression and other mental health conditions.

2) Permits the pilot program to be coordinated by DPH and requires it to be privately funded. Permits the pilot program to include a provider-to-provider or patient-to-provider consultation program, to utilize telehealth or e-consult technologies, and to include the following elements:

   a) Training and toolkits on screening, assessment, and the range of treatment options;
   b) Coordination of care to link women with individual services in their communities; and,
   c) Access to perinatal psychiatric consultations.

3) Requires the California Health and Human Services Agency (CHHS), in consultation with state entities, as necessary, and within six months after the results of the pilot program are reported, to submit a report to the Legislature, as specified. Requires the report to:

   a) Document the impact of the pilot program on increasing the number of women who were screened, assessed, and treated for maternal mental health disorders;

b) Identify methods to expand the pilot program to additional counties or statewide; and,
c) Identify funding opportunities to support the expansion of the pilot program, including federal funding, state funding, and surcharges.

4) Sunsets this bill on January 1, 2025.

FISCAL EFFECT: According to the Appropriations Committee, costs to DPH to conduct a pilot of at least $500,000 to develop a toolkit for use in counties that elect to use it. Other approaches would be more costly and would scale to available resources. This bill indicates the pilot shall be funded by private funds, but in absence of committed private funding there would be General Fund cost pressure to fund a pilot established in state law.

COMMENTS:

1) *Author's statement.* According to the author, about one in five (21.5%) women in California experience depressive symptoms during or after pregnancy. The highest prevalence of these symptoms were found among African American and Latina women; women of lower educational attainment; women utilizing Medi-Cal; and women in poverty. These disorders are widespread in communities of low socioeconomic status. Among those living in poverty, 50% are impacted by maternal mental health (MMH) disorders. It is vital that we improve access to treatment for maternal mental health. This bill will create a pilot program that will accommodate a provider-to-provider psychiatry teleconsultation and provider training programs in Riverside County, among other counties. This will help build the capacity of mental health care providers serving pregnant and postpartum women, and assist in addressing the lack of access to psychiatry and other perinatal services

2) *Background.* According to an April 2017 report by the California Task Force on the Status of MMH Care (CTF report), up to one in five of new or expectant mothers will experience a mental health disorder during pregnancy or the first year following childbirth, including depression, anxiety, and postpartum psychosis, which is less prevalent but the most severe. Depression affects more than 16 million adults each year, and maternal depression is the most common complication of pregnancy in the U.S. All women are at risk of maternal stress and MMH disorders, and the prevalence can soar up to 50% among those living in poverty, compared to 15% to 20% among the general population.

3) *Impacts of MMH in California.* According to the CTF report, untreated MMH disorders significantly and negatively impact the short- and long-term health and well-being of affected mothers and their children, which can lead to adverse birth outcomes, impaired maternal-infant bonding, poor infant growth, childhood emotional and behavioral problems, and significant medical and economic costs. Even when MMH disorders are detected, treatment occurs in less than 15% of identified cases. MMH disorders encompass a range of mental health conditions, and can occur for the first time during the perinatal period or even exist before conception and continuing, or worsening, during the perinatal period. Women who have had prior episodes of depression or anxiety are especially vulnerable at any time during the perinatal period. The CTF report cites Maternal and Infant Health Assessment data that shows the highest prevalence of depressive symptoms during and after pregnancy was found among Black and Hispanic women, women of lower educational attainment, women who are Medi-Cal beneficiaries, and women in poverty. The large proportion of California's birthing population (44%) with income levels at or below the federal poverty guideline (FPG) experience the highest prevalence of maternal depressive symptoms (28.4%) while symptoms decrease significantly (11.8%) among those with income exceeding 300% of FPG.

Maternal depression contributes to the $210.5 billion economic burden the U.S. faces each year for major depressive disorders through absenteeism at work, lost productivity, direct treatment costs, and expenditures related to suicide. The CTF report states the annual cost of not treating a mother with depression is $7,200 in lost income and productivity, with an additional $15,300 attributed to the child. MMH disorders cost California an estimated $2.25 billion each year.

4) *Screening recommendations.* In November 2018, the American College of Obstetricians and Gynecologists (ACOG) issued a guidance (referred to as Opinion Number 757) recommending that obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms. It is recommended that all obstetric care providers complete a full assessment of mood and emotional well-being during the comprehensive postpartum visit for each patient in addition to any screening during pregnancy. ACOG states that there is evidence that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care providers offers maximum benefit. January 2016 U.S. Preventive Services Task Force recommendations call for depression screening for all adults, including pregnant and postpartum women, along with adequate systems to ensure accurate diagnosis, effective treatment, and appropriate follow-up. The American Academy of Pediatrics Bright Futures and Mental Health Task Force states that primary care pediatricians have a unique opportunity to identify maternal depression, and screening can be integrated into the well-child care schedule and included in the prenatal visit. The Bright Future Periodicity table suggests screening should occur by one month, and at two months, four months, and six months postpartum.

5) *21st Century Cures Act (Cures Act).* On December 13, 2016, President Obama signed the Cures Act, which included several mental health provisions, including measures to require parity between insurance coverage for mental and physical health, programs to support early intervention for psychosis, and funds to address the opioid epidemic. The Cures Act also adopted language from the Bringing Postpartum Depression Out of the Shadows Act of 2015, which provides $5 million each fiscal year from 2018 to 2022 to a minimum of three states in the form of grants that support identification and treatment of maternal depression and other MMH disorders. Funds are to be used by states for training and information to health care providers, including obstetrician-gynecologists, pediatricians, psychiatrists, other mental health care providers, and adult primary care clinicians in screening, treatment, follow-up, and community referrals for maternal depression, and may include psychiatric consultations, the use of telehealth technologies, and the formation of linkages of community resources. Congress made the appropriation for these purposes in 2018. DPH applied for this funding, titled Screening and Treatment for Maternal Depression and Related Behavioral Disorders Program, on August 6, 2018, but was not awarded a grant.

6) *Related legislation.* AB 577 (Eggman) extends the duration of the requirement that health plans and health insurers provide continuity of care for pregnant women to up to 12 months from the contract termination date or 12 months from the effective date of coverage, if the woman presents documentation of being diagnosed with a MMH condition. Extends the duration of full scope Medi-Cal coverage for postpartum care for up to one year beginning on the last day of the pregnancy for all women below 138% of the federal poverty level. Requires the Department of Health Care Services, after the 60-day postpartum period of Medi-Cal coverage and coverage through the Medi-Cal Access Program, to provide transition assistance to the individual in applying for and purchasing coverage through

Covered California if the individual is eligible for that coverage. *AB 577 is pending hearing in this Committee.*

7) *Prior legislation.* AB 1893 (Maienschein, Chapter 140, Statutes of 2018) requires DPH to investigate and apply for federal funding opportunities to support MMH, as specified. Requires DPH to notify the Legislature of its efforts to secure and utilize federal funds it receives.

   AB 2193 (Maienschein, Chapter 755, Statutes of 2018) requires health plans and insurers to develop a MMH program to address mental and behavioral issues. Requires health care practitioners who provide prenatal or postpartum care to ensure the mother is offered screening or is appropriately screened for MMH conditions.

   AB 3032 (Frazier, Chapter 773, Statutes of 2018) requires hospitals that have a perinatal unit to develop and implement a program to provide education and information to appropriate health care professionals and patients about MMH conditions.

   AB 244 (Cervantes of 2017) was substantially similar to this bill. *AB 244 was not heard in the Assembly Health Committee.*

8) *Support*. ACOG – District IX writes that to improve clinical outcomes, physicians need to be sure that when a patient is screened positive for mental health issues, they will have the resources available to them to respond and manage the condition. This bill will help address this need by equipping interested counties, including Riverside County, with the means necessary to build capacity for health care providers serving these women.

9) *Policy comments.* Under this bill, the pilot program and DPH's coordination of it is permissive. If DPH does not elect to coordinate the pilot program, what entity will administer the pilot? Who will develop the parameters for the pilots and ensure those are followed? The author may wish to amend this bill to require DPH, working with an entity like the California Taskforce on the Status of Maternal Mental Health, to administer the program.

   This bill also requires CHHS to submit a report to the Legislature about the impact of the pilot, but it doesn't require counties that elect to participate or DPH to share any information with CHHS for these purposes. This bill should be amended to either require pilot counties to provide that information or to require DPH to coordinate the program and submit the report to the Legislature.

SUPPORT AND OPPOSITION:

Support: American College of Obstetricians & Gynecologists - District IX

Oppose: None received

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