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Colorado Postpartum Care and Perinatal Mental Health Utilization Analysis (2019–2024)

Prepared for the Colorado Perinatal Care Quality Collaborative

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Navigation

Perinatal Mental Health Utilization

Final Report

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Summary

This analysis examined postpartum visits and mental health utilization during the perinatal period among individuals who delivered in Colorado between 2019 and part of 2024, utilizing data from the Colorado All-Payer Claims Database (CO APCD). The study assessed patterns by severity of mental health diagnosis, timing (prenatal or postpartum) of visits, provider type, and demographic subgroup for individuals 42 weeks pre-delivery through 12 months postpartum.

Key Insights:

- **Between 2019 and part of 2024, more than 1 in 3 deliveries occurred to individuals with a mental illness diagnosis (75,608 of 206,564, or 36.6%).**
    - Among patients with a mental illness diagnosis, 93% were diagnosed with a non-severe condition (e.g., depression, anxiety) rather than a severe condition (e.g., bipolar disorder, schizophrenia, severe depressive disorder).
    - When looking at the entire patient population, the proportion diagnosed with a non-severe mental illness increased from 33% in 2019 to 37% in 2023, suggesting a potential rise in prevalence or detection.
- **Mental health service use increased from 2019-2023, but remained low, especially prenatally, and especially among those with a *non-severe mental illness* diagnosis versus a *severe mental illness* diagnosis.**
    - The number of mental healthcare visits per patient was typically just one, indicating that patients were not receiving ongoing treatment to improve their well-being.
    - Mental healthcare utilization was highest among those with severe mental illness (SMI). On average, individuals with SMI attended approximately 1.6 mental healthcare visits in the postpartum period.
- **Postpartum visit attendance is improving but opportunities remain. Between 2019-2023, 7 in 10 patients completed a postpartum visit by 12 weeks; 3 in 10 did not.** However, the proportion of individuals attending a postpartum visit by 6 weeks increased over time, indicating a trend towards earlier care in line with best practice guidelines. In this report, *"postpartum visits"* refer specifically to routine obstetric follow-up appointments to monitor physical recovery and overall postpartum health, distinct from visits for mental health care (even if mental health concerns were discussed).

Background

The postpartum period is a high-risk window for complications, especially for individuals with chronic or mental health conditions (Dol et al., 2022). In Colorado, 80% of pregnancy-related deaths between 2016 and 2020 occurred during the postpartum period, underscoring the need for timely and comprehensive follow-up care (Colorado Department of Public Health and Environment, 2023a). Additionally, postpartum is a uniquely vulnerable period for mental health conditions and suicide. Suicide is a leading cause of pregnancy-associated death in Colorado, accounting for 19.5% of pregnancy-associated deaths. Nearly 60% of pregnancy-related deaths from suicide occurred between six weeks and one year postpartum (Colorado Department of Public Health and Environment, 2023a). In the general population of women of reproductive age, 14.5% of deaths were from suicide, whereas 30.0% of pregnancy-related deaths were from suicide. Moreover, 100% of pregnancy-associated suicide deaths between 2016-2020 were preventable (Colorado Maternal Mortality Review Committee).

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This analysis examines perinatal mental health, use of mental healthcare, and postpartum visits, including stratification by severity of mental health condition. Despite its importance, Colorado lacks detailed quantitative data on the utilization of perinatal mental healthcare and postpartum visit rates. Self-reported surveys such as PRAMS and Baby & You suggest high postpartum visit rates (e.g., 89% in the 2024 Baby & You) but may overestimate utilization, particularly among low-income and underserved populations (CDPHE, 2022; CDPHE, 2023b; Bryant et al., 2006).

To address this gap, the Colorado Perinatal Care Quality Collaborative (CPCQC), in partnership with the Center for Improving Value in Health Care (CIVHC), conducted a claims-based analysis in spring 2025 using CO APCD data from 2019 to 2024 (claims data from 2024 was partial at the time of this analysis). Claims data offer a more reliable view of service utilization and can identify care gaps that surveys miss, especially for medically or mentally complex pregnancies (Bennett et al., 2014). The perinatal period was defined as the 42 weeks before delivery through 12 months postpartum, allowing a full view of care patterns during pregnancy and the extended postpartum window.

This analysis supports CPCQC's equity-focused strategies and the results can inform maternal health policy and practice (CDPHE, 2024).

The primary questions guiding this analysis were:

1) What did mental healthcare use look like during the perinatal period, including the number of visits and types of providers seen?
    a) How did mental healthcare vary by severity of mental health diagnosis?
    b) What were the rates of emergency room visits, hospitalizations, and 30-day readmissions for mental health conditions, stratified by mental health severity?
    c) How did mental healthcare vary across demographic groups (e.g., race/ethnicity, geography, and payer type)?
2) What does postpartum appointment completion look like in general, and has it shifted over time?
    a) How did postpartum visit completion vary by severity of mental health diagnosis?

Methodology

Complete definitions, stratification rules, and suppression protocols are included in a companion Excel workbook, which also contains all summary tables and detailed methodology. This workbook is available upon request to CPCQC.

Sample and definitions:

- **Timeframe:** This study employed a cross-sectional analysis of a retrospective cohort derived from the Colorado All-Payer Claims Database (CO APCD) for deliveries which occurred from 2019 through December 31, 2024. Prenatal data includes service dates in 2018 - 2024, and postpartum data includes service dates from 2019 through December 31, 2024. However, postpartum data among those who delivered in 2024 is incomplete due to the timing of this analysis in spring 2025 relative to CO APCD data updates. Because codes for 2024 were incomplete at the time of analysis, 2024 was excluded from any analysis that involved change over time. This timeframe also includes the onset of the COVID-19 pandemic (beginning in 2020), which may have contributed to increased mental health needs and shifts in care utilization and access, particularly in the postpartum period. However, the analysis was not designed to isolate pandemic-related effects.
- **Pregnancy:** The analysis focused on prenatal and postpartum mental healthcare utilization among individuals who delivered in Colorado during this period, regardless of birth outcome (e.g., live birth, stillbirth). The cohort included all individuals with inpatient claims containing CPT, HCPCS, DRG, or ICD-10-CM codes that indicate a delivery hospitalization between January 1, 2019, and December 31, 2023. These delivery code sets are based on commonly used definitions (e.g., HEDIS delivery value sets, AHRQ) to capture delivery hospitalizations consistently.
- **Mental health:** Individuals were categorized into one of three mental health diagnosis groups based on the most severe primary diagnosis observed during the perinatal period (42 weeks before through 12 months after delivery). Labels follow ICD-10 conventions and are used for analytic categorization only, not to indicate severity or impact. Mental health claims were identified when a mental health diagnosis appeared as the primary diagnosis on the claim and the visit had one or more CPT or HCPCS codes indicating a mental health service.
    - **No Mental Illness**
    - **Non-Severe Mental Illness (NSMI)** – Includes diagnoses such as anxiety, adjustment disorders, mild to moderate depression, stress-related and somatoform disorders, behavioral syndromes, personality disorders, and emotional or conduct disorders (e.g., ICD-10 codes F30–F39 [except F30.1–F31 and F33.3], F40–F99, and R45.1–R45.82).
    - **Severe Mental Illness (SMI)** – Includes schizophrenia, schizotypal, and delusional disorders (F20–F29), bipolar disorder (F30.1–F31), and recurrent severe depressive disorder (F33.3).
- **Mental health claims:** Mental health (MH) claims were identified when a mental health diagnosis appeared as the primary diagnosis on the claim and the visit had one or more CPT or HCPCS codes indicating a mental health service. The data reflect diagnoses that occurred at any point during the perinatal window (42 weeks before through 12 months after delivery), and thus may reflect both pre-existing and newly identified mental illness. Because individuals were categorized based on the most severe diagnosis observed during the perinatal period, this report does not describe how many individuals had multiple diagnoses.
- **Exclusions:** Although accidental overdose is the second-leading cause of pregnancy-related death in Colorado, and reflects what is often comorbid mental health conditions and substance use disorders, claims associated with substance use disorders–including overdose, withdrawal, or related care–were excluded due to CO APCD intake restrictions during the study period. More information about this exclusion can be found here.

Key measures:

- Frequency of MH visit (i.e., number of mental health visits per individual, reported as a rate per 1,000 deliveries)
- Timing of MH visits (prenatal vs. postpartum)
- Type of MH claim (inpatient, outpatient, or emergency department)
- Type of MH service provider (e.g., behavioral health specialist, primary care provider, or other/unknown based on provider specialty codes)
- Completion of postpartum visits within 6, 8, and 12 weeks (as defined by the HEDIS postpartum visit noting a visit between 7 and 84 days after discharge)
- Additionally, disease burden markers were assessed across the entire perinatal period, including emergency department visits, inpatient admissions, and 30-day hospital readmission rates
- Analyses were stratified by diagnosis group, year, payer type, race and ethnicity, and geographic region (urban, rural, frontier)

Results

Cohort Summary Statistics

Cohort-level statistics are presented across 2019-2024, using all available data. Because 2024 postpartum and mental health data are incomplete, results may slightly underestimate values for that year.

- From 2019 to 2024, the cohort included 172,316 deliveries among 206,564 individuals in Colorado, an average of 1.2 births per individual.
- Mental illness and mental health (MH) service use:
    - Over one-third (36.6%) of deliveries in this dataset were to individuals with a mental health diagnosis, the majority of which were non-severe mental illness (34.3%). Severe mental illness (SMI) occurred in 2.4% of all patients, or 6.7% of those with mental illness. The vast majority of those with mental illness have non-severe mental illness, such as depression and anxiety (93.3%).
    - While only 2.5% of deliveries were to individuals with SMI, they accounted for 19.2% of all MH claims (7.7x their proportional share), consistent with the greater care needs associated with higher illness severity.
    - The claim volume for mental health services increased by a factor of 1.6 during the study period (2019-2023), indicating a rise in mental health engagement among perinatal populations, potentially due to COVID-era expansions in telehealth access, expanded access to mental healthcare services and postpartum insurance coverage for individuals with Medicaid during this time period, or a greater burden and clinical identification overall of mental health conditions.
- Geography:
    - MH utilization was generally proportional across geography, with urban, rural, and frontier regions accounting for similar shares of deliveries and MH claims. These findings suggest the utility of future analysis to explore trends regarding telehealth and its impact on disparities in access, especially related to geography and payor.
- Ethnicity:

    - Hispanic/Latino individuals represented the largest share of deliveries (33.4%) but only 27.9% of mental health claims—about 16% below their proportional share—while non-Hispanic White individuals accounted for 30.0% of deliveries and 44.9% of claims (1.5× their share). These differences may reflect cultural factors, stigma, or structural barriers affecting access to mental healthcare.
- Insurance:
    - Medicaid covered 61.1% of deliveries but accounted for 75.9% of mental health claims—about 24% above its proportional share—while commercial insurance covered 39.8% of deliveries but only 25.7% of claims. This likely reflects expanded Medicaid coverage and behavioral health access in recent years, as well as higher underlying need among lower-income populations.

Taken together, these patterns illustrate a complex relationship between mental health need, access, and utilization among perinatal populations in Colorado. Higher claim volumes among individuals with SMI, non-Hispanic White patients, and Medicaid-covered deliveries likely reflect both greater mental health burden and greater availability of or engagement with services. Lower claim volume among Hispanic/Latino individuals may indicate differences in access or diagnosis—but could also reflect protective community or cultural factors that support mental wellbeing.

Overall, the growth in mental health claims from 2019–2023 points to increasing awareness, demand, and engagement with behavioral health services. Continued investment in accessible, equitable, and culturally responsive mental health care—and ongoing monitoring for emerging disparities—will be critical to ensuring progress benefits all Coloradans.

Impact Measures

Mental Health Utilization: Patterns

Perinatal mental health utilization increased steadily between 2019 and 2023 among those with severe mental illness and non-severe mental illness.

As shown in Figure 1, rates of postpartum visits specifically for mental healthcare among the SMI group (i.e. with a mental health diagnosis, mental health provider, and relevant procedure code) reached 1,605 visits per 1,000 deliveries in 2023, more than three times the rate of those with NSMI, whose utilization also rose, but remained lower across all years. Mental healthcare utilization was also higher in the postnatal period than the prenatal period across all mental health diagnosis groups. This may reflect greater stressors experienced in the postpartum period relative to the prenatal period, and greater attention to postpartum mental health conditions among perinatal healthcare workers.

Despite this upward trend, service use was highly concentrated among a small portion of the population. Mean adjusted visit rates remained stable over time: 1-2 visits per perinatal period for SMI *and fewer than one* for NSMI (the much larger group). Across the full study period, individuals with SMI averaged 1.46 visits per delivery, compared to 1.30 among those with NSMI. For context, recommended treatment for mild to moderate perinatal mental mood and anxiety disorders includes regular mental health therapy for 3-6 months, in addition to medication management as clinically indicated, underscoring that 1-2 visits per perinatal patient indicates overall low utilization within the time period of 42 weeks pre-delivery through 12 months postpartum.

Notably, the median visit rate stayed near zero for both groups, indicating that most patients had little or no engagement with mental health services during the postpartum period. Low engagement among individuals with NSMI may reflect underutilization of care. While this analysis cannot assess unmet need directly, it is an important area for future exploration and could point to gaps in access, identification, or follow-up.

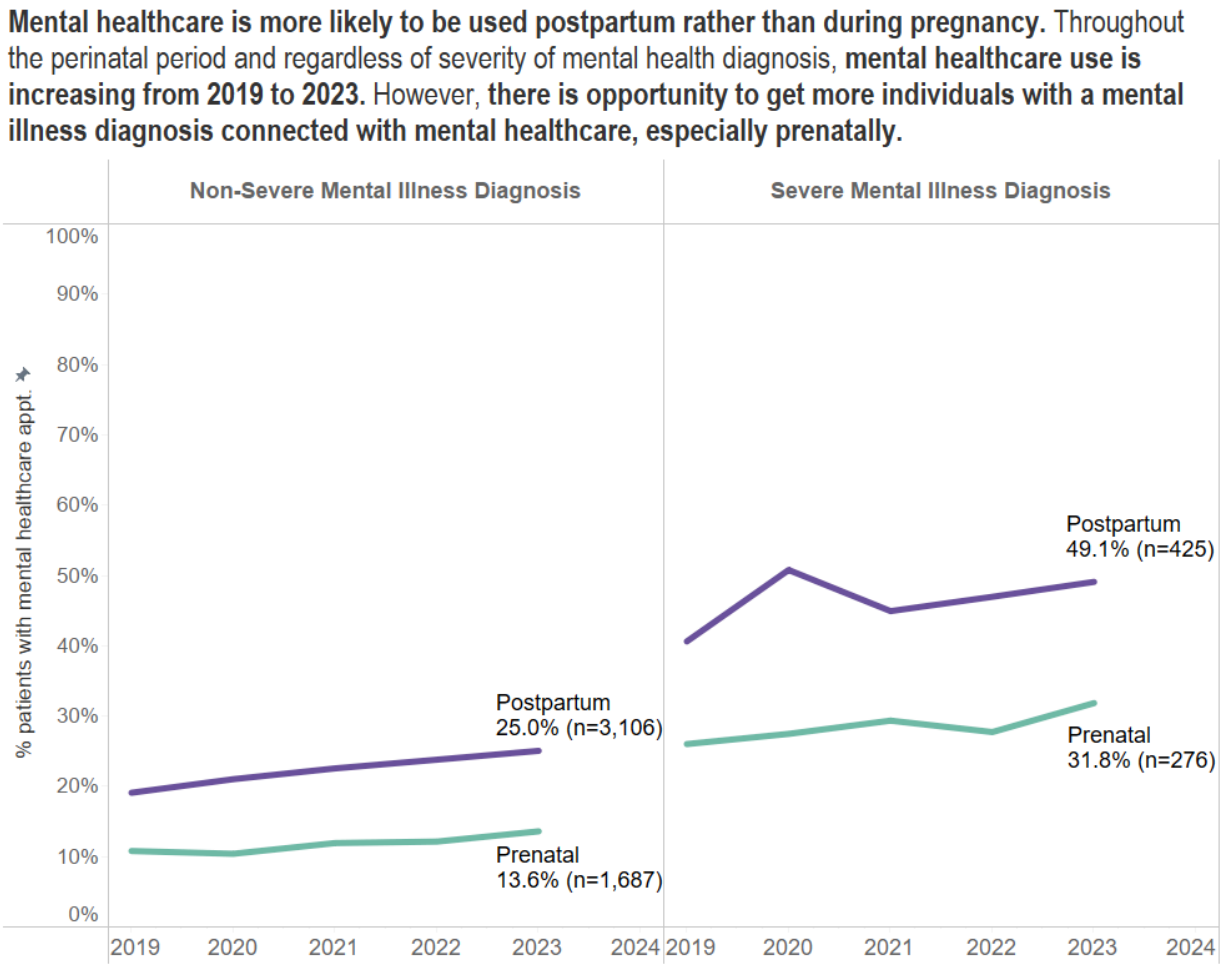


Figure 1. Overall mental health utilization by diagnosis severity, year (2019-2023), and timing (prenatal vs. postpartum).

Care Settings

Across all years, more than 95% of MH claims were delivered in outpatient settings, and engagement is increasing, particularly among high-risk populations. Fewer than 2% of claims were emergency department visits.[1] No mental health-related inpatient admissions or 30-day readmissions were observed for any of the groups.

This does not necessarily reflect a lack of clinical indication for higher-acuity admissions; these patterns reflect a system in which MH needs are primarily addressed through lower-acuity care, in part driven by payor encouragement of lower-acuity care settings to reduce costs. It is also possible that higher-acuity services may be underreported, misclassified, underutilized, or inaccessible for a variety of reasons. For example, at the time of this analysis, Colorado does not have any inpatient units which allow birthing people to bring their babies with them into the treatment setting.

As shown in Figure 2, ED visits were rare among those with NSMI, with 1.1%–1.9% of all delivery events resulting in a MH ED visit within the perinatal period. While ED use among individuals with SMI was consistently higher (which is an expected observation among patients with SMI, whose overall and ED-specific healthcare utilization tends to be higher), rates declined substantially over time—from 12.5% of deliveries in 2019 to 9.1% in 2023.

The share of deliveries with multiple MH ED visits followed a similar trend. This overall decrease may reflect multiple systemic factors, including payor benefit design to encourage lower-acuity care settings, the expansion of telehealth, increased and extended Medicaid enrollment and coverage during the postpartum period overall and for MH services specifically, and targeted support during the COVID-19 pandemic, which may have mitigated crisis care needs despite ongoing provider shortages. The sharper decline among those with SMI suggests a narrowing of disparities in ED utilization over time.

[1] All MH claims required a primary mental health diagnosis for billing, which may contribute to the low observed rates of inpatient or ED claims if MH was recorded as a secondary concern during more acute events.

Very few mental health visits occured in the emergency department (ED), and the proportion visiting the ED dropped from 2019-2023. Those with a severe mental illness diagnosis were much more likely than those with a non-severe mentall illness diagnosis to present to the ED for mental health, but the proportion dropped fom 2019-2023.

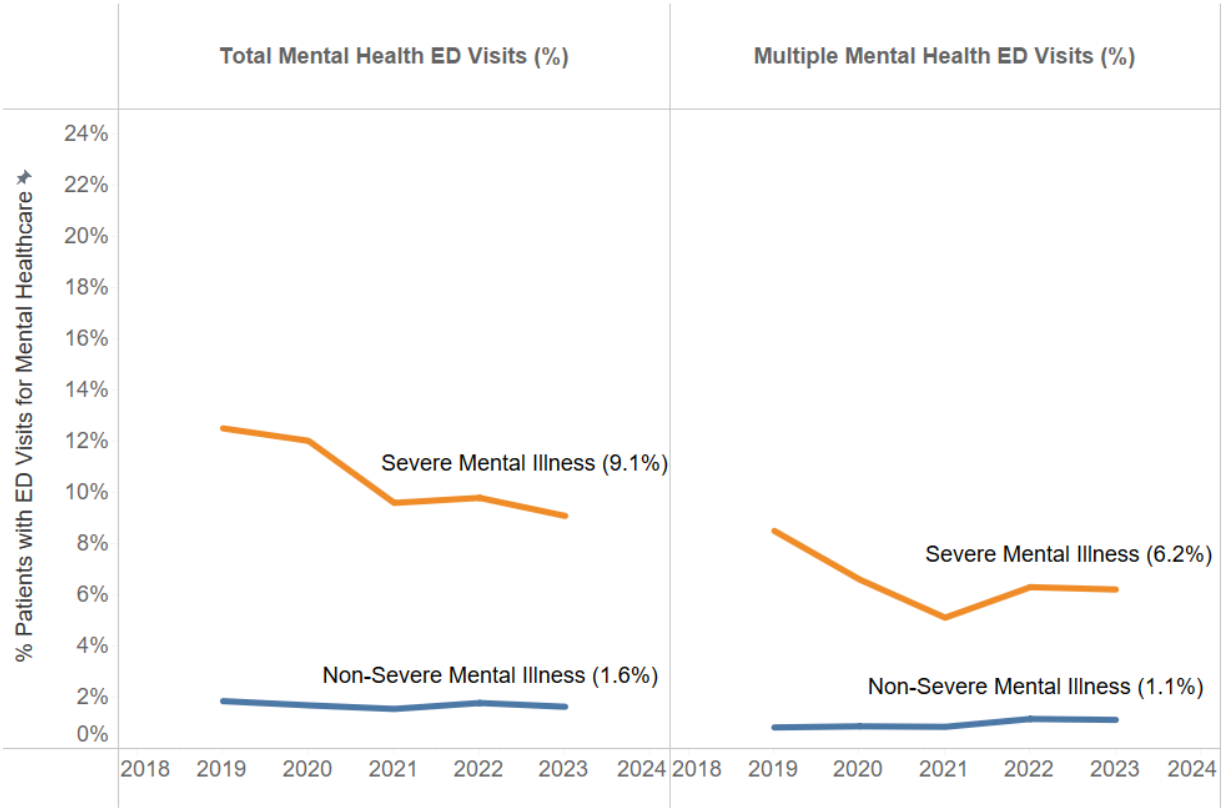


Figure 2. Emergency department admissions for mental health by diagnosis severity and year (2019-2023).

From 2021 to 2023, over 70% of MH claims were associated with mental health and social service taxonomies. This group includes licensed clinical social workers, professional and mental health counselors, psychologists, marriage and family therapists, clinical nurse specialists, and psychiatrists However, these figures may undercount actual mental health service use, as many therapists, psychologists, and other outpatient MH providers do not accept insurance and thus may not be reflected in claims data; this may also affect the mix of claims between commercial and Medicaid payors.

Data indicating that less than 5% of MH claims were associated with primary care physicians may be due to the methodology of this analysis, which required that MH be the primary diagnosis on the claim. This may exclude MH-related care that is occurring as a result of referral to a MH specialist that occurred via an initial visit in the primary care setting. It may also reflect the exclusion of MH care, such as lower-acuity medication management, that is occurring in primary care as part of broader physical health visits.

Variance by Race and Ethnicity

Mental health service utilization during the perinatal period varied significantly across demographic groups, particularly by race, ethnicity, and type of insurance. These differences suggest potential disparities in access, diagnosis, or care-seeking behavior that extend beyond clinical needs.

Among all deliveries between 2019 and 2024, Hispanic or Latino individuals of any race accounted for the largest share of births (33.4%), followed closely by non-Hispanic White individuals (30.0%). However, when mental health claims were examined, non-Hispanic White individuals made up 44.9% of all MH claims, whereas Hispanic or Latino individuals accounted for only 27.9%. This imbalance suggests potential underutilization or underdiagnosis of mental health services among Hispanic/Latino birthing people relative to their representation in the delivery population. This may also be reflective of protective community factors, cultural values or stigma related to mental healthcare, and social determinants of health such as income, language, and immigration status impacting healthcare access. While this dataset does not allow us to assess proportionality between race and mental health diagnosis severity, this is a potential area for future analysis.

Other racial groups experienced a more proportional use of mental health services. For instance, non-Hispanic Black individuals comprised 5.3% of deliveries and 6.0% of MH claims. In comparison, non-Hispanic American Indian/Alaska Native (AI/AN) individuals accounted for 0.6% of deliveries and 0.9% of MH claims. While these differences are less pronounced, smaller subgroup sizes limit the ability to fully assess equity in care access or intensity. Although 13.1% of the cohort had unknown race or ethnicity, this group accounted for 7.3% of the MH claims. The “unknown” category is mostly driven by commercial payors who either do not collect race/ethnicity data consistently or have lower reporting from members. This is a limitation, particularly because this group likely includes a mix of underserved populations. More information on race, ethnicity, and demographic data in the CO APCD can be found here.

Variance by Payor Group

Insurance status appeared to be a strong driver of mental health utilization. Medicaid covered 61.1% of deliveries in the cohort but accounted for 75.9% of mental health claims. In contrast, commercial insurance covered nearly 40% of deliveries but was associated with only 25.7% of MH claims.

These patterns are suggestive of several factors. First, between 2018-2025, Colorado's Medicaid agency greatly expanded benefits and access to behavioral health services. It more than doubled the number of behavioral health providers accepting Medicaid, from 6,000 to 13,000, while increasing provider rates, adding new benefits, and ending prior authorization requirements for psychotherapy services; this accounted for a growth of 115% in behavioral health service dollars between fiscal years 2018/2019 to 2023/2024, overlapping the study period of this analysis (Colorado Department of Healthcare Policy and Financing, 2025). At the same time, effective July 2022, Colorado extended Medicaid eligibility from sixty days to twelve months postpartum for all pregnant Medicaid enrollees. An April 2024 study published in Health Affairs suggests that postpartum eligibility extensions in Colorado were associated with increased treatment of perinatal mood and anxiety disorders (Gordon et. al, 2024). This, combined with differing levels of access to in-network mental health providers or varying approaches to screening and referral across payor systems, may account for the high proportion of mental health claims covered by Medicaid in the study period. In addition, Medicaid-insured individuals may be more likely to need mental health services, as individuals with low income often face greater adversity due to a variety of intersecting social and structural factors.

These findings underscore the importance of culturally responsive care, payer-specific outreach, and benefit design reforms in enhancing access to mental health services, particularly for groups that underutilize these services despite having access, as well as for groups at clinical risk.

Variance by geography

Mental health utilization was generally proportional to the distribution of deliveries across Colorado's geographic regions. Urban counties accounted for 87.7% of all deliveries and 88.3% of MH claims. Similarly, 1.9% of deliveries and 1.8% of claims were among members living in frontier counties, suggesting equitable utilization at the aggregate level.

Although statewide patterns appear balanced, these findings do not rule out the possibility of extensively reported-upon local access barriers. Still, current data offer reassurance that MH services are broadly reaching perinatal populations across geographic settings. These findings suggest the utility of future analysis to explore trends regarding telehealth and its impact on disparities in access, particularly during and after the onset of the COVID-19 pandemic in 2020.

Postpartum Visit Completion

Including for patients actively engaged in mental health care, dedicated postpartum visits remain essential for comprehensive care. From 2019-2023, 44% of patients did not complete a routine postpartum visit within 6 weeks, and 32% did not have a postpartum visit by 12 weeks. Overall, 28% of patients with either SMI or NSMI did not receive the ACOG-recommended full exam by 12 weeks.

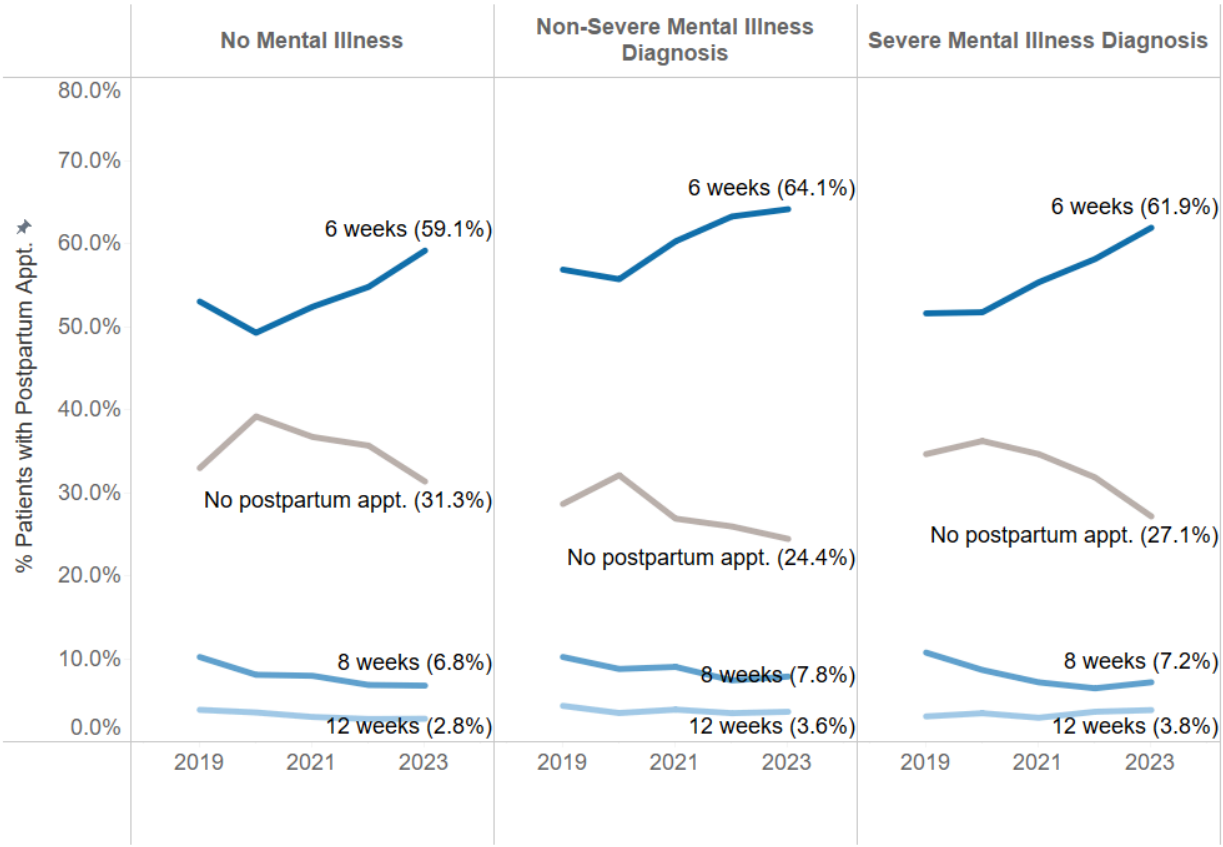
Gaps by Mental Health Diagnosis

Individuals with SMI were more likely to attend mental health visits, but they had lower rates of postpartum visit (PPV) completion compared to those with NSMI. The American College of Obstetricians and Gynecologists (ACOG) recommends a postpartum check-in within three weeks of birth and a full exam by 12 weeks (American College of Obstetricians and Gynecologists, May 2018).

This highlights the opportunity for providers to encourage not only mental health visits among this population, but routine postpartum visits as well. Interestingly, individuals with SMI and NSMI had consistently higher PPV rates than those with no mental illness diagnosis, while individuals with SMI had higher rates than those with no diagnosis in most years.[2]

These findings underscore the importance of developing integrated care models that bridge mental health and obstetric follow-up for high-risk individuals. An area for future analysis could explore trends for individuals who had a mental health diagnosis prior to pregnancy versus those who received one for the first time during the perinatal period. This would shed light on chronic and new-onset mental health needs during the perinatal period.

Most patients attend a 6-week postpartum appointment, regardless of diagnosis. A much smaller proportion of patients complete a PPV after 6 weeks. **The percent of patients attending a 6 week appointment increased from 2019-2023.**



[2]Individuals were classified as having either severe (SMI) or non-severe (NSMI) mental illness if a corresponding diagnosis appeared on any claim at any point during their perinatal period. Because this includes individuals who may have received their diagnosis during a postpartum visit, it is possible that higher postpartum visit rates among those with SMI or NSMI partly reflect when their diagnosis was identified. However, the available data do not allow us to determine the timing of diagnoses or confirm this relationship.

Figure 3. Percent of deliveries with a postpartum visit at 6, 8, and 12 weeks postpartum, and percent with no postpartum appointment, by diagnosis severity and year (2019-2023).

Discussion and Next Steps

This analysis provides a detailed view of MH utilization during the perinatal period in Colorado, highlighting both progress and persistent gaps. Despite growing engagement with mental health services, particularly in the postpartum period and among individuals with SMI, timely postpartum care remained inconsistent and often incomplete. Even among individuals with high mental health engagement, postpartum visit completion rates were not consistently high, suggesting that increased mental health utilization does not always translate to increased postpartum care visits (Bryant et al., 2006; CDPHE, 2023a). Emergency department visits for mental health reasons were much more common for individuals with SMI, but there was no corresponding increase in inpatient admissions or readmissions. This pattern may reflect stabilization in outpatient settings or underreporting of inpatient mental care (Dol et al., 2022), as well as potential lack of desirability of available inpatient mental healthcare for perinatal persons in Colorado.

Demographic disparities in mental health utilization were also evident. Hispanic/Latino individuals accounted for one-third of deliveries but just 28% of MH claims, echoing findings from the CDPHE's Baby & You survey, where emotional distress was reported but engagement with services remained low for this population (CDPHE, 2023b). Similarly, commercially insured individuals utilized MH care at lower rates than those with Medicaid, suggesting potential differences in access related to cost or benefit design (Bennett et al., 2014). Geographic utilization appeared to be proportional overall; however, this does not preclude local access challenges. Further study could investigate spatial inequities, especially in counties with limited access to providers, particularly for specialized care such as psychiatry, or inadequate infrastructure (CDPHE, 2022).

Taken together, these findings suggest that Colorado needs better integration of postpartum and mental health services, targeted outreach to underrepresented groups, and structural support for continuity of care are key next steps to improve outcomes.

Limitations

This analysis is based on insurance claims data from the Colorado APCD, which excludes uninsured individuals and those covered solely by the Indian Health Service (IHS), the Veterans Administration (VA), or approximately half of ERISA-covered plans. As a result, the database captures approximately 34,000 to 36,000 deliveries per year, compared to an estimated 69,000 births statewide (CDPHE, 2025), and findings may not be representative of the full birthing population in Colorado. It also relies on payer-reported race and ethnicity, which may not be complete.

Mental health conditions may be underdiagnosed, particularly among underserved populations, and services may be undercounted due to coding discrepancies. Additionally, the reporting of provider types was limited — psychiatric services were grouped under "Other or Unknown Provider Type" due to their low volume.

Postpartum visit rates for deliveries in 2024 may appear artificially low because only claims through December 31, 2024, were included as of this report. Thus, deliveries occurring in 2024 did not have a full year of postpartum data available. The same issue applies to deliveries covered by Medicare Fee-for-Service in 2023, as this data is subject to a one-year lag. However, the total proportion of delivery events was low for these members and is unlikely to significantly affect most of the reported measures.

Finally, this was a descriptive analysis. The analysts did not control for potential confounding factors such as comorbidities, prior mental health history, or social determinants of health, all of which may influence diagnosis and service use. The COVID-19 pandemic also likely played a significant role in shaping mental health needs, access, and utilization patterns across the study period, though this impact was not explicitly analyzed. Furthermore, no statistical tests were conducted to assess the significance of the reported differences, which merit further exploration in future studies.

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