

Association of Medicaid Status with Patient Mental Health Diagnosis: Data from the WA State Perinatal
Psychiatry Consultation Line

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Abstract

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Background: Despite Medicaid’s critical role in covering perinatal and behavioral health care costs, many enrollees face barriers to timely mental health diagnosis and treatment. Understanding how insurance shapes access to mental health services and how this intersects with race and ethnicity is critical in addressing inequities in perinatal mental health care. The relationship between Medicaid insurance status and mental health diagnosis during the perinatal period, as well as the role of race and ethnicity in this relationship, is understudied.

Methods: The study sample included 1,494 patients aged 18 to 40 (764 Medicaid enrollees and 730 non-Medicaid) identified from the Perinatal Psychiatry Consultation Line 2021-2024. Diagnosis of caller reported perinatal mental health diagnosis was categorized into three mutually exclusive groups: (1) depression and/or anxiety only, (2) bipolar disorder, substance use, PTSD, ADHD, or medical conditions only, and (3) any combination of bipolar substance use, PTSD, ADHD, or medical conditions diagnosis

with depression and/or anxiety. Multinomial logistic regression models were used to calculate unadjusted and adjusted odds ratios relating insurance type (Medicaid insurance status as the exposure) to caller-reported perinatal mental health diagnosis. We repeated these analyses among Black or African American patients as well as non-Hispanic White patients to assess effect modification by race/ethnicity.

Results: Among patients, 491 (32.9%) had depression and/or anxiety only diagnosis; 496 (33.2%) had bipolar disorder, substance use, PTSD, ADHD, or medical conditions only diagnosis; and, 507 (33.9%) had bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety. In adjusted multinomial logistic regression models, using the depression and/or anxiety only diagnosis category as the reference group, Medicaid-enrolled patients had significantly higher odds of having a caller-reported perinatal mental health diagnosis of bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 2.47, 95% CI: 1.85, 3.29), as well as bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 1.93, 95% CI: 1.46, 2.54). Among Black or African American patients, Medicaid-enrolled patients had higher odds of having a caller-reported diagnosis of bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 2.27; 95% CI: 0.79, 6.57) and bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 1.43; 95% CI: 0.51, 4.06), compared to depression and/or anxiety only. However, these estimates were not statistically significant. Among non-Hispanic White patients, patients with Medicaid also had higher odds of having a caller-reported diagnosis of bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 3.48; 95% CI: 0.75, 16.23) and bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 2.22; 95% CI: 0.49, 10.00), compared to depression and/or anxiety only. However, these estimates were also not statistically significant.

Conclusion: Perinatal individuals who have Medicaid insurance have higher odds of having a caller-reported perinatal mental health diagnosis of bipolar, substance use, PTSD, ADHD, or medical conditions

only, or in combination with depression and/or anxiety, compared with depression and/or anxiety only diagnosis. Whether the association between insurance type and mental health diagnosis differs by race/ethnicity is not clear. Findings suggest the importance of increasing support and tailored mental health services for Medicaid-insured perinatal patients, who may be at higher risk for complex or co-occurring mental health conditions

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Introduction

The perinatal period is a time of heightened vulnerability to maternal mental health challenges¹. In the U.S., approximately 1 in 5 birthing people experience a perinatal mental health condition, defined as experiencing mental health challenges such as depression, anxiety, bipolar disorder, or psychosis from conception to one year postpartum². Left undiagnosed or untreated, perinatal mental health conditions can lead to an increased risk of adverse outcomes such as suicide, a leading cause of maternal mortality¹. According to the Centers for Disease Control, mental health conditions in the perinatal period account for roughly 23% of all pregnancy-related deaths².

Despite the prevalence of these conditions, access to support and treatment remains uneven for perinatal patients based on their insurance type, particularly for perinatal individuals enrolled in Medicaid³. Medicaid is the largest payer of behavioral health and substance use treatment services in the U.S. and covers the cost of approximately 50% of all births^{3,4}. Yet, many enrollees encounter significant barriers to accessing mental health care, including limited provider availability, coverage gaps, administrative hurdles, and delayed care initiation due to enrollment processes that are not automatic in many states, including Washington³. These disruptions can prevent timely access to mental health services during the perinatal period. For minoritized populations, groups that have been socially, economically, or politically marginalized due to structural inequities, these barriers are compounded. Black perinatal individuals, in particular, encounter significant challenges across the care continuum, shaped not only by limited access but also by systemic biases, such as race-based assumptions in clinical decision-making. Gaps or delays in perinatal mental health treatment can lead to worsening mental health outcomes and increased risk of severe complications, including suicide and substance use disorders⁵.

Understanding how insurance shapes access to mental health services and how this intersects with race and ethnicity is critical in addressing inequities in perinatal mental health care. However, the relationship between Medicaid insurance status and mental health diagnosis during the perinatal period is understudied. Existing literature focuses on non-perinatal individuals, specific mental health diagnoses

like depression⁶, changes in coverage across the perinatal period⁷, or the impacts of specific types of insurance⁸.

To our knowledge, no study has specifically examined the relationship between Medicaid enrollment and mental health diagnosis among perinatal patients, nor how this relationship may vary by race or ethnicity. This study aimed to address this gap. We hypothesized that perinatal individuals with mental health diagnoses and Medicaid insurance will be more likely to have caller-reported bipolar disorder, substance use, PTSD, ADHD, or medical conditions with or without depression and/or anxiety diagnosis. This pattern may reflect more complex mental health presentations among patients with Medicaid insurance compared to those with non-Medicaid insurance. Additionally, we hypothesized that these differences in mental health diagnosis among patients with Medicaid insurance status will be more pronounced among Black perinatal individuals than among non-Hispanic White perinatal individuals. This may be due to systemic inequities in mental health care access, provider bias, and the disproportionate burden of structural stressors affecting Black perinatal individuals. Understanding these patterns can help inform strategies to reduce disparities in mental health care access and outcomes, particularly for minoritized perinatal populations.

Methods

Study Design and Study Setting

Our study used a cross-sectional design. The analysis aimed to determine the relationship between insurance type and caller-reported mental health diagnosis among perinatal patients, as well as the role of race/ethnicity in the relationships. This study used data collected through the Perinatal Psychiatry Consultation Line (Perinatal PCL) in Washington State. Operated by the University of Washington's Department of Psychiatry and Behavioral Sciences, the Perinatal PCL is a statewide teleconsultation line providing recommendations, referrals, and guidance to Washington state healthcare providers who care for pregnant and postpartum individuals⁹. Most calls originate from providers within Washington State; however, providers from other states occasionally call in to the Perinatal PCL.

Study Population

The study participants consisted of perinatal individuals whose healthcare providers sought consultation through the Perinatal PCL. Eligible participants were individuals who contacted the Perinatal PCL, indicated that they were planning a pregnancy, currently pregnant, or postpartum, and whose cases were discussed during an initial provider consultation call. To be included, participants also needed to have provider-reported patient diagnosis and insurance information documented. Participants were excluded if they were under 18 years of age or if diagnosis or insurance data were missing, incomplete, or declined. **Figure 1** details the study inclusion process. After applying these criteria, the final study sample included 1,494 participants. The University of Washington Institutional Review Board (IRB) determined that the use of Perinatal PCL data for research does not meet the federal definition of "human subjects" research and, therefore, does not require exempt status or IRB review. All data were securely stored and analyzed in accordance with institutional policies and ethical guidelines to protect patient confidentiality.

Data Collection

The data used for this study were obtained from the Perinatal PCL database, specifically consultation calls made between July 2021 and October 2024. During each call, a navigator completed a brief intake form that collected demographic information about patient age, insurance type, and race/ethnicity from the calling provider [see Supplemental Material]. Perinatal PCL psychiatrists then added information on pregnancy stage, diagnosis, and medications based on the provider's report. These data were then recorded in the Perinatal PCL database. Key data items for this study include insurance type, patient diagnosis, patient race and ethnicity, age, provider type, and pregnancy stage, all as reported by the calling providers.

Exposures, Outcome, and Covariates

Our primary exposure variable was perinatal patients' insurance status (Medicaid vs non-Medicaid), categorized based on the insurance coverage reported by the calling provider at the time of consultation. The outcome variable was the provider-reported patient diagnosis during the initial consultation call. Patient diagnosis was categorized into 3 exclusive groups: (1) diagnoses of depression or anxiety only, (2) bipolar disorder, substance use, PTSD, ADHD, or medical conditions only (e.g., chronic pain, fibromyalgia, or insomnia), (3) any combination of a bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety. Importantly, patients who had a diagnosis of bipolar disorder with depression were categorized in Group 2, as depression is a diagnostic feature of bipolar disorder rather than a comorbid condition in this context¹⁰.

This analysis adjusted for *a priori* identified potential confounders based on existing literature review examining the association between insurance type and diagnosis: age, pregnancy stage, provider type, and race/ethnicity. We used the Perinatal PCL categories for age: 18-25, 26-30, 31-35, 36-40, and >40. We also used the Perinatal PCL categories for the pregnancy stage: planning, pregnant, or postpartum, excluding those not identified as perinatal patients. Provider type was categorized as mental health specialty (e.g., psychiatrists, therapists, psychiatric nurses) or non-mental health specialty (e.g.,

obstetricians, primary care physicians, doulas) provider. We used the Perinatal PCL categories of race/ethnicity: American Indian or Alaska Native, Asian, Black or African American, Hispanic or Latino, Middle Eastern, Native Hawaiian or Other Pacific Island, White, non-Hispanic.

Statistical Analysis

After cleaning the data, we conducted descriptive analyses by summarizing the distribution of variables. This included calculating frequencies for our categorical variables: insurance type, patient race/ethnicity, substance use, pregnancy stage, and caller-reported mental health diagnoses by outcome category. To visually illustrate the distribution of caller-reported diagnoses by insurance type, we created a bar chart stratified by insurance. We used multinomial logistic regression models to estimate unadjusted and adjusted odds ratios (aORs), comparing the relative odds of being categorized into one of two diagnosis groups—(1) bipolar disorder, substance use, PTSD, ADHD, or medical conditions only, or (2) any combination of a bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety—relative to the reference group (depression and/or anxiety only).

The models were adjusted for a priori identified confounding variables: age, pregnancy stage, provider type, and race/ethnicity. To evaluate the potential for effect modification by race/ethnicity, we fitted the models described above among Black and non-Hispanic White participants in stratified analysis. In addition, we tested for the statistical significance of effect modification by including an interaction term between insurance type and race/ethnicity in our adjusted logistic regression model among all participants.

Results were presented as odds ratios (ORs), adjusted odds ratios (aORs), and corresponding 95% confidence intervals (CIs). Statistical significance was determined based on whether the 95% confidence intervals excluded the null value (OR = 1). Data were analyzed using R (version 4.3.1).

Results

Study participant characteristics, overall and across diagnosis groups, are shown in **Table 1**. Among patients, 491 (32.9%) had a depression and/or anxiety only diagnosis; 496 (33.2%) had a bipolar disorder, substance use, PTSD, ADHD, or medical conditions only diagnosis; and 507 (33.9%) had any combination of a bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety. Most patients (about 83%) were below 36 years old. Patients who were 18–25 years old constituted a lower percentage of patients with depression and/or anxiety only diagnosis while patients aged 31–35 years old constituted a higher percentage of patients with depression and/or anxiety only diagnosis. Percentages of the other age groups were largely similar across the diagnostic groups we considered—bipolar disorder, substance use, PTSD, ADHD, or medical conditions only, and bipolar disorder, substance use, PTSD, ADHD, or medical conditions with depression and/or anxiety. White, non-Hispanic patients represented the largest proportion of the sample at 55.1%, while Black or African American patients accounted for 7.7%. The proportion of individuals identifying as Black or African American was slightly lower in the bipolar disorder, substance use, PTSD, ADHD, or medical conditions with depression and/or anxiety group (6.3%) compared to the depression and/or anxiety only group (7.9%) and bipolar disorder, substance use, PTSD, ADHD, or medical conditions only group (8.9%). Among diagnosis groups, the highest proportion of mental health specialist involvement was in the bipolar disorder, substance use, PTSD, ADHD, or medical conditions only group (57.3%), compared to 33.6% in the depression and/or anxiety only group. Most patients (51.6%) were pregnant at the time of consultation. The percentages of patients who were pregnant or postpartum were lower and higher, respectively, among the depression and/or anxiety only group, compared with similar percentages in the other diagnosis groups.

The prevalence of patients with Medicaid insurance was 55.7% overall. Overall, the majority of participants with the diagnosis of bipolar disorder, substance use, PTSD, ADHD, or medical conditions only, as well as participants with bipolar disorder, substance use, PTSD, ADHD, or medical conditions with depression and/or anxiety diagnosis had Medicaid insurance (59.3% and at 53.3%, respectively). On

the other hand, the majority of participants with depression and/or anxiety only diagnosis had non-Medicaid insurance (59.3%). These patterns are further illustrated in **Figure 2**, which shows the distribution of diagnosis categories stratified by insurance type. As depicted, a greater proportion of patients with bipolar disorder, substance use, PTSD, ADHD, or medical conditions only and bipolar disorder, substance use, PTSD, ADHD, or medical conditions with depression and/or anxiety diagnosis were enrolled in Medicaid, while a greater proportion of those with depression and/or anxiety only diagnosis were mere enrolled in non-Medicaid insurance.

In unadjusted multinomial logistic regression models (**Table 2**), using depression and/anxiety only as the reference group, Medicaid-enrolled patients had significantly higher odds of being diagnosed with bipolar, substance use, PTSD, ADHD, or medical conditions only (OR= 2.12, 95% CI: 1.64, 2.73), as well as, bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (OR=1.66, 95% CI: 1.29, 2.13). After adjusting for age, pregnancy stage, provider type, and race/ethnicity, using the depression and/or anxiety only diagnosis category as the reference group, Medicaid-enrolled patients had significantly higher odds of being diagnosed with bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 2.47, 95% CI: 1.85, 3.29), as well as, bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 1.93, 95% CI: 1.46, 2.54).

Among Black or African American patients (**Table 3**), Medicaid-enrolled patients had higher odds of having bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 2.27, 95% CI: 0.79, 6.57) and bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 1.43, 95% CI: 0.51, 4.06), compared to being diagnosed with depression and/or anxiety only. However, these estimates were not statistically significant. Among White non-Hispanic patients, patients with Medicaid also had higher odds of having bipolar, substance use, PTSD, ADHD, or medical conditions only (aOR = 3.48, 95% CI: 0.75, 16.23) and bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 2.22, 95% CI: 0.49, 10.00), compared to being diagnosed with depression and/or anxiety only. However,

these estimates were also not statistically significant. The interaction term between Medicaid insurance status and race/ethnicity was not significant ($p\text{-value} = 0.43$).

Discussion

In the current study, we found that, after adjusting for age, pregnancy stage, provider type, and race/ethnicity, perinatal patients with Medicaid insurance had higher odds of having a caller-reported diagnosis categorized as bipolar disorder, substance use, PTSD, ADHD, or medical conditions only (aOR = 2.47, 95% CI: 1.85, 3.29) and any combination of bipolar disorder, substance use, PTSD, ADHD, or medical conditions diagnosis with depression and/or anxiety (aOR = 1.93, 95% CI: 1.46, 2.54), compared to patients with non-Medicaid insurance. We did not find significant differences in the observed associations across provider-reported patient race.

To our knowledge, this study is the first to assess the association between insurance type and mental health diagnoses among perinatal patients. Previous research often categorizes mental health diagnosis groups by “severity” (no diagnosis, any diagnosis, severe diagnosis), or individual diagnoses (e.g. “Depression”) when examining an exposure outcome relationship^{11–13}. Our finding that Medicaid insurance is associated with higher odds of being categorized as having bipolar disorder, substance use, PTSD, ADHD, or medical conditions as well as combinations of these with depression and/or anxiety suggests that individuals with Medicaid insurance may lack protective factors that reduce the likelihood of complex psychiatric diagnoses during the perinatal period. This is consistent with prior research in non-perinatal populations, which found that individuals categorized as having serious mental illness (SMI) were more likely to be enrolled in Medicaid insurance compared to those with no mental illness^{11,13}. Vick et al. (2012) found that individuals with SMI had three times the odds of living in poverty¹³. Socioeconomic differences may partly explain these patterns, as individuals with low-income, likely to enroll in Medicaid, report significantly higher rates of psychological distress compared to those with higher socioeconomic status¹⁴.

While demographic disparities in perinatal mental health outcomes are well-documented,^{3,15,16} gaps persist in understanding how race and ethnicity—proxies for structural racism—affect diagnostic practices. Black perinatal individuals face significant barriers across the pathway to mental health care. Compared to non-Hispanic White counterparts, Black birthing people are less likely to be screened,

initiate treatment when a mental health condition is diagnosed, and less likely to receive medication for perinatal mood and anxiety disorders⁶⁻⁸. We did not observe statistically significant differences in diagnostic patterns by insurance type across race/ethnicity-defined groups. Rather than indicating a lack of disparity, these findings may reflect the influence of unmeasured structural factors. For example, race bias, or the tendency to assign greater diagnostic validity to certain racial or ethnic groups over others, may exacerbate inequities in mental health care¹⁷. This bias, in combination with the underdiagnosis of perinatal mental health conditions in those without a psychiatric history, disproportionately affect Black women, who have historically had limited access to care and lower rates of documented diagnoses¹⁸. Additional structural barriers, including mistrust of mental health professionals, fear of child custody loss, and cultural incongruence with the mental health system, may further hinder diagnosis and treatment. It is also possible that our study was underpowered to detect differences in the patient race-stratified models due to smaller sample sizes in these subgroups. Our study highlights the importance of investigating how broader systemic factors such as differential access to screening, referrals, culturally competent care, and perinatal psychiatric care may interact with both race/ethnicity and insurance status to influence mental health diagnoses in the perinatal period.

Study findings have important implications for perinatal mental health research, clinical practice, and policy development. Grouping diagnoses together may reveal patterns such as stigma, underdiagnosis, or inconsistent screening that could be missed when looking at diagnoses in isolation. The observed differences in diagnosis patterns by insurance type may reflect underlying structural inequities rather than the direct effect of insurance itself. For example, perinatal patients with non-Medicaid insurance may have greater access to protective factors such as continuity of care, better provider access, and comprehensive services, while Medicaid enrolled patients may experience more fragmented care or structural barriers that contribute to more complex diagnoses and lack of access to providers with perinatal psychiatry training. Clinically, these results highlight the need to examine potential disparities in screening rates across insurance types and the importance of provider training in identifying complex or comorbid mental health diagnoses, particularly in Medicaid-enrolled populations.

From a policy perspective, these findings support more standardized perinatal mental health screening protocols and culturally responsive training programs for perinatal providers.

This study offers several notable strengths. First, our use of provider-level data allows us to consider clinical decision-making and diagnostic practices within the context of perinatal mental health care, capturing dimensions that may be missed in administrative data or electronic health records. Additionally, our categorization of mental health diagnoses into mutually exclusive groups provides a more nuanced understanding of diagnostic patterns. However, this study should also be considered within the context of several limitations. Both the exposure and outcome variables are based on provider-reported data, which may introduce secondary observation bias. Additionally, there is likely variation in the calling providers' training, experience, and comfort with identifying and diagnosing mental health conditions. The Perinatal PCL team is aware of this limitation and actively advises providers during consultation calls to only report a variable when they are certain of its accuracy in an effort to minimize potential inaccuracies. We also excluded participants under 18 years of age as this group may face additional barriers to perinatal mental health care compared to other age groups. Further, patients with missing information on caller-reported mental health diagnosis or insurance type were excluded, which could introduce bias and limit the representativeness of our findings. Unmeasured confounding may also affect the observed associations, particularly social determinants of health such as educational attainment and household income. These factors may vary across insurance groups and could influence both mental health diagnoses and outcomes. Potential misclassification of outcomes could occur as patient diagnoses were manually categorized into three groups. Lastly, the generalizability of findings is limited to residents of Washington State and other states with similar demographics, health systems, and cultural norms. The percentage of Black or African American perinatal patients in the sample was approximately 3% lower than their representation in Washington State live births, while the percentage of non-Hispanic White patients was about 3 points higher¹⁹.

In summary, in the current study, Medicaid-enrolled perinatal patients had higher odds of having a caller-reported diagnosis of bipolar disorder, substance use, PTSD, ADHD, or medical conditions, either

alone or combined with depression and/or anxiety, compared to patients with non-Medicaid insurance.

Services such as Perinatal PCL can support high-quality treatment for these patients by providing timely consultation and recommendations for treatment. Additionally, our race/ethnicity findings showed that the relationship between insurance and mental health diagnoses did not significantly differ by race/ethnicity.

Future investigations into the pathways connecting insurance type and mental health diagnosis may reveal how differences in continuity of care, provider availability, and other structural inequities contribute to the disparities we observed between Medicaid and non-Medicaid insured populations. Understanding the relationship between insurance, mental health diagnoses, and race/ethnicity can inform tailored policy and clinical strategies aimed at equitable screening methods and tailored interventions to improve perinatal mental health outcomes across diverse patient groups.

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Tables and Figures

Table 1. Demographic and health characteristics among selected adults grouped by diagnosis categories from the Perinatal Psychiatry Consultation Line (2021-2024)

Characteristics	Diagnosis Categories			Overall (N = 1494)
	Depression and/or Anxiety Only (N = 491)	Bipolar Substance use, PTSD, ADHD, Medical Diagnoses Only (N = 496)	Any Combination of Bipolar Substance use, PTSD, ADHD, Medical Diagnoses + depression and/or anxiety (N = 507)	
	<i>n</i> (%) unweighted)	<i>n</i> (%) unweighted)	<i>n</i> (%) unweighted)	<i>n</i> (%) unweighted)
<i>Age Categories (years)</i>				
18-25	94 (19.1)	148 (29.8)	127 (25.0)	369 (24.7)
26-30	137 (27.9)	148 (29.8)	141 (27.8)	426 (28.5)
31-35	169 (34.4)	138 (27.8)	145 (28.6)	452 (30.3)
36-40	78 (15.9)	54 (10.9)	78 (15.4)	210 (14.1)
>40	13 (2.6)	*	16 (3.2)	37 (2.5)
<i>Provider Reported Patient Race ^a</i>				
American Indian or Alaska Native	14 (2.9)	18 (3.6)	15 (3.0)	47 (3.1)
Asian	21 (4.3)	22 (4.4)	20 (3.9)	63 (4.2)
Black or African American	39 (7.9)	44 (8.9)	32 (6.3)	115 (7.7)
Hispanic or Latino	*	*	*	12 (0.8)
Middle Eastern	*	*	*	*
Native Hawaiian or Other Pacific Island	*	*	*	11 (0.7)
White, non-Hispanic	276 (56.2)	261 (52.6)	286 (56.4)	823 (55.1)
<i>Calling Provider Type</i>				
Mental Health Specialty	165 (33.6)	284 (57.3)	262 (51.7)	711 (47.6)
Non-Mental Health Specialty	326 (66.4)	212 (42.7)	245 (48.3)	783 (52.4)
<i>Pregnancy Stage</i>				
Planning	66 (13.4)	86 (17.3)	79 (15.6)	231 (15.5)
Pregnant	211 (43.0)	291 (58.7)	269 (53.1)	771 (51.6)
Postpartum	214 (43.6)	119 (24.0)	159 (31.4)	492 (32.9)
<i>Insurance Type</i>				
Medicaid	200 (40.7)	294 (59.3)	270 (53.3)	764 (55.7)
Non-Medicaid	291 (59.3)	202 (40.7)	237 (46.7)	730 (44.3)

All variables have less than 5% missing data; unweighted percentages are presented

All characteristics are based on caller-reported data

* Values less than 10 have been suppressed to protect confidentiality

^a Patient race was reported by healthcare providers at the time of consultation and may not reflect self-identified race.

Table 2. Unadjusted and adjusted odds ratios for diagnosis category among selected adults in Medicaid and non-Medicaid groups, Perinatal Psychiatry Consultation Line, 2021–2024

Diagnosis Category	Non-Medicaid / Medicaid <i>n</i> (%)	Unadjusted ORs (95% CI)	^a Adjusted ORs (95% CI)
Depression and/or Anxiety Only (ref)	291 (39.9%) / 200 (26.2%)	1.00 (ref)	1.00 (ref)
Bipolar, Substance Use, and Medical Diagnoses Only	202 (27.7%) / 294 (38.5%)	2.12 (1.64, 2.73) *	2.47 (1.85, 3.29)*
Any Combination of Bipolar Substance use, PTSD, ADHD, Medical Diagnoses + depression and/or anxiety	237 (32.5%) / 270 (35.3%)	1.66 (1.29, 2.13) *	1.93 (1.46, 2.54)*

^a Adjusted for age, pregnancy stage, provider type, and race/ethnicity

* Indicates statistical significance.

All odds ratios (ORs) are estimated using multinomial logistic regression.

Medicaid status is the primary independent variable of interest.

Table 3. Adjusted odds ratios for diagnosis category among Medicaid and non-Medicaid groups, stratified by race (Black or African American and non-Hispanic White), Perinatal Psychiatry Consultation Line, 2021–2024

Diagnosis Type	Black or African American non-Medicaid/Medicaid <i>n</i> (%)	^a OR (95% CI)	non-Hispanic White non-Medicaid/Medicaid <i>n</i> (%)	^a OR (95% CI)
Depression and/or Anxiety Only (ref)	14 (45.2) / 25 (29.8)	1.00 (ref)	186 (42.7) / 90 (23.3)	1.00 (ref)
Bipolar, Substance Use, and Medical Diagnoses Only	* / 36 (42.9)	2.27 (0.79, 6.57)	103 (23.6) / 158 (40.8)	3.48 (0.75, 16.23)
Any Combination of Bipolar Substance use, PTSD, ADHD, Medical Diagnoses + depression and/or anxiety	* / 23 (27.4)	1.43 (0.51 4.06)	147 (33.7) / 139 (35.9)	2.22 (0.49, 10.0)

^a Adjusted for age, pregnancy stage, provider type, and race/ethnicity

* Values less than 10 have been suppressed to protect confidentiality

Race/ethnicity used for stratification is based on provider-reported data.

Odds ratios (aORs) are estimated using stratified multinomial logistic regression models.

Medicaid status is the primary independent variable of interest.

Figure 1. Flow Chart for the data loading and cleaning process used in this study, Perinatal Psychiatry Consultation Line, 2021–2024

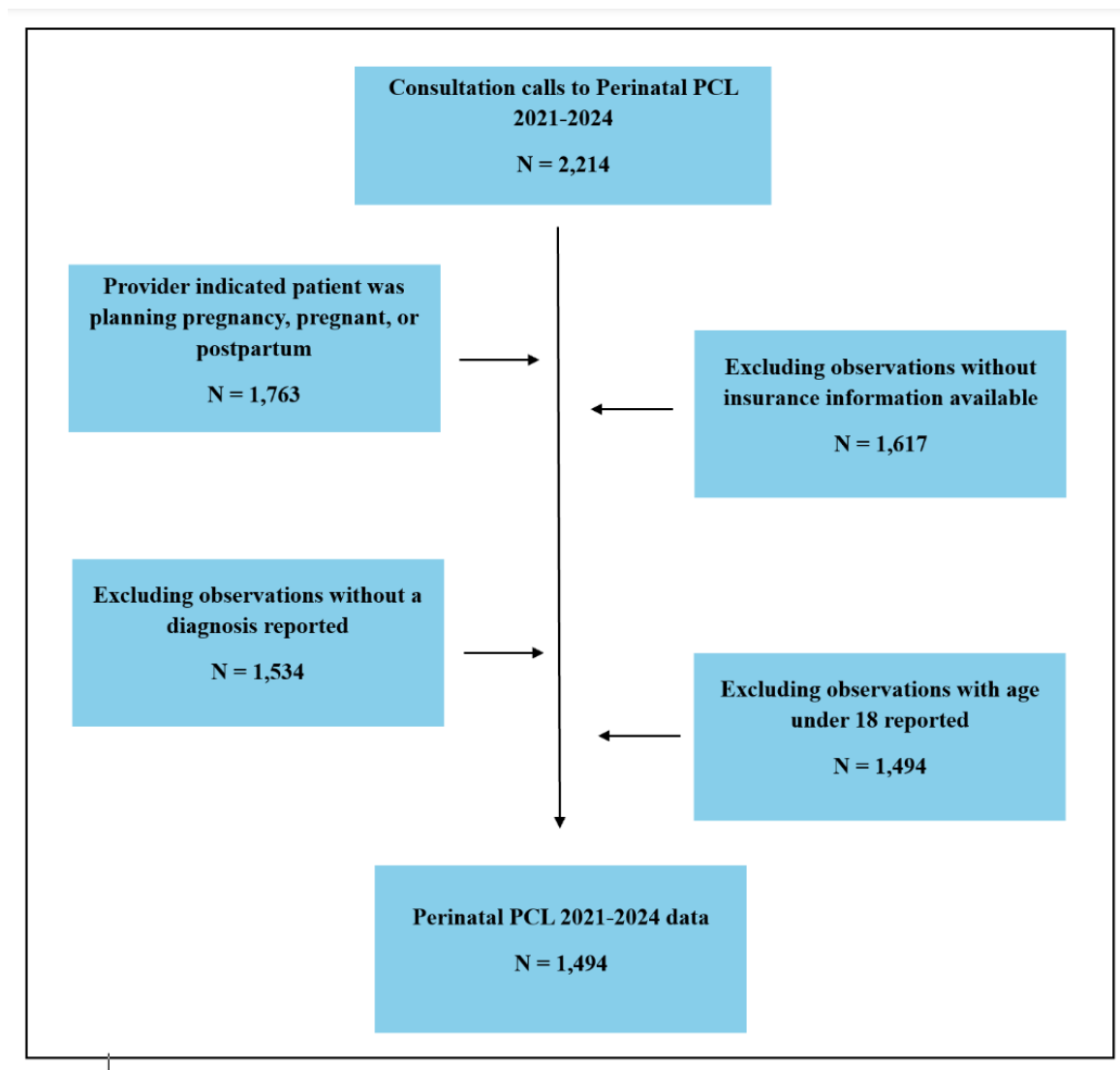
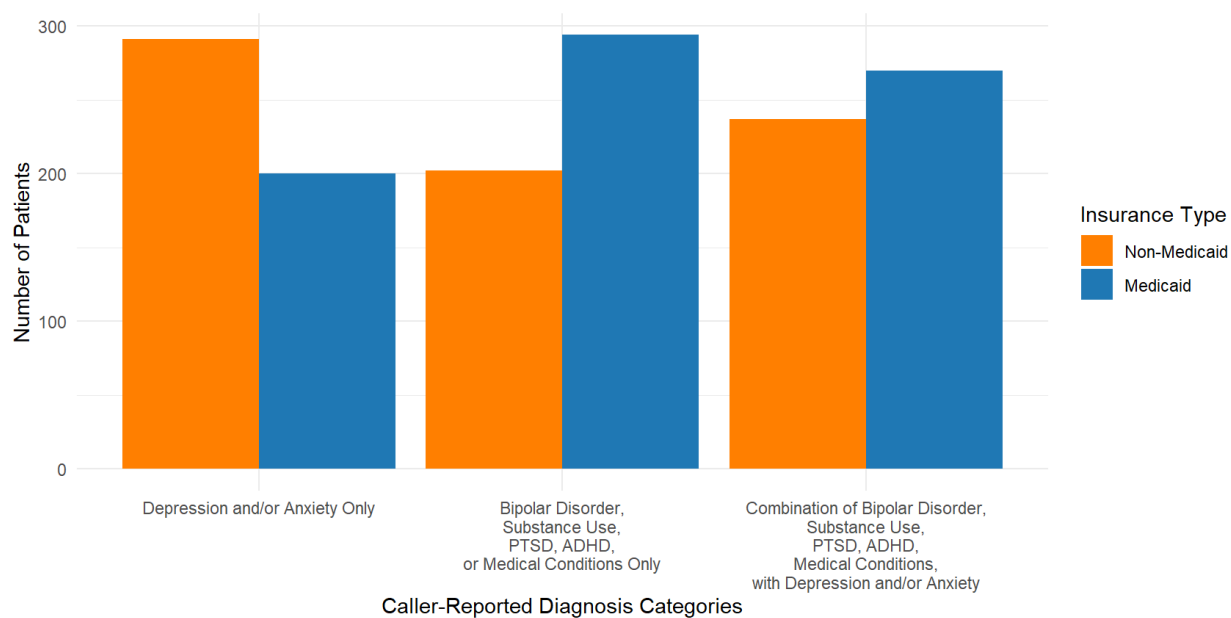


Figure 2. Distribution of diagnoses by insurance type among perinatal patients, Psychiatry Consultation Line Patients, 2021–2024.



Supplemental Material

Supplemental Material A. Intake questions asked by the navigator during Perinatal PCL calls with consulting providers.

Caller Type	Questions
First-time callers only	What is your first and last name?
	What's the best phone number for you?
	What's the best email address? (We'll send written recommendations after the call.)
	What organization do you work for?
	What city do you practice in?
	How did you hear about us?
All callers	What is your patient's first and last name?
	What is your patient's date of birth?
	What city does your patient live in?
	What insurance does your patient have? If not sure: Do you know if they have Medicaid or non-Medicaid insurance?
	How does your patient identify their race and ethnicity? (If guessing: We can skip this question if you're not sure.)
	Does your patient face any systemic barriers to care?