Medicaid and CHIP and the COVID-19 Public Health Emergency

Preliminary Medicaid and CHIP Data Snapshot

Services through January 31, 2022

Medicaid and CHIP Content Overview

Medicaid and CHIP Population: Based on an analysis of T-MSIS submissions during the COVID-19 Public Health Emergency (PHE), from March 2020 – January 2022, over 123 million* Americans, including children, pregnant women, parents, seniors, and individuals with disabilities, were enrolled across each state's Medicaid or the Children's Health Insurance Program (CHIP) for at least one day during the PHE period. This count of enrollees includes all Medicaid and CHIP beneficiaries with full, comprehensive, and partial benefits. About 39% of beneficiaries were children, which translates to about 49 million beneficiaries, and 9% of beneficiaries were over the age of 65. Approximately 55% of beneficiaries were female. 14% of the population were dually-eligible for Medicare and Medicaid. 34% of the population were white, 24% of the population were of unknown race, 20% were Hispanic, 16% were black, 4% were Asian, and 1% were American Indian and Alaska Native, Hawaiian/Pacific Islander, or multiracial.

COVID-19 Treatment Rate: We use the following International Classification of Diseases (ICD), Tenth Revision (ICD-10), diagnosis codes to identify beneficiaries who received treatment for COVID-19:

- B97.29 (other coronavirus as the cause of diseases classified elsewhere) – before April 1, 2020
- U07.1 (2019 Novel Coronavirus, COVID-19) – from April 1, 2020 onward.

Although CMS does use lab claims for identifying COVID-19 treatment, CMS does not receive lab results from states and cannot determine whether a lab test was positive. Therefore, Medicaid and CHIP COVID-19 cases are only identifiable in TAF data when there is a corresponding COVID-19 related service.

Medicaid and CHIP Data Processing: Medicaid and CHIP providers, managed care organizations, and Pharmacy Benefit Managers submit administrative claims data to state Medicaid and CHIP agencies for processing. Those agencies subsequently submit the data to CMS on a monthly basis via T-MSIS. These submissions have considerable variation in terms of completeness and quality. CMS processes states' submissions and transforms them into the T-MSIS Analytic Files (TAF), which form the basis of this analysis. Given this process, there may be a significant "claims lag" between when a service occurs and when it is represented in TAF. Therefore, users should interpret the results with caution.

Data Quality Concerns: The results are based on T-MSIS submissions through March 2022, which include services through the end of February 2022. Because data for February are mostly incomplete, results are only presented through January 31, 2022. For additional information regarding state variability in data quality, please refer to the TAF DQ Atlas.

*This enrollment count includes beneficiaries enrolled for at least one day during the PHE with full, comprehensive, or partial benefits.

What You Should Know When Using the Data

Claims Lag: You should use caution when interpreting the data. We collect Medicaid and CHIP data for programmatic purposes, but not for public health surveillance. There will always be a delay, or "claims lag," between when a service occurs and when the claim or encounter for that service is reflected in our database. The length of the lag depends on the submitting state, claim type, and the delivery system. It is possible that there is a longer claims lag due to the pandemic. For Medicaid and CHIP data, no claims are submitted to CMS in the same month the service was delivered. Historically, 90% of FFS claims across all claims types are submitted within 7 months, while 90% of encounters across all claims types are submitted within 12 months. There is significant variation across states, with some states submitting 90% of all claims within only 4 months, while other states take nearly a year. On average, states need 9 months to submit 95% of all claims.

Percent of Medicaid and CHIP claims received by months after service was delivered (based on March 2018 service date)					
Months after service	**1**	**3**	**6**	**9**	**12**
Fee-for-service claims submission, %					
Inpatient	21.8*	76.4	92.3^	96.3^	97.8^
Long-term care	14.9*	89.3	96.8^	98.5^	99.2^
Other services	26.3*	83.0	95.1^	97.5^	98.5^
Prescription drug	64.0	98.5^	99.0^	99.1^	99.2^
Managed Care encounters submission, %					
Inpatient	6.3*	68.7	84.7	91.3^	96.3^
Long-term care	3.6*	57.4	81.4	89.1	94.8^
Other services	9.8*	77.6	90.8^	94.5^	97.1^
Prescription drug	34.6*	93.2^	97.6^	98.3^	99.0^

*Less than 50 percent of claims submitted.

^Greater than 90 percent of claims submitted.

State Variation in Inpatient Hospital Claims Lag

Claims Lag: Use caution when interpreting the data. We collect Medicaid and CHIP data for programmatic purposes, but not for public health surveillance. There will always be a delay, or "claims lag," between when a service occurs and when the claim or encounter for that service is reflected in our database. The length of the lag depends on the submitting state, claim type, and the delivery system. It is possible that there is a longer claims lag due to the pandemic. For Medicaid and CHIP data, no claims are submitted to CMS in the same month the service was delivered.

Inpatient Hospital file: The Inpatient Hospital (IP) file contains inpatient institutional claims, which are included based on the month and year of the discharge date or the most recent service end date associated with the claim if the discharge date is missing. Historically, 90% of both FFS and encounter inpatient claims are submitted within 6 months. There is significant variation across states in terms of claims submissions. Some states submit 90% of inpatient hospital claims within only 3 months, while other states take nearly a year.

Percent of Medicaid and CHIP Inpatient Hospital claims received by months after service was delivered (based on March 2018 service date)					
Months after service	**1**	**3**	**6**	**9**	**12**
Fastest claims submission, Inpatient Hospital claims %					
Colorado	50.2	83.1	91.0^	94.1^	95.5^
Rhode Island	43.5*	70.2	80.1	83.3	94.0^
Wyoming	39.9*	84.2	93.9^	97.2^	99.9^
Connecticut	37.3*	92.1^	97.9^	99.1^	99.6^
Longest claims submission, Inpatient Hospital claims %					
Puerto Rico	0.0*	68.7	89.3	90.8^	91.1^
Massachusetts	0.0*	20.3*	69.1	97.7^	99.0^
Hawaii	0.2*	58.8	86.5	94.4^	96.7^
Illinois	1.6*	35.3*	69.0	85.5	90.1^

*Less than 50 percent of claims submitted.

^Greater than 90 percent of claims submitted.

State Variation in Other Services Claims Lag

Claims Lag: Use caution when interpreting the data. We collect Medicaid and CHIP data for programmatic purposes, but not for public health surveillance. There will always be a delay, or "claims lag," between when a service occurs and when the claim or encounter for that service is reflected in our database. The length of the lag depends on the submitting state, claim type, and the delivery system. It is possible that there is a longer claims lag due to the pandemic. For Medicaid and CHIP data, no claims are submitted to CMS in the same month the service was delivered.

Other Services file: The Other Services file contains outpatient facility claims and professional claims. This includes, but is not limited to physician services, outpatient hospital services, dental services, other physician services (e.g., chiropractors, podiatrists, psychologists, optometrists, etc.), clinic services, laboratory services, X-ray services, sterilizations, home health services, personal support services, and managed care capitation payments. Historically, 90% of both FFS claims and encounter records in this file are submitted within 6 months. There is significant variation across states in terms of claims submissions. Some states submit 90% of all other services claims within only 3 months, while other states take nearly a year.

Percent of Medicaid and CHIP Other Services claims received by months after service was delivered (based on March 2018 service date)					
Months after service	**1**	**3**	**6**	**9**	**12**
Fastest claims submission, Other Services claims %					
Colorado	58.0	91.6^	97.0^	98.6^	99.3^
Nebraska	49.7*	90.9^	96.4^	98.4^	99.2^
South Dakota	40.3*	92.8^	98.4^	99.5^	99.8^
Arkansas	39.2*	87.8	96.1^	97.6^	98.3^
Longest claims submission, Other Services claims %					
Puerto Rico	1.1*	87.7	99.2^	99.6^	99.8^
Missouri	2.9*	79.7	90.0^	92.5^	93.4^
Illinois	4.9*	48.7*	74.2	86.8	93.2^
Hawaii	5.0*	76.6	89.7	94.1^	95.7^

*Less than 50 percent of claims submitted.
^Greater than 90 percent of claims submitted.

Table of Contents

Medicaid and CHIP enrollment and service use patterns during the COVID-19 PHE

- Medicaid enrollment increased during the PHE for children and adults, especially among beneficiaries enrolled in adult and pregnant eligibility groups.
- In response to the PHE, Congress passed the Families First Coronavirus Response Act, which includes a federal funding increase for state Medicaid agencies that meet certain conditions, including a maintenance of eligibility requirement. In accepting the federal funding increase, states may not disenroll most beneficiaries who lose eligibility during the PHE. One important group affected by this policy is pregnant beneficiaries who may now remain enrolled in Medicaid past the 60-day postpartum period.
- Despite increased enrollment, there was still a gap in the rate of health care services compared to prior years when service utilization did not keep up with the growth in enrollment.
- The number of mental health and reproductive health services provided to adults during the PHE nearly returned to pre-PHE levels, but the rate of these services per 1,000 beneficiaries remained below pre-PHE levels, likely reflecting the increase in enrollment.
- For children, both the volume and rate of primary and preventive service use rebounded to close to pre-PHE levels, but rates have not reached pre-PHE levels for dental and mental health services.

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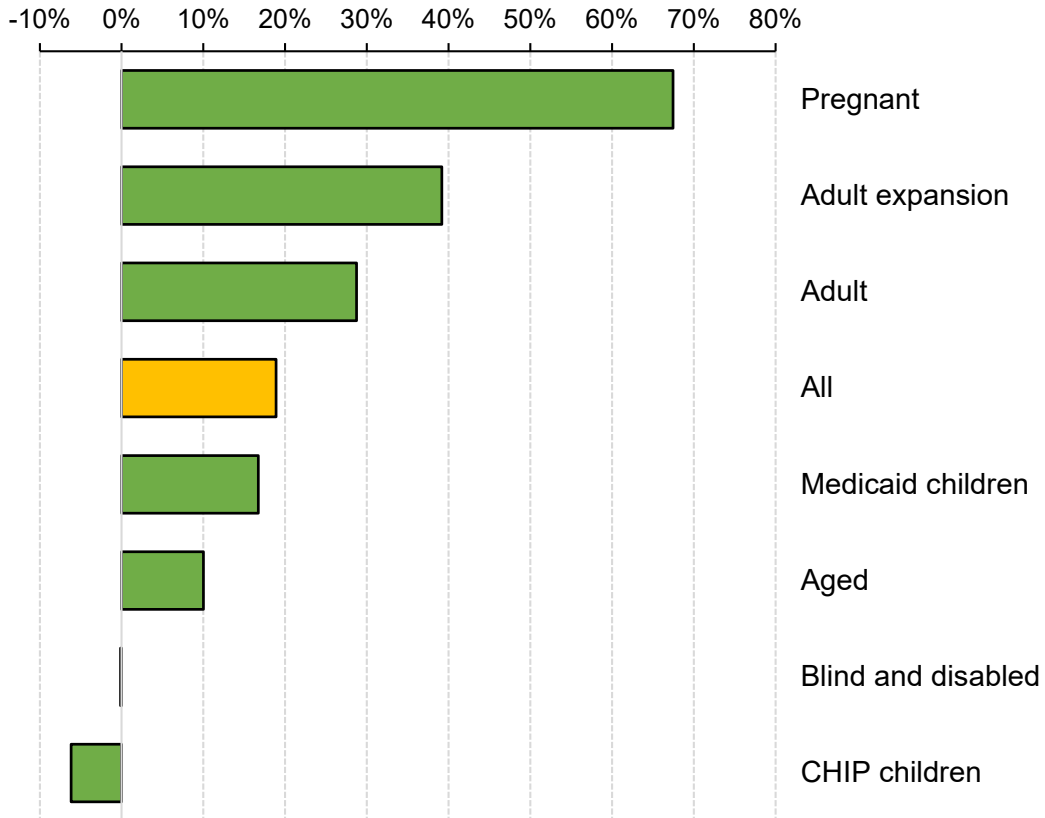
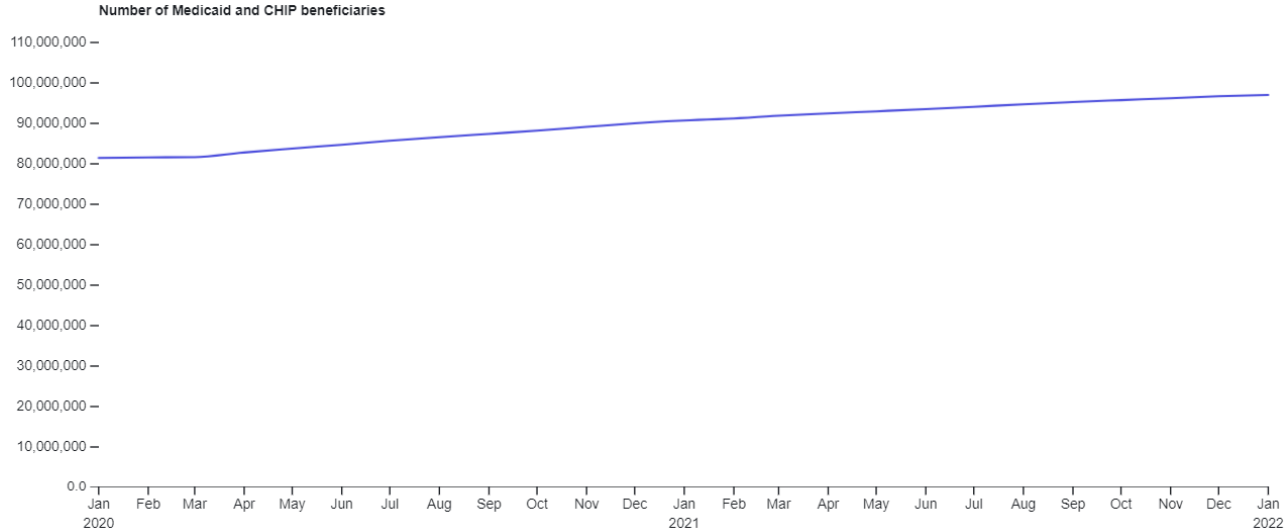
Medicaid and CHIP Enrollment during the COVID-19 Public Health Emergency

Preliminary data comparing January 2022 to February 2020 show overall enrollment in Medicaid and CHIP for beneficiaries with full, comprehensive, and partial benefits increased by 19%, with the greatest percentage increases found in the pregnant, adult expansion, and adult eligibility groups

Percent change in number of Medicaid and CHIP beneficiaries, by eligibility group, comparing January 2022 to February 2020



Number of Medicaid and CHIP beneficiaries, by month



Comparing January 2022 to February 2020, the data show **~19% more** (15.4 million) beneficiaries enrolled in Medicaid or CHIP, **~67% more** (682,000) beneficiaries in the pregnant eligibility group, **~39% more** (6.2 million) beneficiaries in the adult expansion eligibility group, and **~29% more** (3.0 million) beneficiaries in the adult eligibility group. There were **~17% more** beneficiaries in the Medicaid children eligibility group, **~10% more** beneficiaries in the aged eligibility group, **~0.1% fewer** beneficiaries in the blind and disabled eligibility group, and **~6% fewer** beneficiaries in the CHIP children eligibility group.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect. They are based on March T-MSIS submissions with enrollment through the end of February. Recent dates of enrollment have very little time for runout, and we expect some changes in enrollment after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The baseline period includes Medicaid and CHIP eligibility data from February 2020 and the comparison period includes eligibility data from January 2022. These enrollment counts include Medicaid and CHIP beneficiaries with full, comprehensive, and partial benefits.

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Monitoring COVID-19: Treatment, Acute Care Use, and Testing

What You Should Know When Using the Data

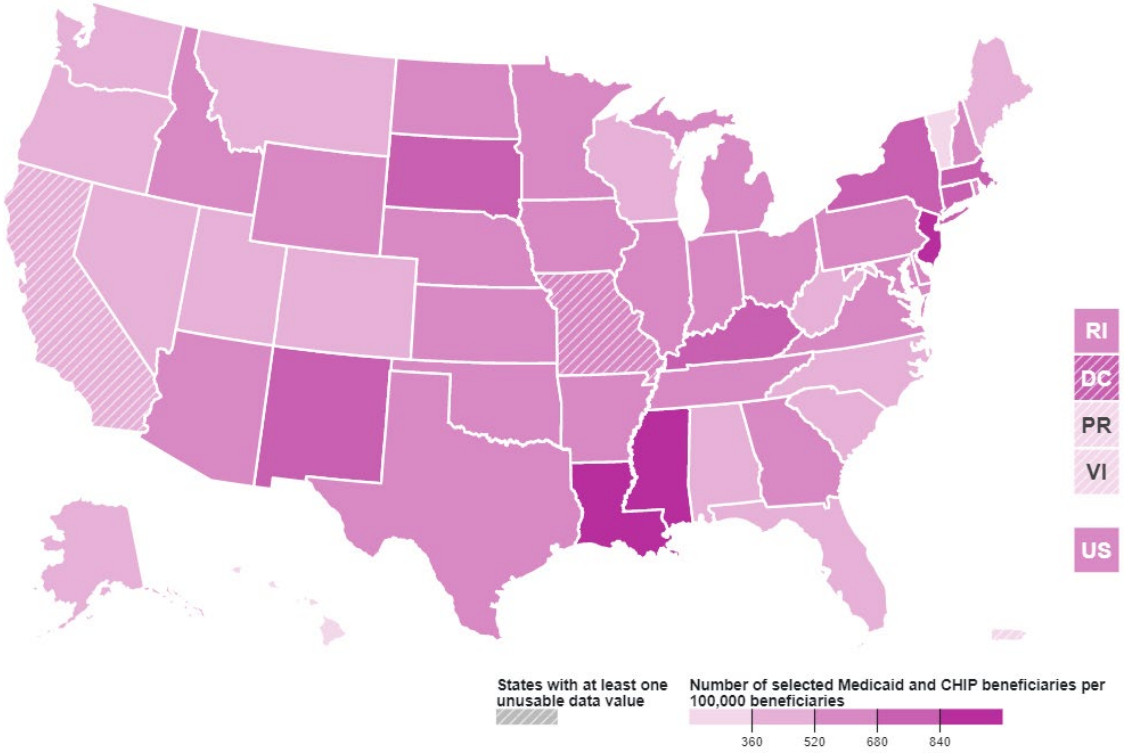
- These estimates reflect COVID-19 treatment, services, and outcomes that are paid for by Medicaid and CHIP.
- Services covered by other insurance programs, such as Medicare, as well as services covered by public health programs or other COVID-related funding are not included in these results.
- In 2019, there were 12.3 million dually eligible beneficiaries enrolled in both Medicare and Medicaid.[1]
- These results are unlikely to reflect the full scope of COVID-related treatments for beneficiaries dually eligible for Medicare, as Medicare pays first for Medicare-covered services that are also covered by Medicaid because Medicaid is generally the payer of last resort.[2]
- For more information about COVID-related cases and hospitalizations among dually eligible beneficiaries covered by Medicare, refer to CMS' Medicare COVID-19 Data Snapshot.

1. Centers for Medicare and Medicaid Services. Medicare-Medicaid Coordination Office. "Data Analysis Brief: Medicare-Medicaid Dual Enrollment 2006 through 2019." Available at: https://www.cms.gov/files/document/medicaremedicaiddualenrollmenteverenrolledtrendsdatabrief.pdf.

2. Centers for Medicare and Medicaid Services. Medicare-Medicaid Coordination Office. "Dually Eligible Individuals – Categories." Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

Medicaid and CHIP beneficiaries treated for COVID-19

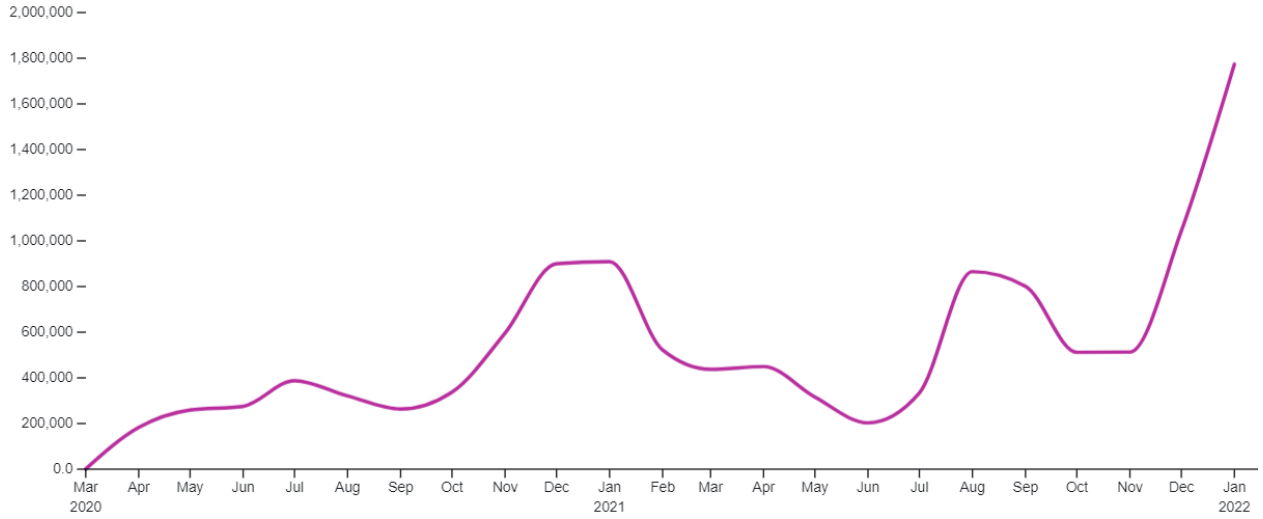
Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE



Beneficiaries treated for COVID-19 during the PHE: **8,943,102**

COVID-19 treatment rate during the PHE: **7,258 per 100,000 beneficiaries**

Number of Medicaid and CHIP beneficiaries treated for COVID-19 during the PHE, by month



Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among dually eligible beneficiaries covered by Medicare, refer to CMS' Medicare COVID-19 Data Snapshot.

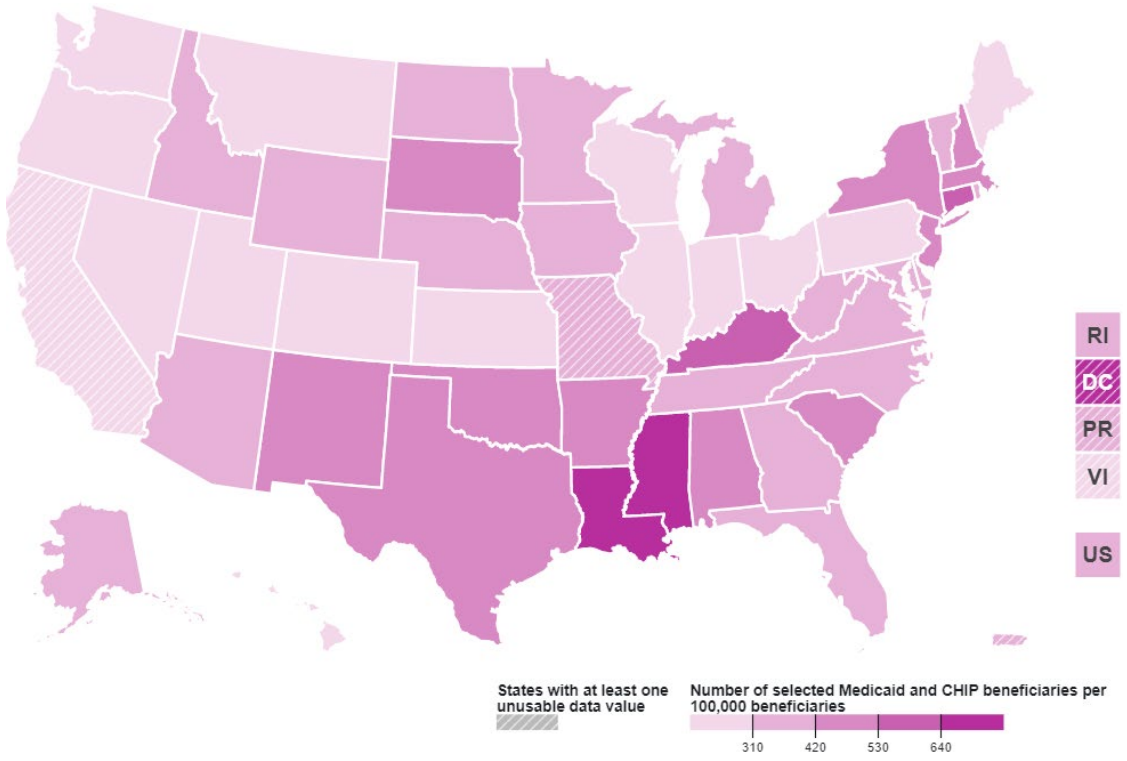
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022.

Medicaid and CHIP beneficiaries under age 19 treated for COVID-19

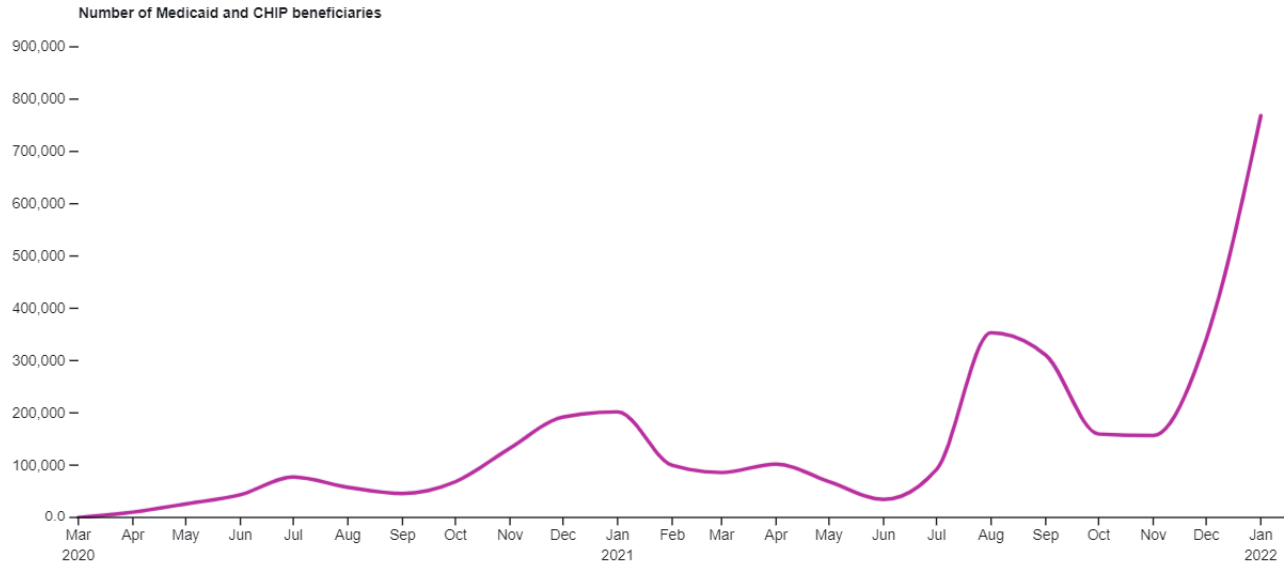
Beneficiaries under age 19 treated for COVID-19 during the PHE: **3,120,565**

COVID-19 treatment rate during the PHE: **6,430 per 100,000 beneficiaries < age 19**

Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE



Number of Medicaid and CHIP beneficiaries under age 19 treated for COVID-19 during the PHE, by month



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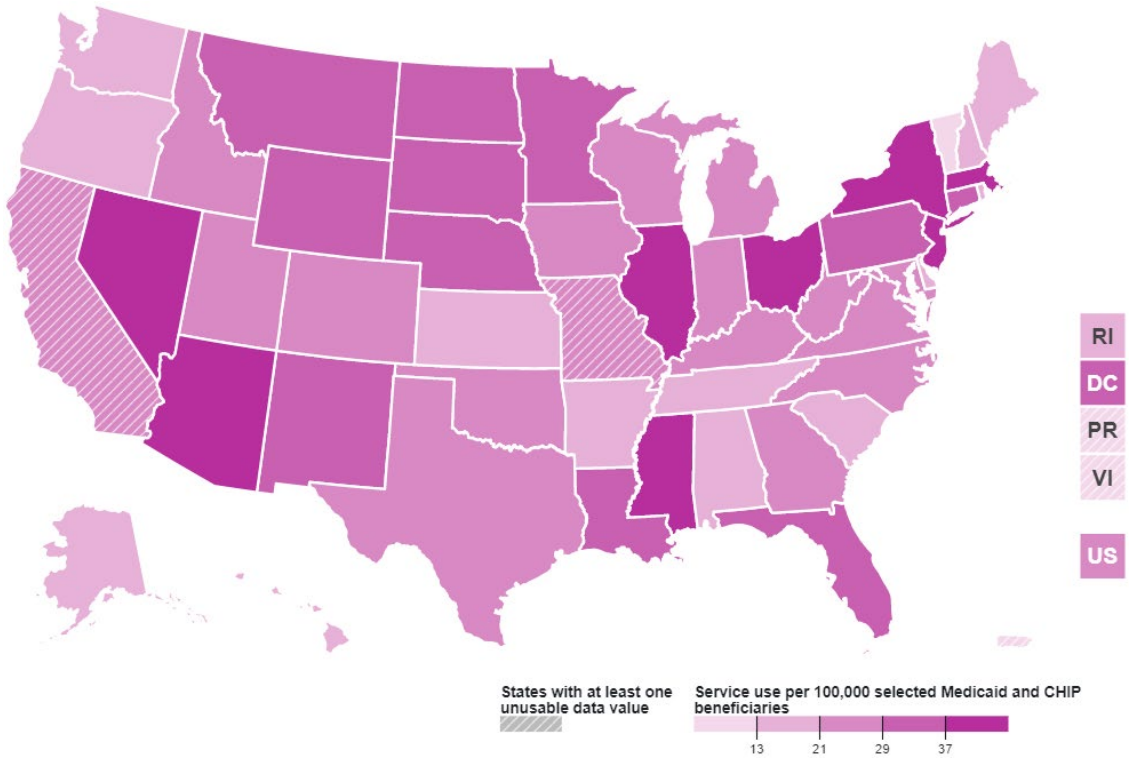
COVID-19 acute care use among Medicaid and CHIP beneficiaries

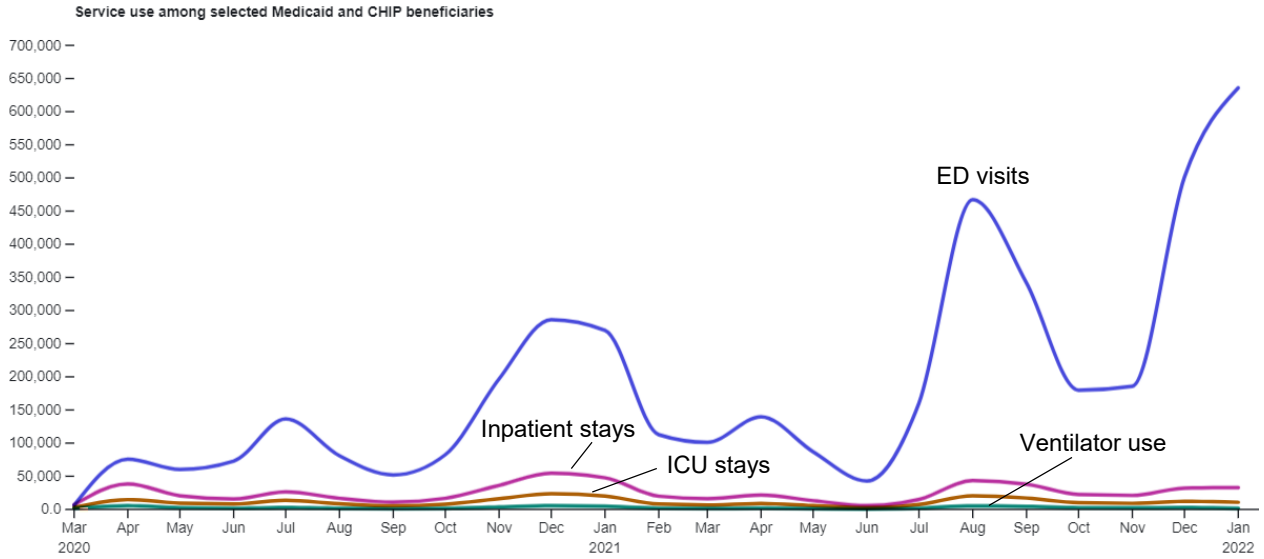
Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE



Number of COVID-19 hospitalizations during the PHE:
573,968

Rate of COVID-19 hospitalizations during the PHE:
466 per 100,000 beneficiaries

Number of acute care services for Medicaid and CHIP beneficiaries treated for COVID-19 during the PHE, by month



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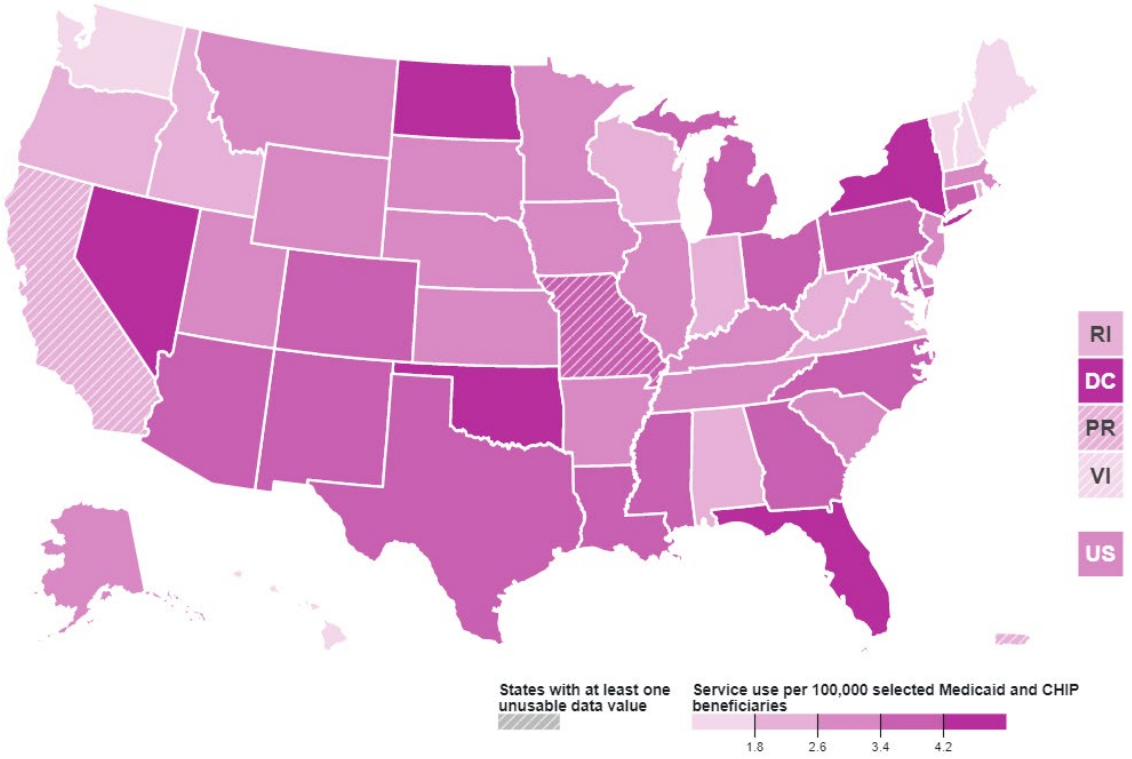
COVID-19 acute care use among Medicaid and CHIP beneficiaries under age 19

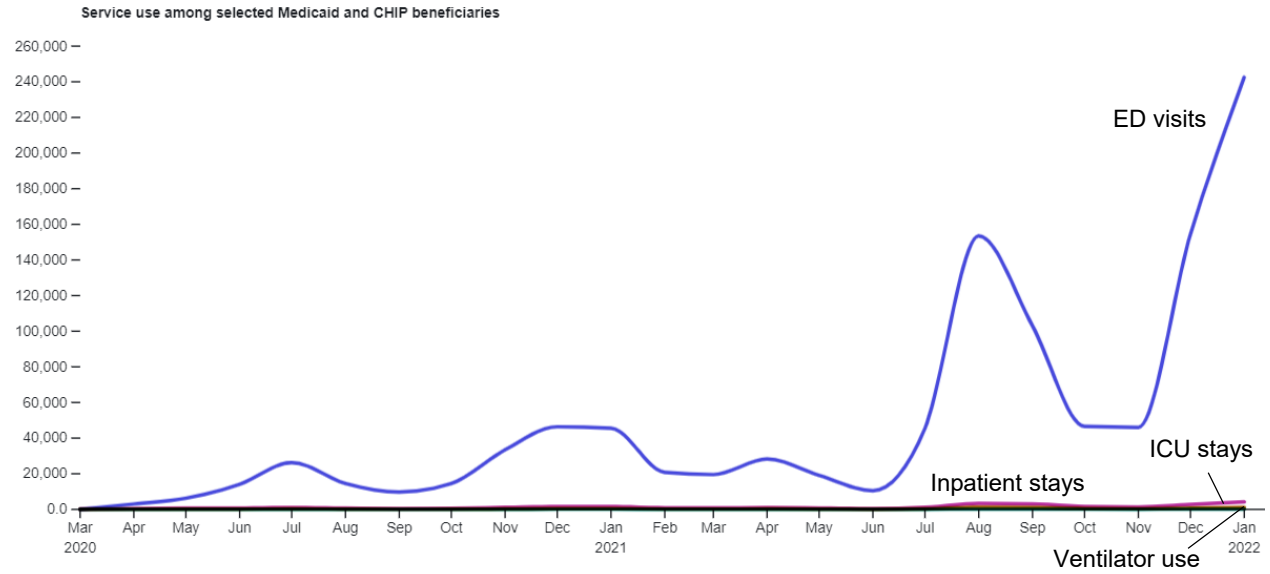
Number of COVID-19 hospitalizations for beneficiaries under age 19 during the PHE: **29,750**

Rate of COVID-19 hospitalizations during the PHE: **61 per 100,000 beneficiaries < age 19**

Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE



Number of acute care services for Medicaid and CHIP beneficiaries under age 19 treated for COVID-19 during the PHE, by month



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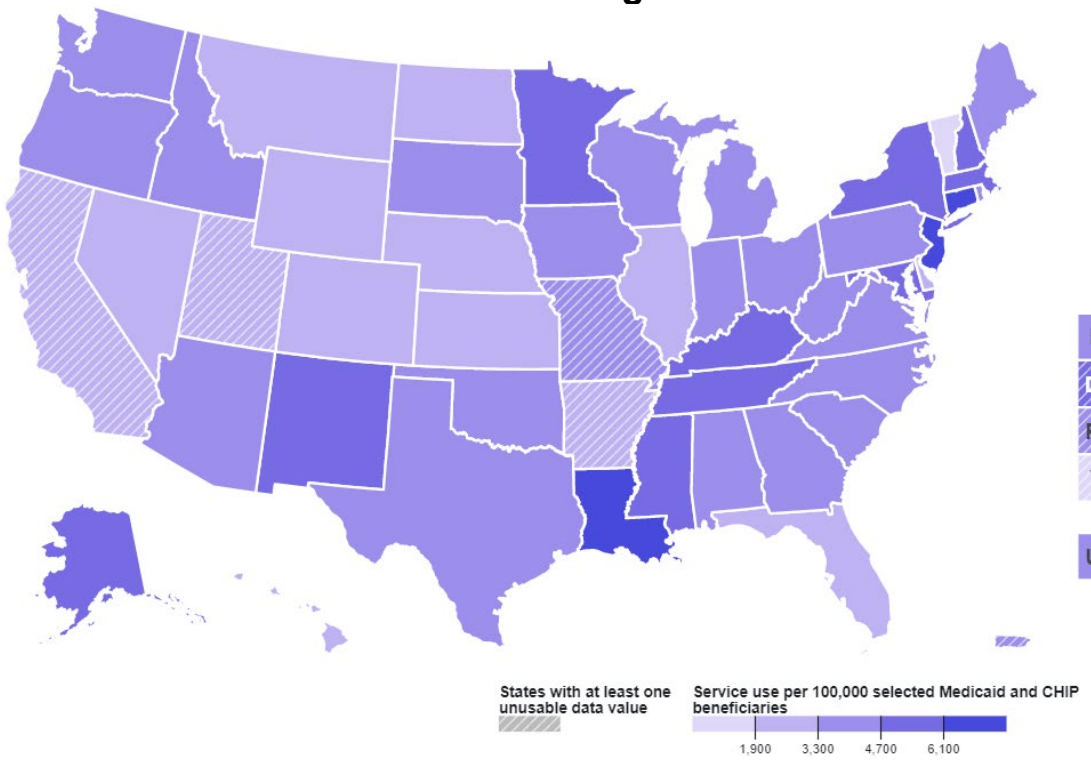
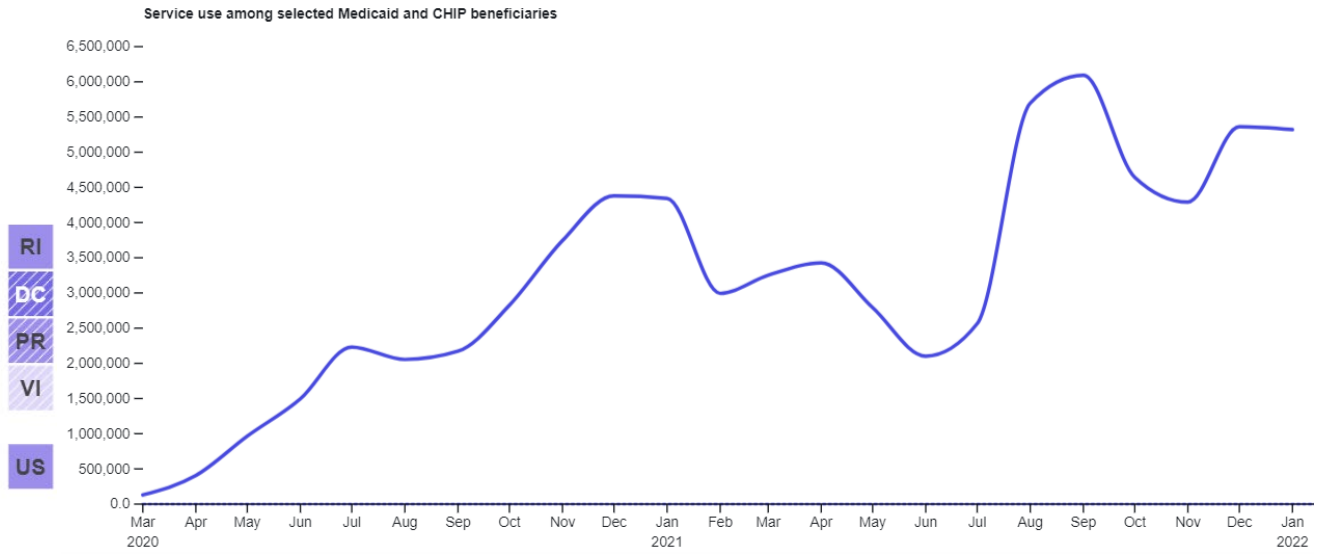
Preliminary data show that Medicaid and CHIP paid for nearly 73.3 million COVID-19 tests during the PHE

Average monthly rate of COVID-19 tests paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE (March 2020 – January 2022): 3,989.0

Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE



Number of COVID-19 tests or testing-related services paid by Medicaid and CHIP during the PHE, by month



Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among dually eligible beneficiaries covered by Medicare, refer to CMS' Medicare COVID-19 Data Snapshot.

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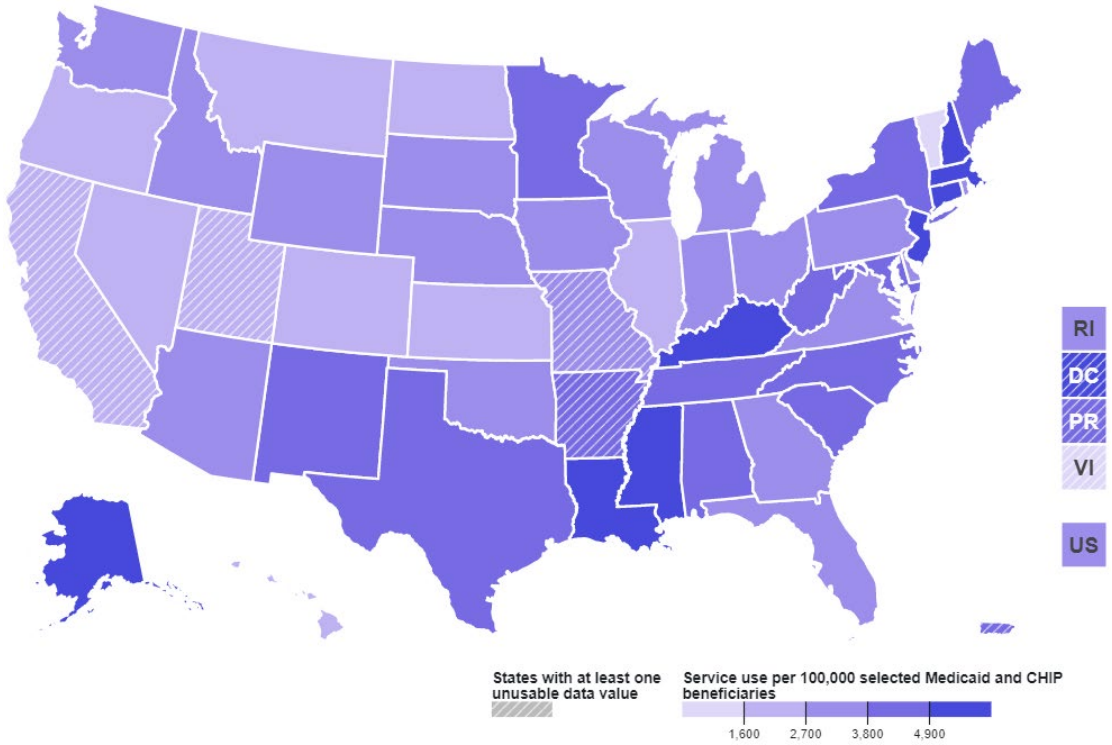
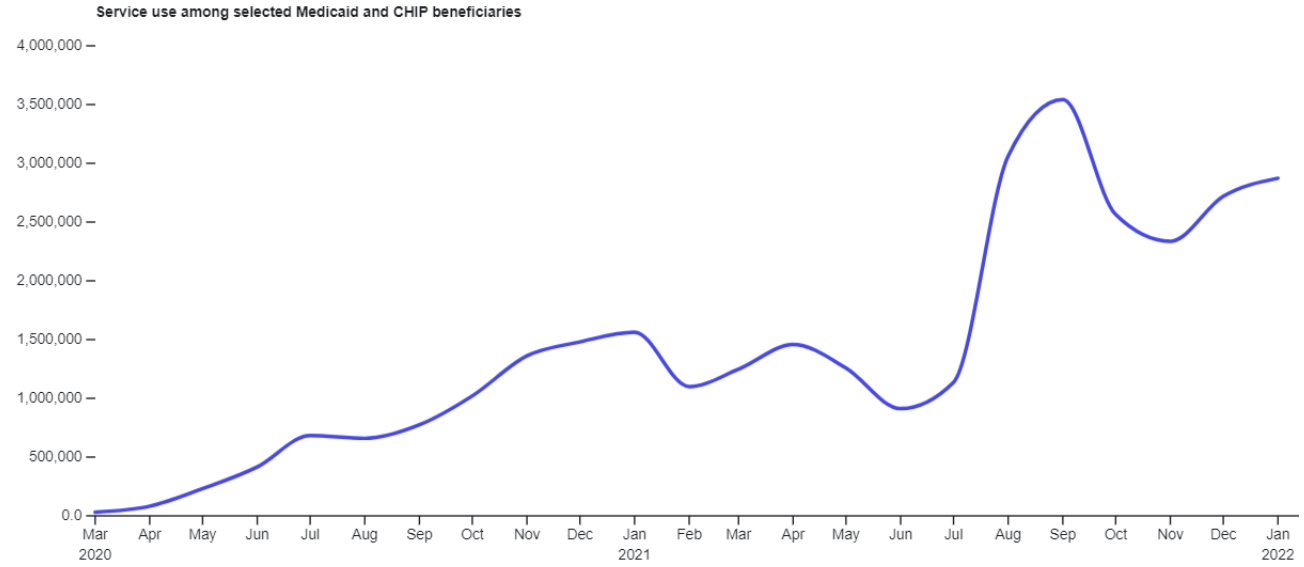
Preliminary data show that Medicaid and CHIP paid for more than 32.5 million COVID-19 tests for beneficiaries under age 19 during the PHE

Average monthly rate of COVID-19 tests paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE (March 2020 – January 2022): 3,546.1

Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE



Number of COVID-19 tests or testing-related services paid by Medicaid and CHIP among beneficiaries under age 19 during the PHE, by month



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Service Use Among Medicaid and CHIP Beneficiaries Under Age 19 during the COVID-19 Public Health Emergency

Medicaid and CHIP cover more than 4 in 10 children nationally and provide critical services

- Medicaid and CHIP covered nearly 49 million children during the COVID-19 Public Health Emergency (PHE) between March 2020 and January 2022
- The programs cover three quarters of children living in poverty[1]
- Approximately four in ten children covered under the programs have a special health care need[2]

1. Cornachione, Elizabeth, Robin Rudowitz, and Samantha Artiga. 2016. Children's Health Coverage: The Role of Medicaid and CHIP and Issues for the Future. Kaiser Family Foundation. Available at: https://www.kff.org/reportsection/childrens-health-coverage-the-role-of-medicaid-and-chip-and-issues-for-the-future-issue-brief/.

2. Musumeci, MaryBeth and Priya Chidambaram. 2019. Medicaid's Role for Children with Special Health Care Needs: A Look at Eligibility, Services, and Spending. Kaiser Family Foundation. Available at: https://www.kff.org/medicaid/issue-brief/medicaids-role-for-children-with-special-health-care-needs-a-look-at-eligibility-services-and-spending/.

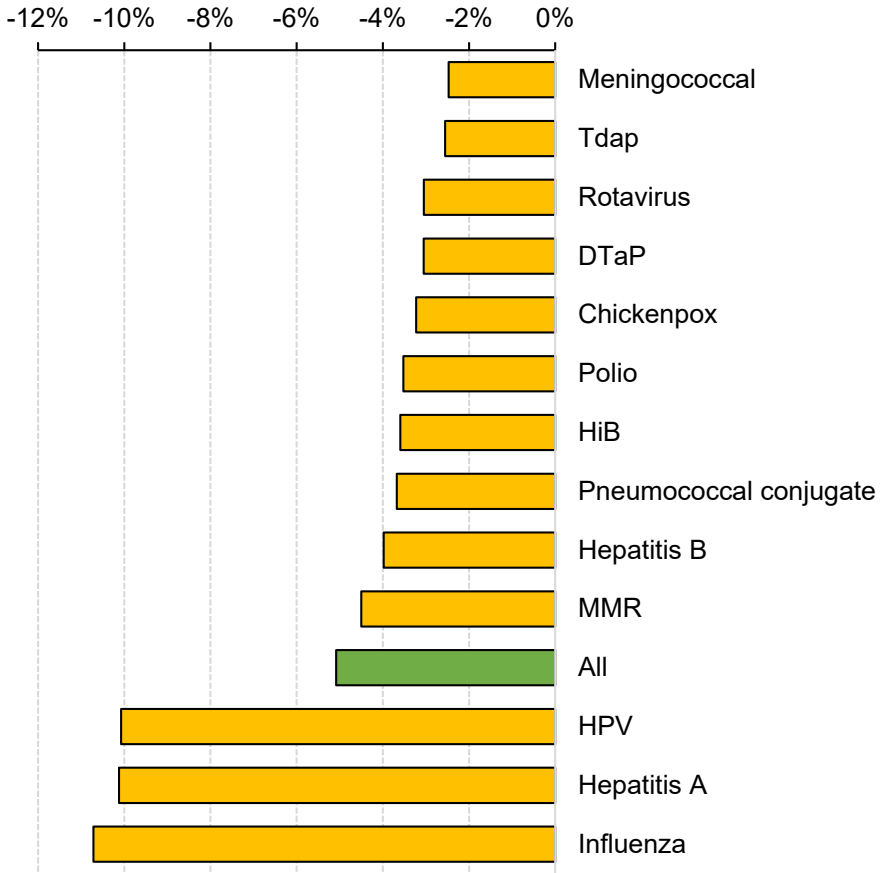
Service use among children under age 19 during the COVID-19 PHE: Key highlights

Preliminary data suggest that, during the PHE:

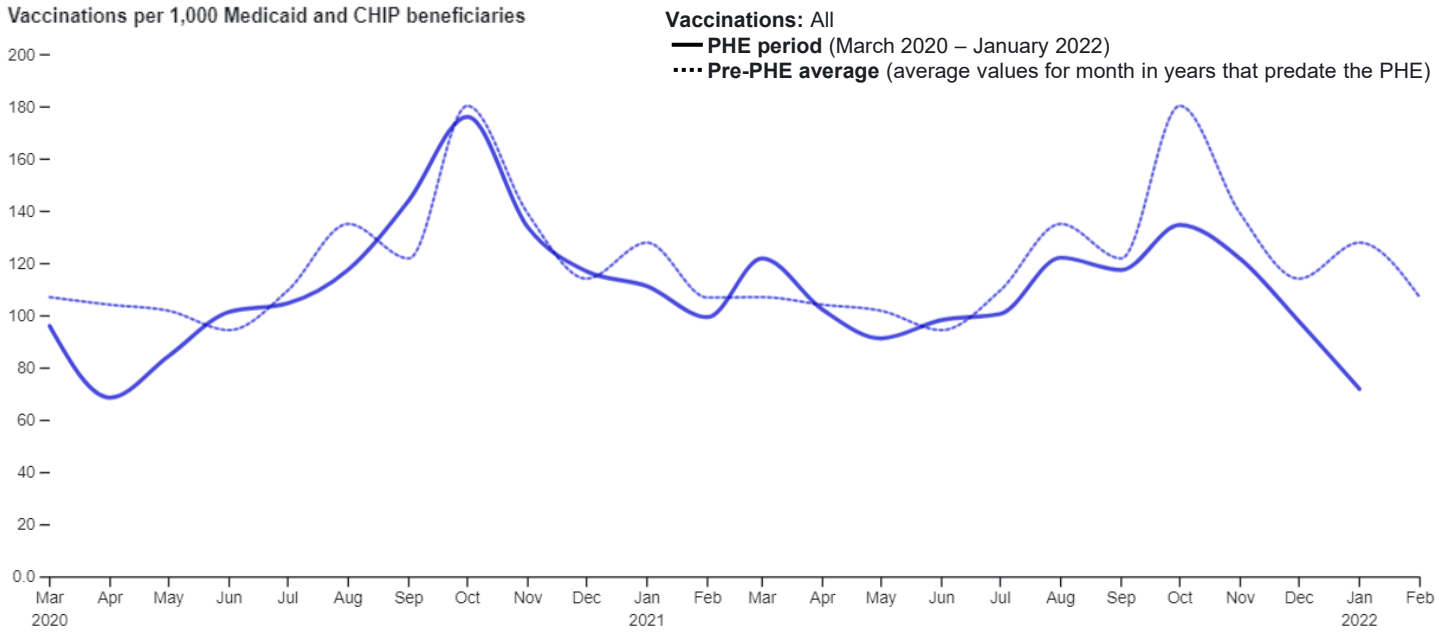
- The volume and rate of primary, preventive, and mental health service use declined among children under age 19 in April 2020. Although rates rebounded through March 2021 for most primary and preventive care services, millions of services still need to be delivered to make up for those missed between March 2020 and January 2022.
- Of all services examined in this analysis, the smallest improvement was for mental health services.
- Because the number of beneficiaries enrolled in child eligibility groups increased during the PHE, especially for Medicaid children, counts of services increased in some instances, but there were gaps in the rate of services delivered compared to prior years when utilization did not keep up with the growth in enrollment.
- Service delivery via telehealth for children increased dramatically starting in April 2020 compared to prior years.
- The COVID-19 treatment rate for children has remained low; ~6.4% of Medicaid or CHIP beneficiaries received a COVID-19 diagnosis and fewer than 29,800 were hospitalized through January 2022.

Preliminary data show the vaccination rate among beneficiaries under age 19 declined for all vaccines during the PHE period compared to prior years, and the percent decline varied by vaccination type

Percent change in the number of vaccinations delivered to children under age 19 during the PHE compared to the pre-PHE period



Number of vaccinations per 1,000 Medicaid and CHIP beneficiaries under age 19, by month

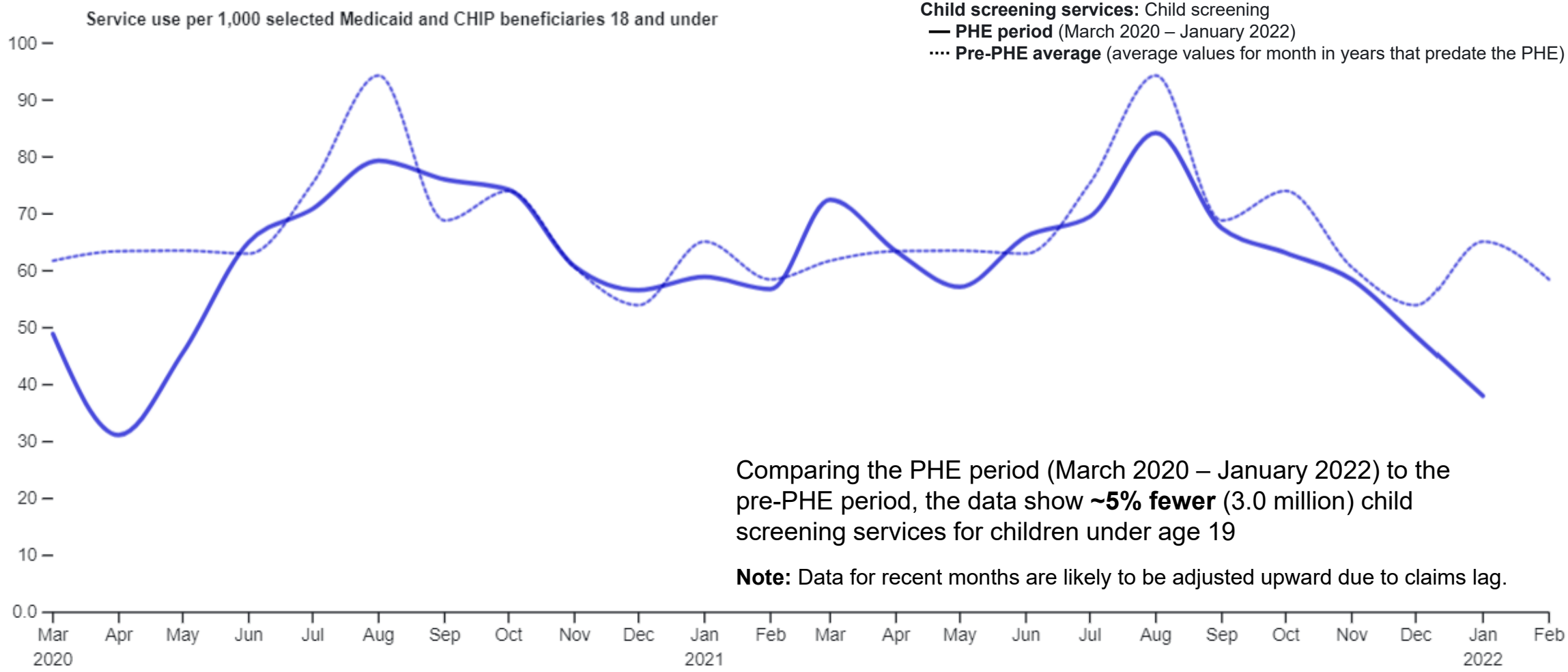


Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~5% fewer** (5.3 million) vaccinations for children under age 19

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data suggest that after an initial decline, the rate of child screening services during the PHE remained close to pre-PHE levels

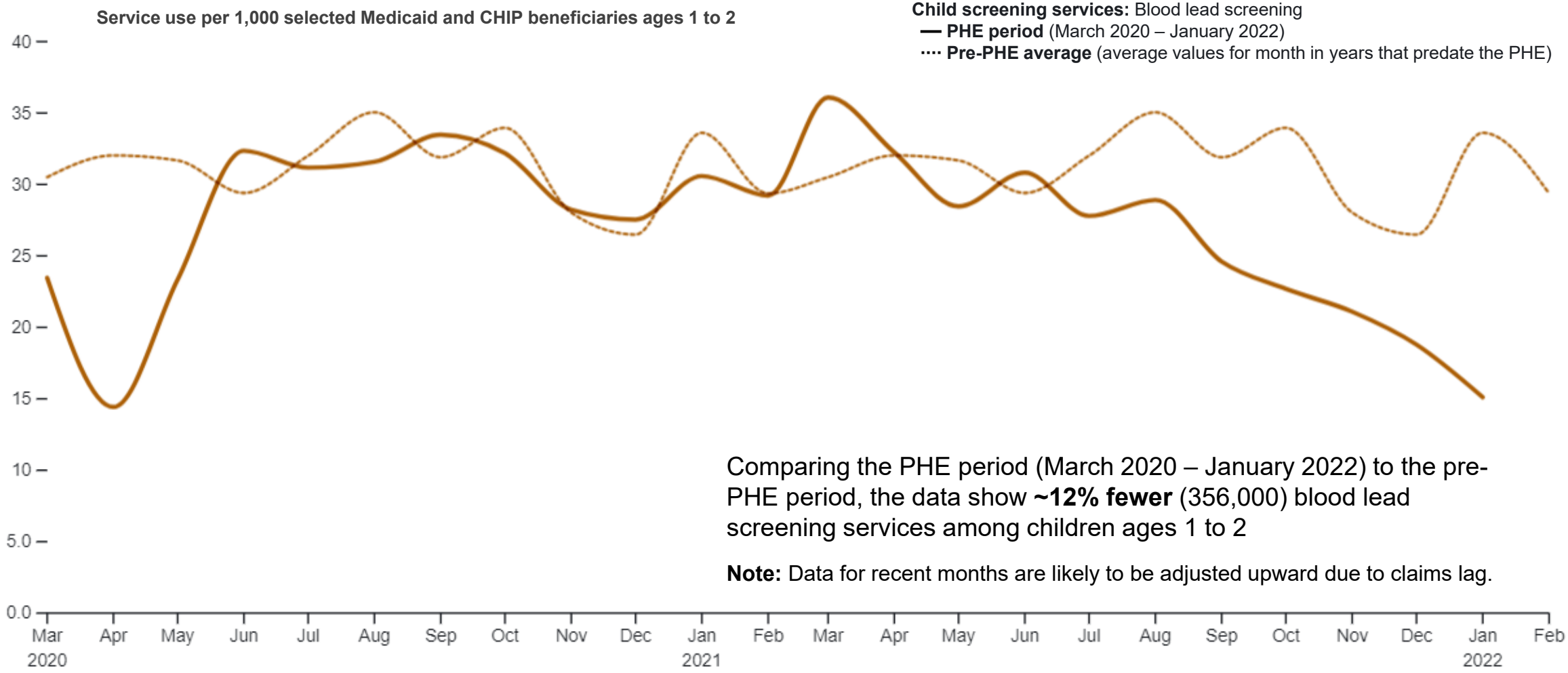


Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~5% fewer** (3.0 million) child screening services for children under age 19

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the rate of blood lead screening services for children ages 1 to 2 declined in April 2020 and rebounded to pre-PHE levels by June 2020, declining again after June 2021

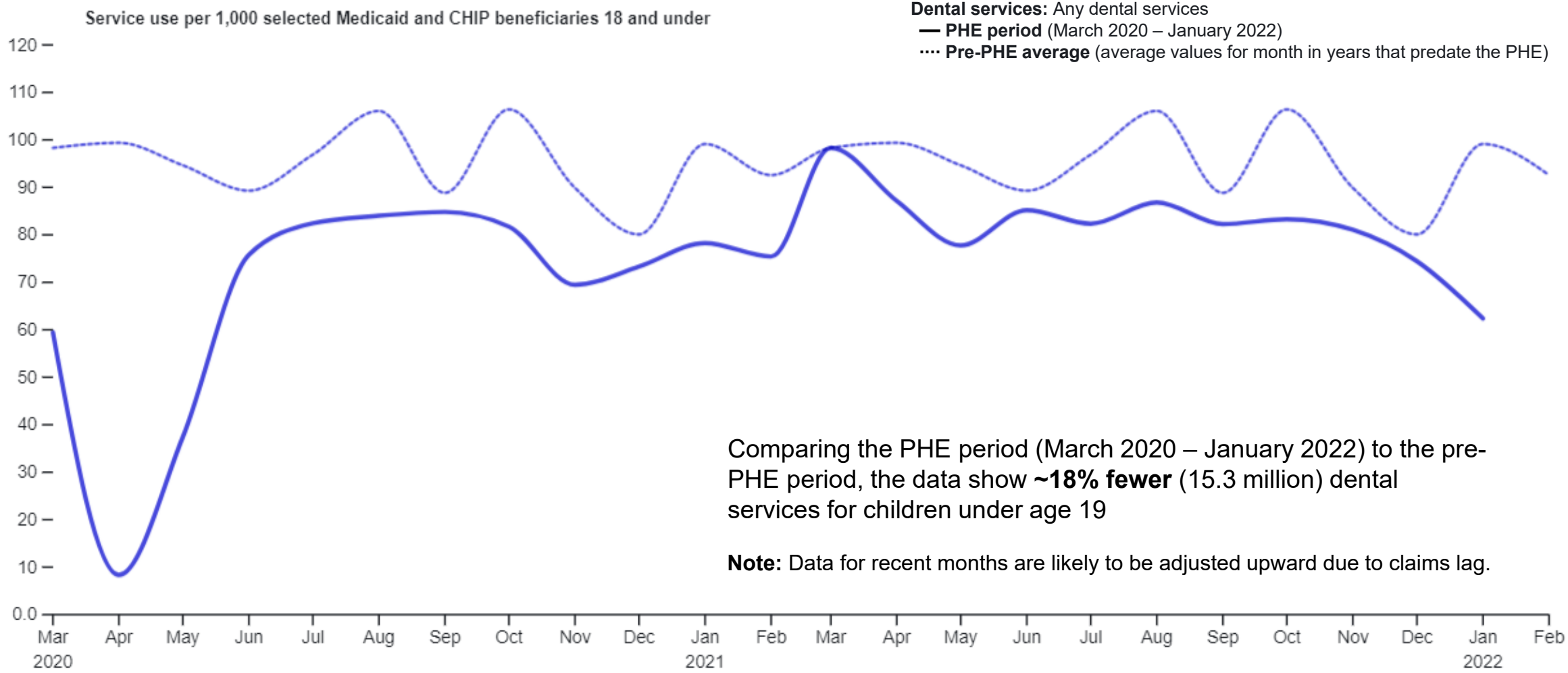


Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~12% fewer** (356,000) blood lead screening services among children ages 1 to 2

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the rate of dental services for children during the PHE, after an initial steep decline, remained slightly below pre-PHE levels

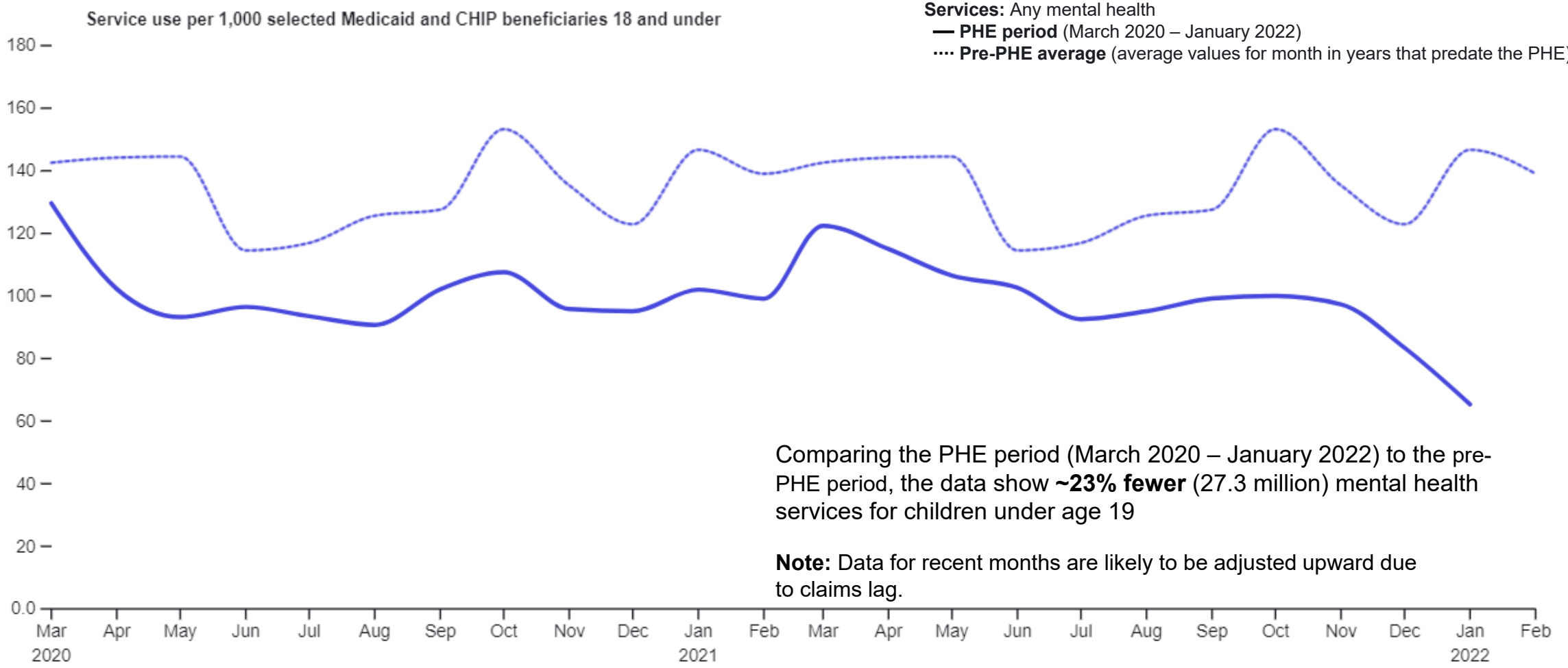


Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~18% fewer** (15.3 million) dental services for children under age 19

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the rate of mental health services for children under age 19 generally declined throughout the PHE and remained below pre-PHE levels



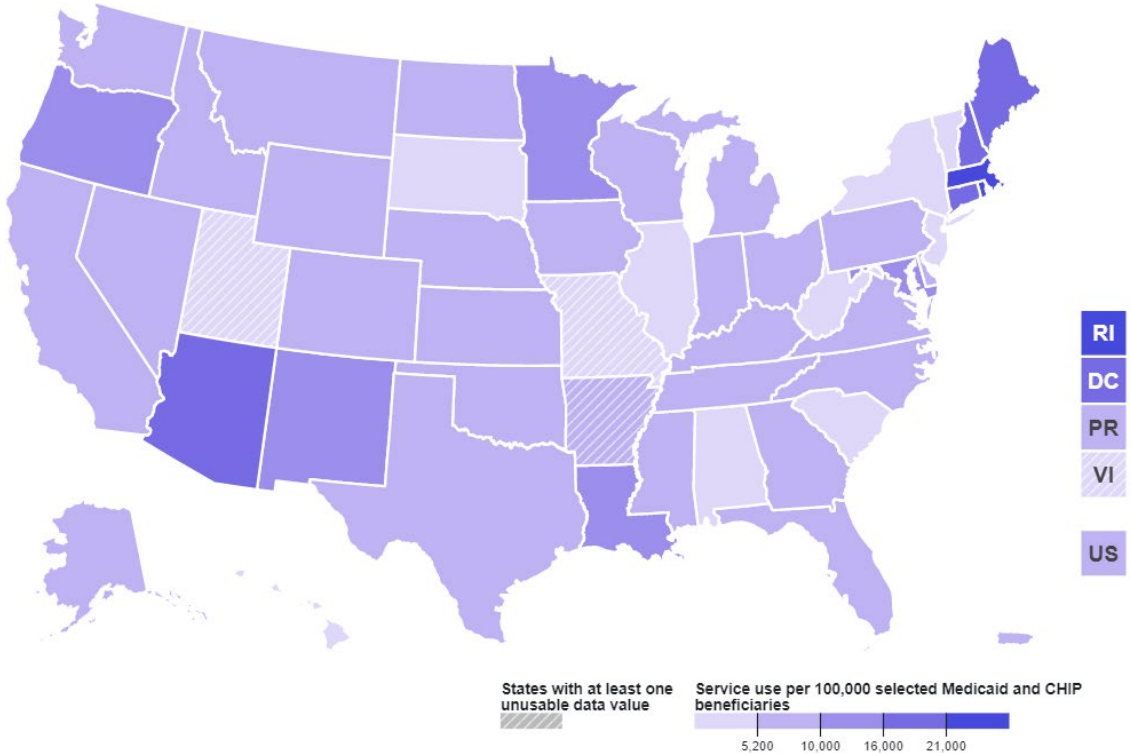
Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~23% fewer** (27.3 million) mental health services for children under age 19

Note: Data for recent months are likely to be adjusted upward due to claims lag.

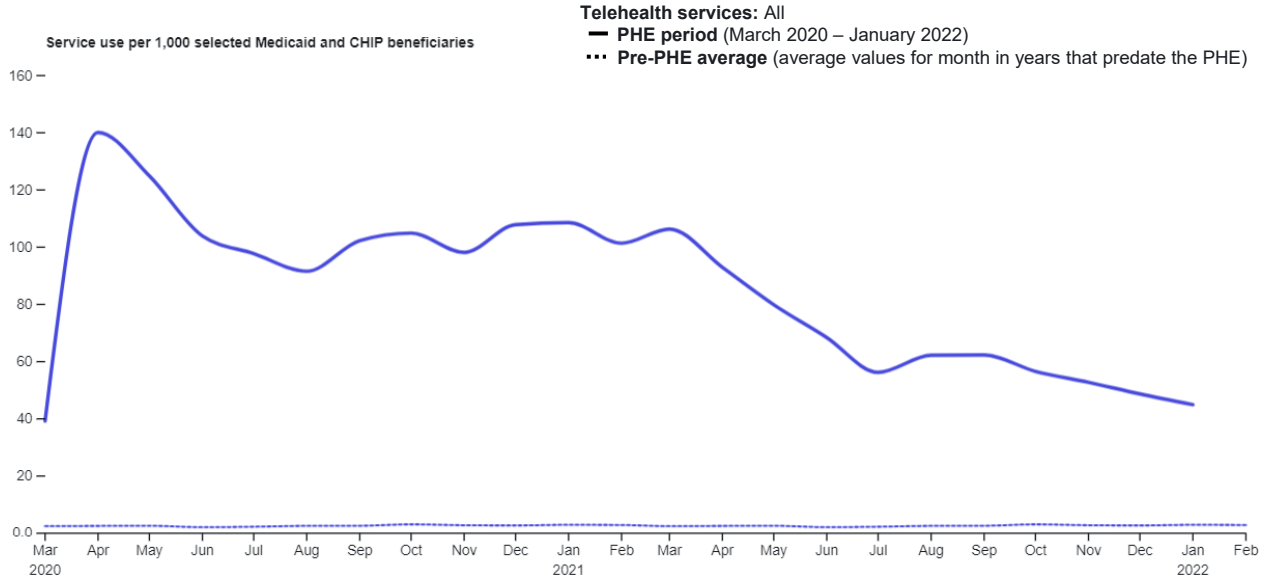
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show rates of services delivered via telehealth to children under age 19 during the PHE remained relatively steady from June 2020 to March 2021 and declined through January 2022

Average monthly rate of services delivered via telehealth per 100,000 beneficiaries under age 19 during the PHE



Number of services delivered via telehealth per 1,000 Medicaid and CHIP beneficiaries under age 19 during the PHE, by month



Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Services Delivered via Telehealth to Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency

Services delivered via telehealth in Medicaid and CHIP

To identify services delivered via telehealth, we used a combination of Current Procedural Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes, place of service codes, and procedure code modifiers.

Type of service delivered via telehealth	Description
Live audio/video	Real-time, two-way audiovisual connection between a patient and provider (synchronous)
Store and forward	Transmission of recorded health history to a provider (asynchronous)
Remote patient monitoring	Use of electronic tools to monitor and record a patient's physiological status which then transmit the data to a provider in a setting other than where the patient is physically located
Other telehealth visits	Any other services delivered via telehealth

Use of telehealth during the COVID-19 PHE: Key highlights

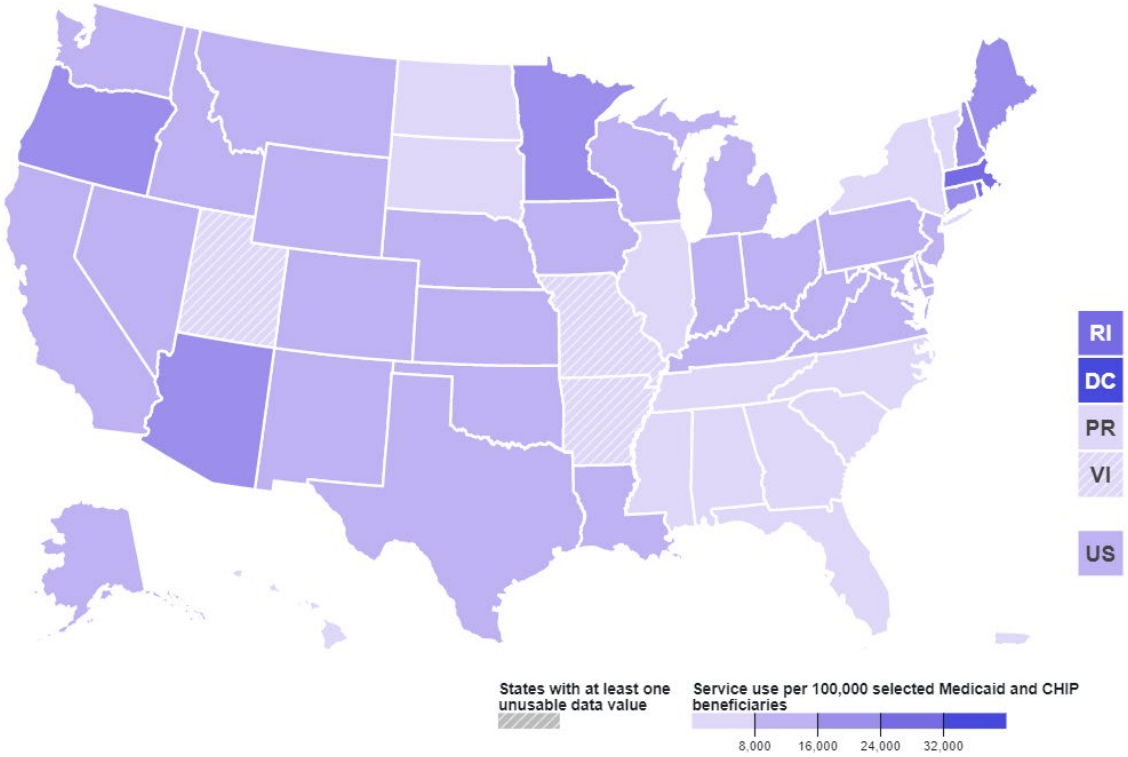
Preliminary data suggest that, during the PHE:

- In the US, among all age groups, the rate of services delivered through telehealth during the PHE remain considerably higher than pre-PHE levels but have generally declined since April 2020.
- Services delivered through telehealth per 100,000 beneficiaries were highest among adults ages 19 to 64, while children under age 19 and adults age 65 and older had lower, comparable rates.
- These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. Most beneficiaries ages 65 and older are likely to be dually eligible for both Medicare and Medicaid, and the results for this age group likely underestimate telehealth use among older adults.

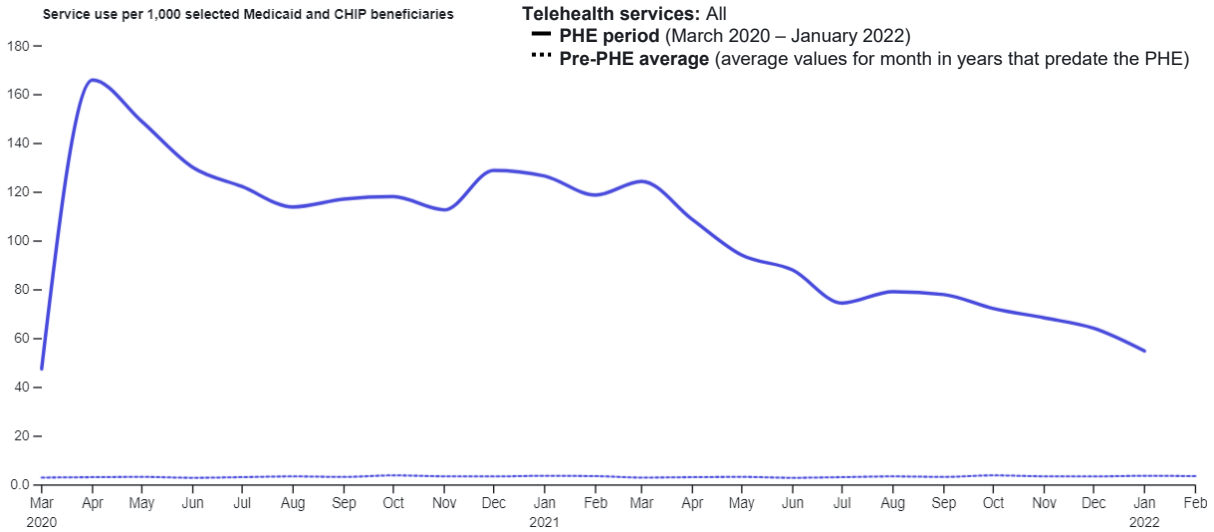
Preliminary data show rates of services delivered through telehealth peaked in April 2020, stabilized from June 2020 through March 2021, and then decreased through January 2022

Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show 205,145,099 more services delivered through telehealth, an increase of 3,095%

Average monthly rate of services delivered via telehealth per 100,000 Medicaid and CHIP beneficiaries during the PHE



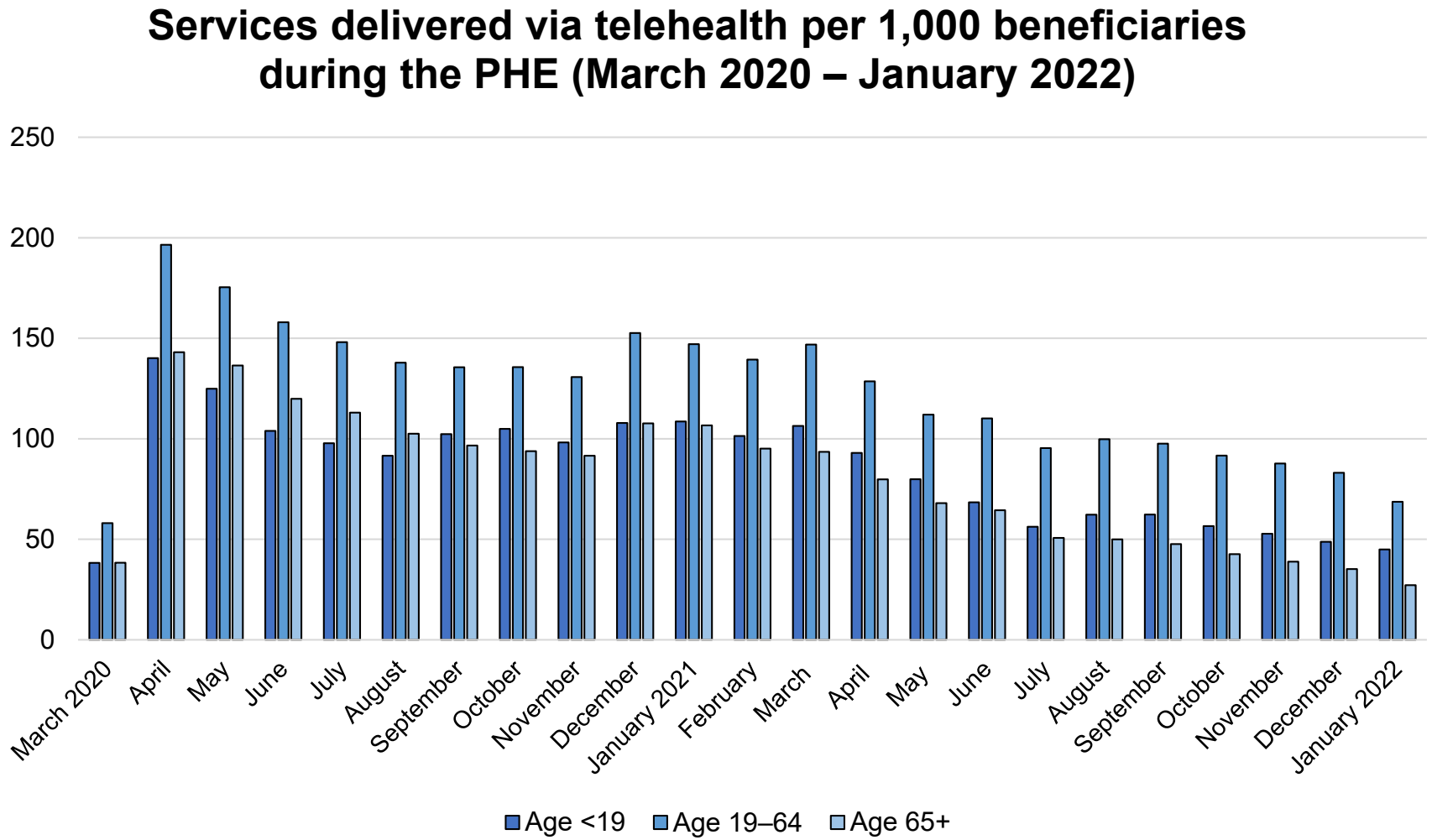
Number of services delivered via telehealth per 1,000 Medicaid and CHIP beneficiaries during the PHE, by month



Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data suggest that services delivered through telehealth increased for beneficiaries of all age groups during the PHE, but were highest among the 19 to 64 age group



Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. Many beneficiaries age 65 and older are likely to be dually eligible for both Medicare and Medicaid and the results for this age group likely underestimate telehealth utilization among older adults.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Services for Mental Health and Substance Use Disorders Among Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency

Mental health and substance use care in Medicaid and CHIP

- Medicaid is the largest payer for behavioral health services, including both mental health and SUD services, in the US.[1]
- Individuals suffering from mental health conditions or SUD face many challenges accessing care and often do not seek treatment.[2,3]
- As of 2019, nearly a quarter of adult Medicaid and CHIP beneficiaries received mental health or SUD services. Nearly four times as many beneficiaries received mental health services as compared to SUD services.[4]

1. Nardone, M., Snyder, S., and Paradise, J. "Integrating Physical and Behavioral Health Care: Promising Medicaid Models." Menlo Park, CA: The Kaiser Commission on Medicaid and the Uninsured, 2014. Available at https://www.kff.org/wp-content/uploads/2014/02/8553-integrating-physical-and-behavioral-health-care-promising-medicaid-models.pdf.

2. Medicaid and CHIP Payment and Access Commission. "Chapter 2: Medicaid and the Opioid Epidemic." In *June 2017 Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC, 2017. Available at https://www.macpac.gov/wp-content/uploads/2017/06/June-2017-Report-to-Congress-on-Medicaid-and-CHIP.pdf. Accessed October 19, 2020.

3. Mojtabai, R., Olfson, M., Sampson, N. A., Jin, R., Druss, B., Wang, P. S., ... & Kessler, R. C. (2011). Barriers to mental health treatment: results from the National Comorbidity Survey Replication (NCS-R). *Psychological medicine*, *41*(8), 1751.

4. Mathematica analysis of 2019 TAF data. October 2020.

Mental health and substance use disorders during the COVID-19 PHE

- Preliminary evidence suggests a sharp increase in the number of adults reporting adverse mental or behavioral health conditions during the COVID-19 pandemic compared to prior years.[1]
- Survey data indicate that racial and ethnic minority groups are experiencing higher rates of depression, substance use, and self-reported suicidal thoughts/ideation during the COVID-19 pandemic.[2]
- Similarly, preliminary evidence indicates an increase in drug-related mortality during the COVID-19 pandemic.[3]

1. Czeisler MÉ , Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24 – 30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049 – 1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

2. McKnight-Eily LR, Okoro CA, Strine TW, et al. Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic — United States, April and May 2020. MMWR Morb Mortal Wkly Rep 2021;70:162 – 166. Available at: https://www.cdc.gov/mmwr/volumes/70/wr/mm7005a3.htm.

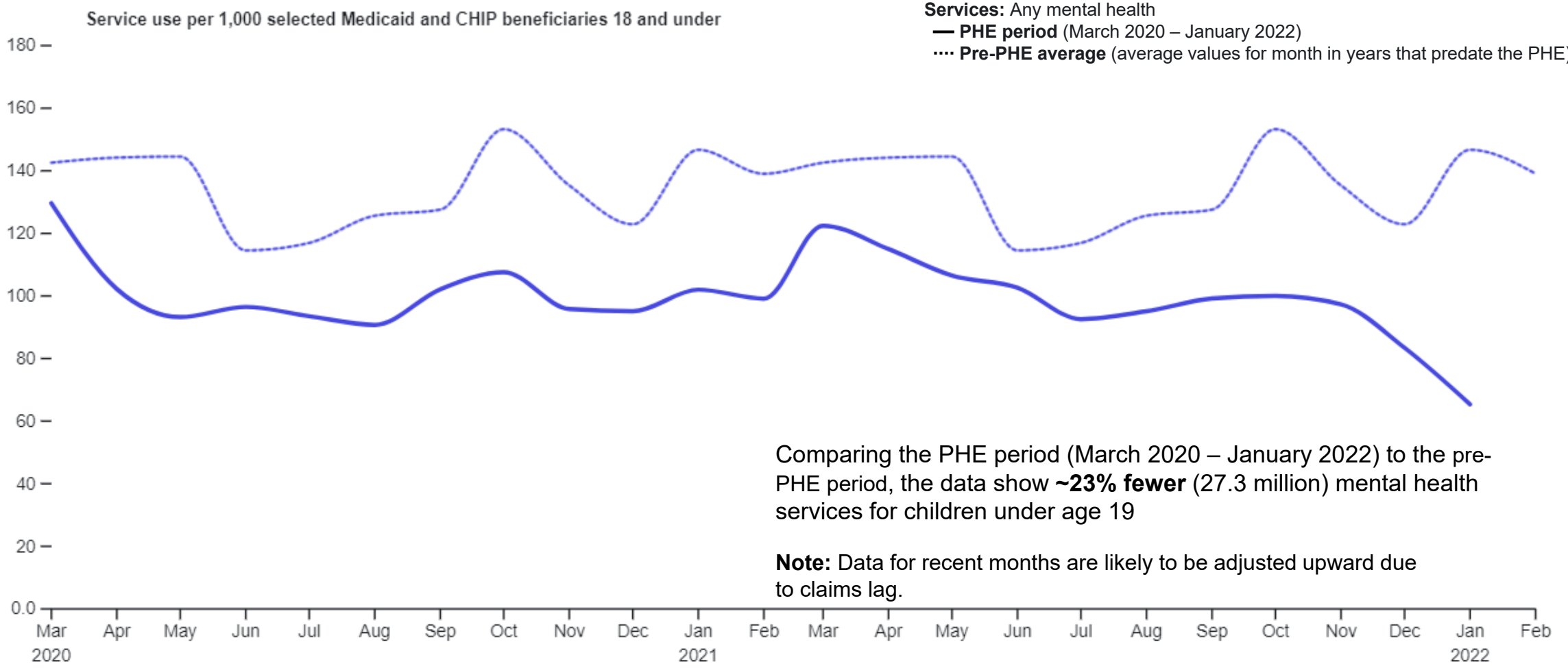
3. Centers for Disease Control and Prevention (CDC). "Press Release: Overdose Deaths Accelerating During COVID-19." December 17, 2020. Available at: Overdose Deaths Accelerating During COVID-19 | CDC Online Newsroom | CDC.

Mental health and SUD service use during the COVID-19 PHE: Key highlights

Preliminary data suggest that, during the PHE:

- Mental health services for beneficiaries under age 65 and SUD services for adolescents ages 15 to 18 declined throughout the PHE and were consistently lower than prior years' levels.
- The number of substance use disorder (SUD) services for adults ages 19 to 64 declined during the beginning of the PHE period and nearly recovered to prior years' levels by June 2020.
- For adults ages 19 to 64, the differences in the rates of mental health and SUD services per 1,000 beneficiaries during the PHE compared to pre-PHE levels were larger than the differences in counts of services provided. This trend likely reflects increases in the number of beneficiaries in adult eligibility groups during the PHE despite a steady volume of services provided.
- Behavioral health services delivered through telehealth increased dramatically during the PHE. However, delivery of certain services via telehealth, such as intensive outpatient and partial hospitalizations for SUD, may not be appropriate to deliver via telehealth, and poses a unique challenge for care delivery during the PHE.

Preliminary data show the rate of mental health services for children under age 19 generally declined throughout the PHE and remained below pre-PHE levels

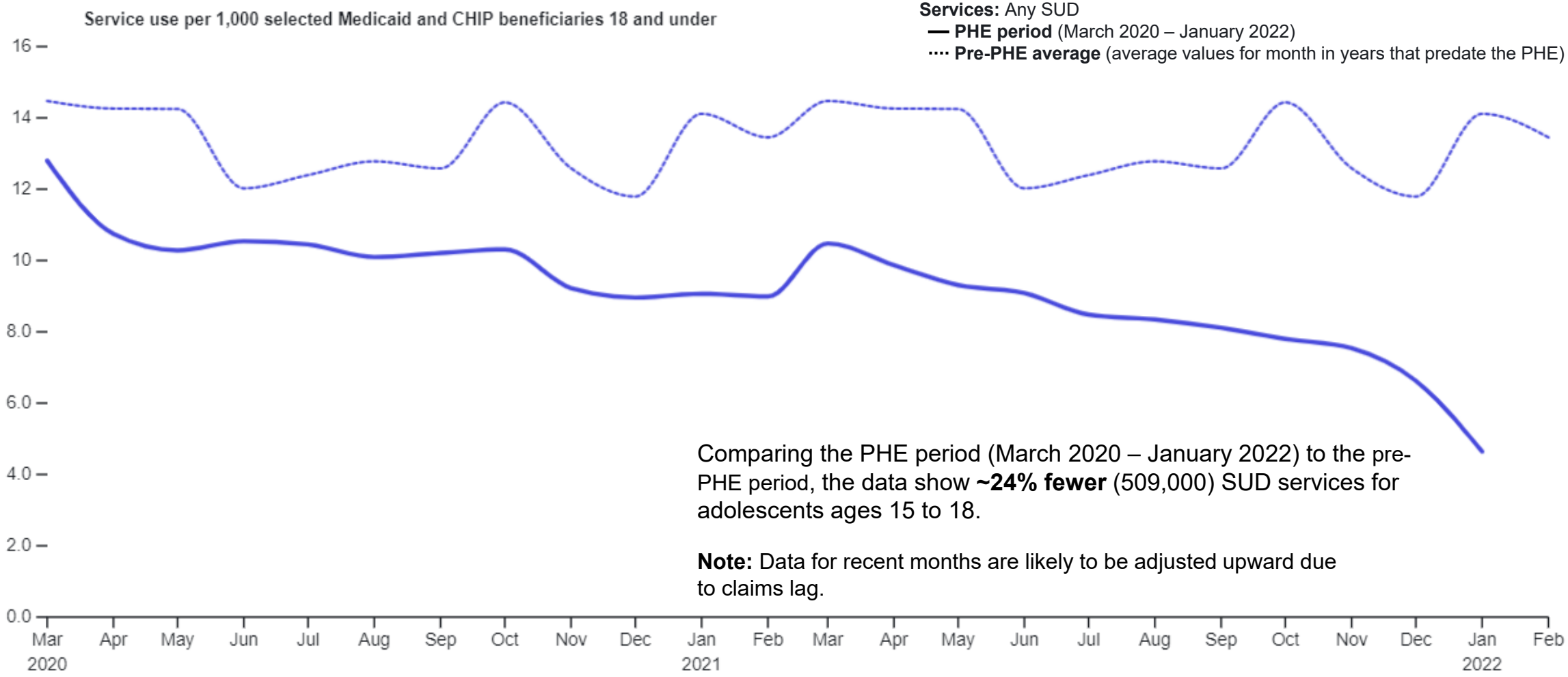


Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~23% fewer** (27.3 million) mental health services for children under age 19

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the rate of SUD services for adolescents ages 15 to 18 generally declined throughout the PHE and remained below pre-PHE levels



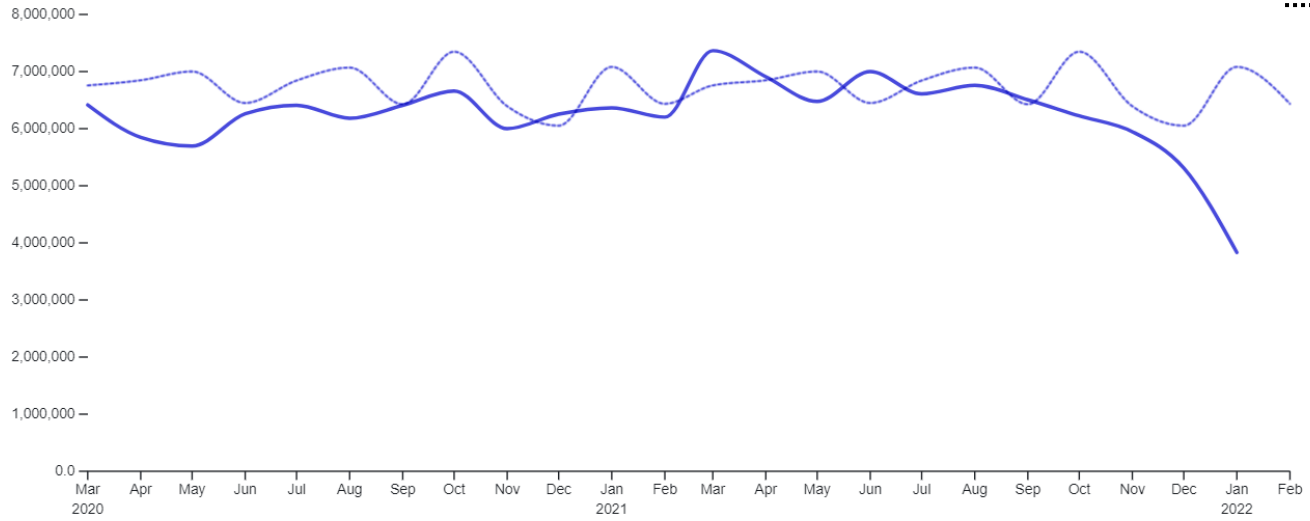
Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~24% fewer** (509,000) SUD services for adolescents ages 15 to 18.

Note: Data for recent months are likely to be adjusted upward due to claims lag.

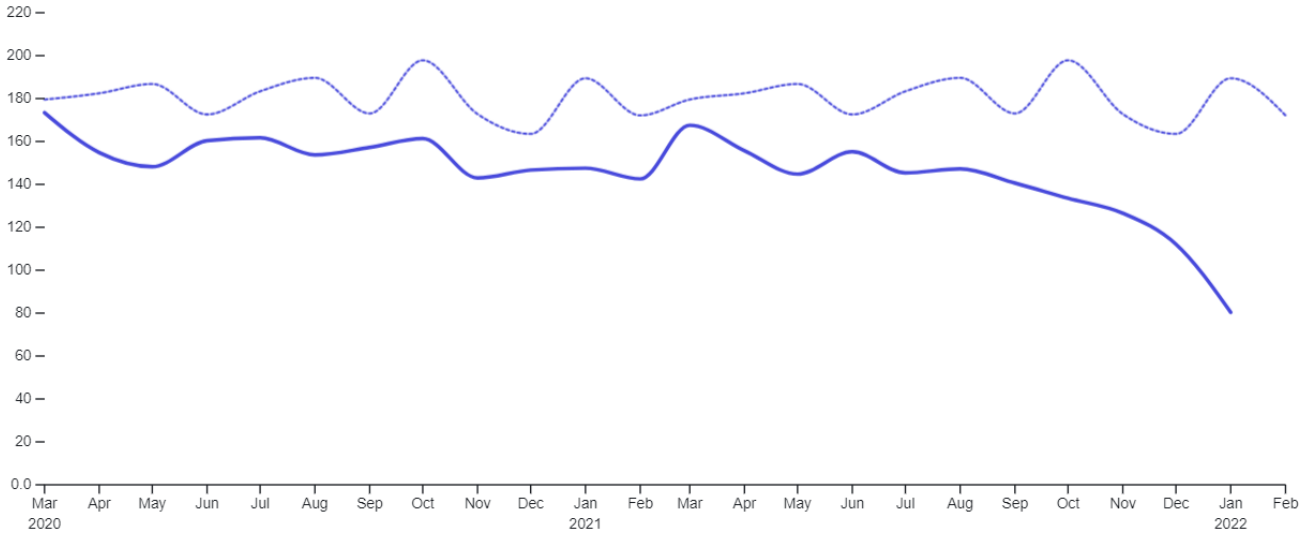
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the volume of mental health services for adults ages 19 to 64 during the PHE were close to pre-PHE levels, but the gap in the rate of services grew, likely due to increased enrollment

Number of mental health services among Medicaid and CHIP beneficiaries, ages 19-64



Number of mental health services per 1,000 Medicaid and CHIP beneficiaries, ages 19-64



Services: Any mental health
— **PHE period** (March 2020 – January 2022)
···· **Pre-PHE average** (average values for month in years that predate the PHE)

Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~7% fewer** (11.5 million) mental health services for adults ages 19 to 64.

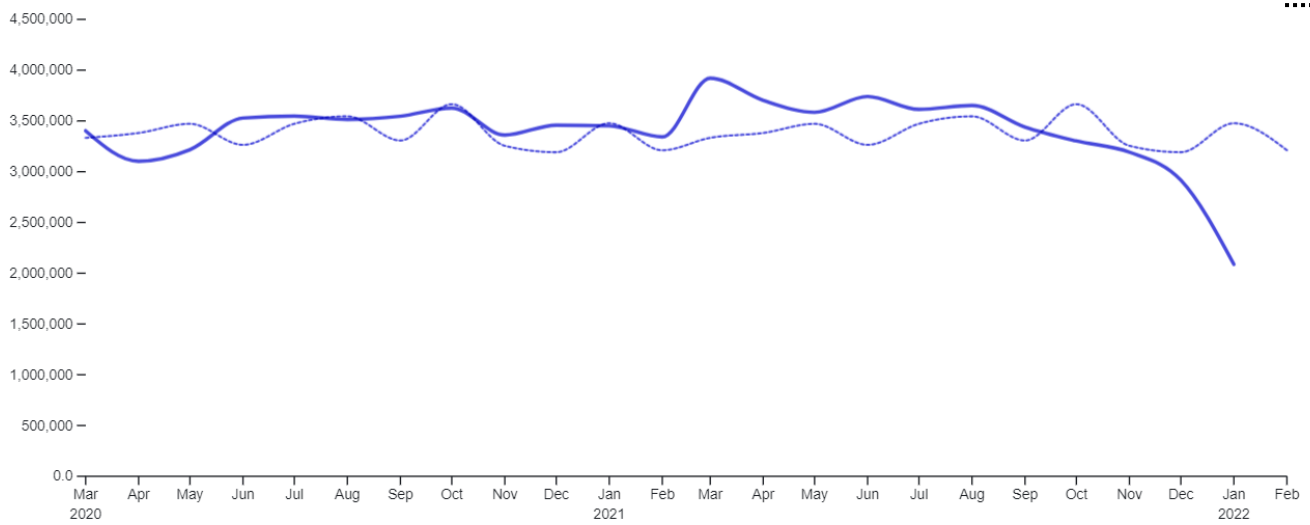
The average monthly rate of mental health services per 1,000 beneficiaries is **~19% lower** during the PHE period.

Note: Data for recent months are likely to be adjusted upward due to claims lag. The top figure displays the monthly count of services, and the bottom figure displays the monthly service use rate per 1,000 beneficiaries. The PHE period rate may not be directly comparable to the pre-PHE average rate since, for some states, there are increased suspensions of eligibility redeterminations during the PHE, which may inflate the denominator Medicaid population.

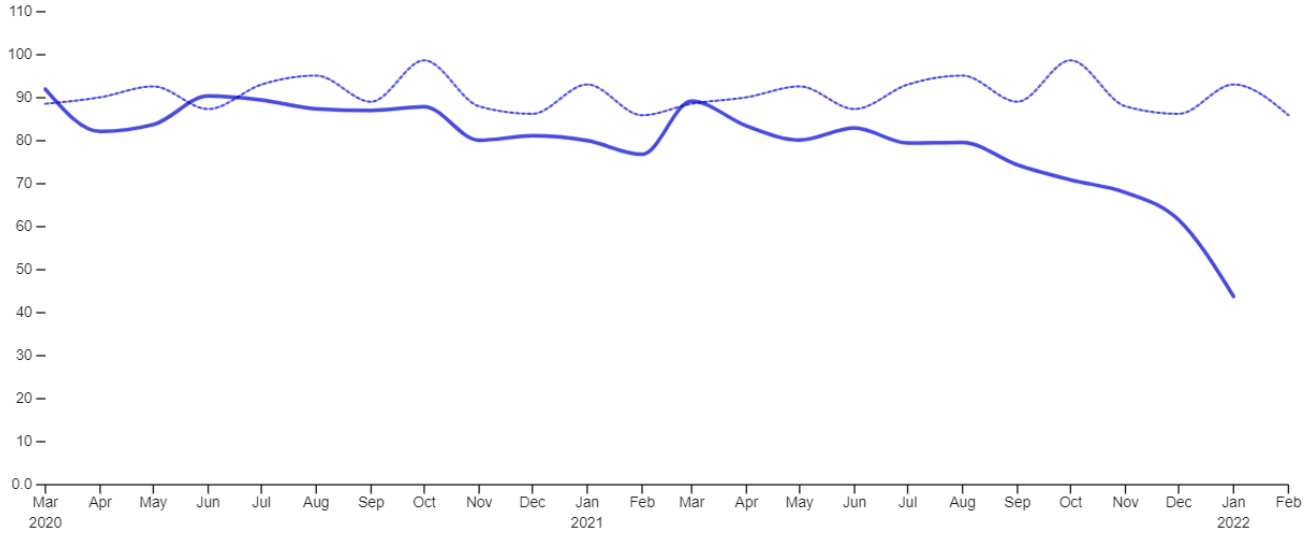
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the volume of SUD services for adults ages 19 to 64 during the PHE were close to pre-PHE levels, but the gap in the rate of services grew, likely due to increased enrollment

Number of SUD services among Medicaid and CHIP beneficiaries, ages 19-64



Number of SUD services per 1,000 Medicaid and CHIP beneficiaries, ages 19-64



Services: Any SUD service
— **PHE period** (March 2020 – January 2022)
···· **Pre-PHE average** (average values for month in years that predate the PHE)

Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~0.2% more** (135,000) SUD services for adults ages 19 to 64.

The average rate of SUD services per 1,000 beneficiaries is **~13% lower** during the PHE period.

Note: Data for recent months are likely to be adjusted upward due to claims lag. The top figure displays the monthly count of services, and the bottom figure displays the monthly service use rate per 1,000 beneficiaries. The PHE period rate may not be directly comparable to the pre-PHE average rate since, for some states, there are increased suspensions of eligibility redeterminations during the PHE, which may inflate the denominator Medicaid population.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Reproductive Health Services for Female Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency

Medicaid and CHIP coverage of pregnant women and maternity care

- Medicaid is the largest payer for maternity care in the United States, covering more than 4 in 10 births. Nearly two of every three adult women enrolled in Medicaid are of reproductive age (ages 19 to 44).[1]
- As a response to the COVID-19 PHE, Congress passed the Families First Coronavirus Response Act, which includes a federal funding increase for state Medicaid agencies that meet certain conditions, including a maintenance of eligibility requirement pregnant women. During the PHE, women who reach the end of the 60-day postpartum period could remain enrolled in Medicaid.[2]

1. Martin JA, Hamilton BE, Osterman MJK. Births in the United States, 2019. NCHS Data Brief, no 387. Hyattsville, MD: National Center for Health Statistics. 2020.

2. H.R.1319 - American Rescue Plan Act of 2021. More information is available at: https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-HD0A062309C1143928EF82EC5845217C3/.

Reproductive health care services in Medicaid and CHIP

- Medicaid and CHIP also cover a variety of reproductive health care services, including prenatal services, deliveries, and postpartum services, as well as family planning services and contraceptive methods, such as long-acting reversible contraception (LARC).
- Maternity care services, including prenatal care, delivery, and postpartum care, can be billed either separately for each service or as a “bundle” of services with a bundled payment procedure code.
- Prenatal and postpartum care are essential to improve maternal and perinatal health outcomes and address pregnancy-related health disparities.[1]

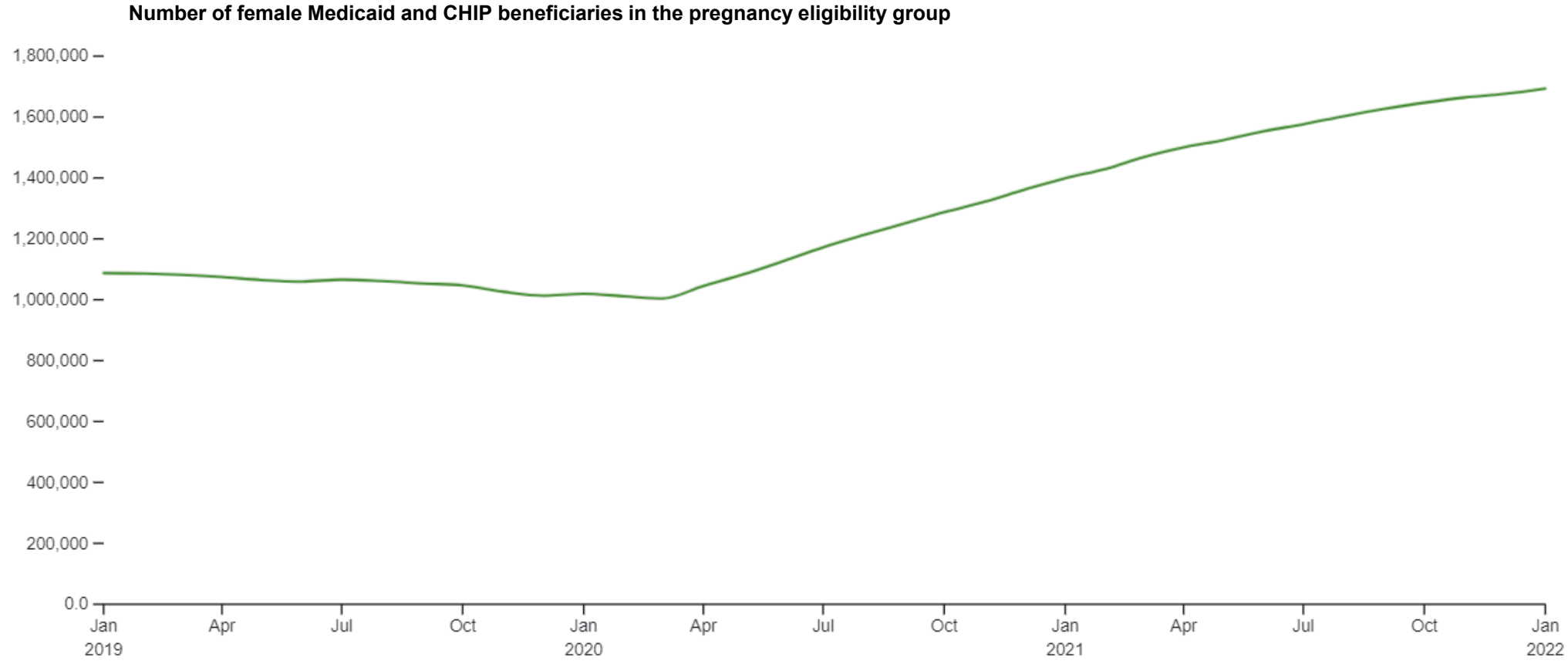
1. More information is available at: Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health December 2020.

Reproductive health service use among women during the COVID-19 PHE: Key highlights

Preliminary data suggest that, during the PHE:

- The number of Medicaid and CHIP beneficiaries in the pregnant eligibility group steadily increased since April 2020.
- The volume of contraceptives and long-activing reversible contraception delivered during the PHE were close to pre-PHE levels, but the gap in the rate of contraceptives continued to grow.
- The volume of live births during the PHE were lower than prior years' levels, while the volume of miscarriages and stillbirths are now higher than the pre-PHE period.
- The number of beneficiaries in adult eligibility groups increased, especially for pregnant women and expansion adults. Despite this trend, reproductive health service use declined or remained steady during the PHE.
- Perinatal services including prenatal and postpartum visits and bundled payments tracked closely with pre-PHE levels or declined.

Preliminary data show that the number of Medicaid and CHIP beneficiaries in the pregnant eligibility group steadily increased starting in April 2020 and continued through January 2022

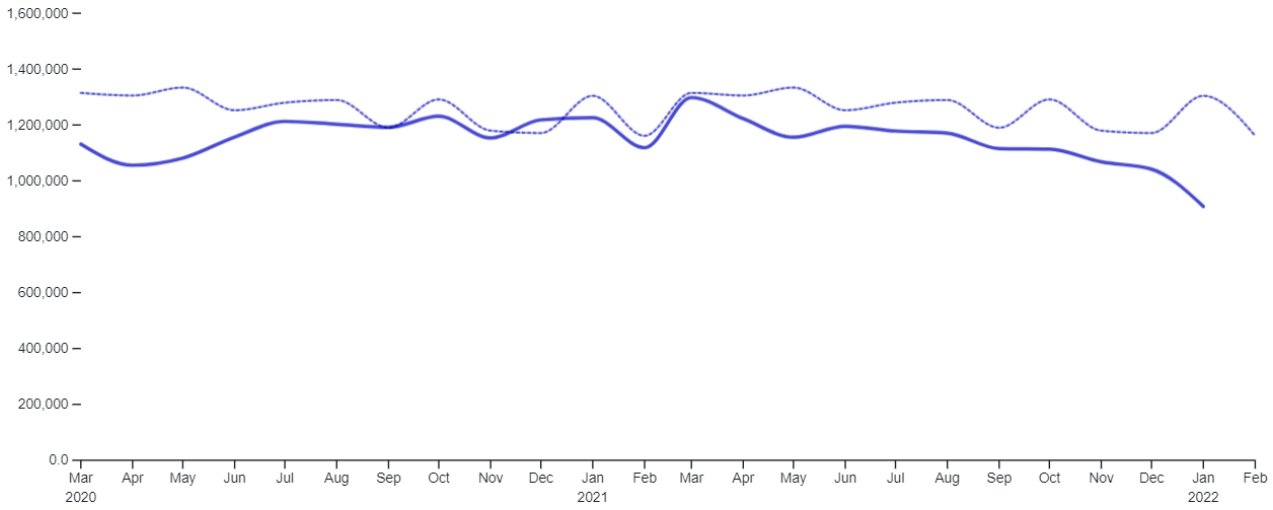


Comparing January 2022 to February 2020, the data show **~67% more** (682,000) beneficiaries in the pregnant eligibility group. Steady increases in pregnancy eligibility enrollment during the PHE is likely due in part to maintenance of effort requirements under the CARES Act Program to ensure continuous coverage for 12 months after a delivery.

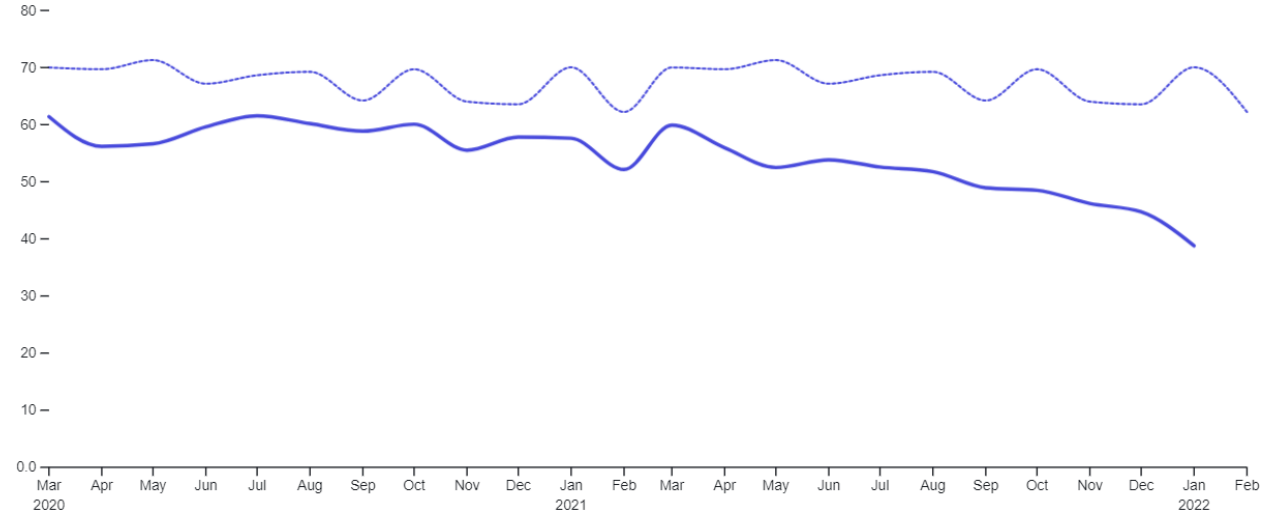
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect. They are based on March T-MSIS submissions with enrollment through the end of February. Recent dates of enrollment have very little time for runout and we expect some changes in enrollment after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022.

Preliminary data show the volume of contraceptives provided during the PHE are close to pre-PHE levels, but the gap in the rate of services grew, likely due to increased enrollment

Number of contraceptives provided among female Medicaid and CHIP beneficiaries, ages 15-44



Number of contraceptive services provided per 1,000 female Medicaid and CHIP beneficiaries, ages 15-44



Services: Any contraceptive
— **PHE period** (March 2020 – January 2022)
···· **Pre-PHE average** (average values for month in years that predate the PHE)

Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~9% fewer** (2.5 million) contraceptives provided to women ages 15 to 44.

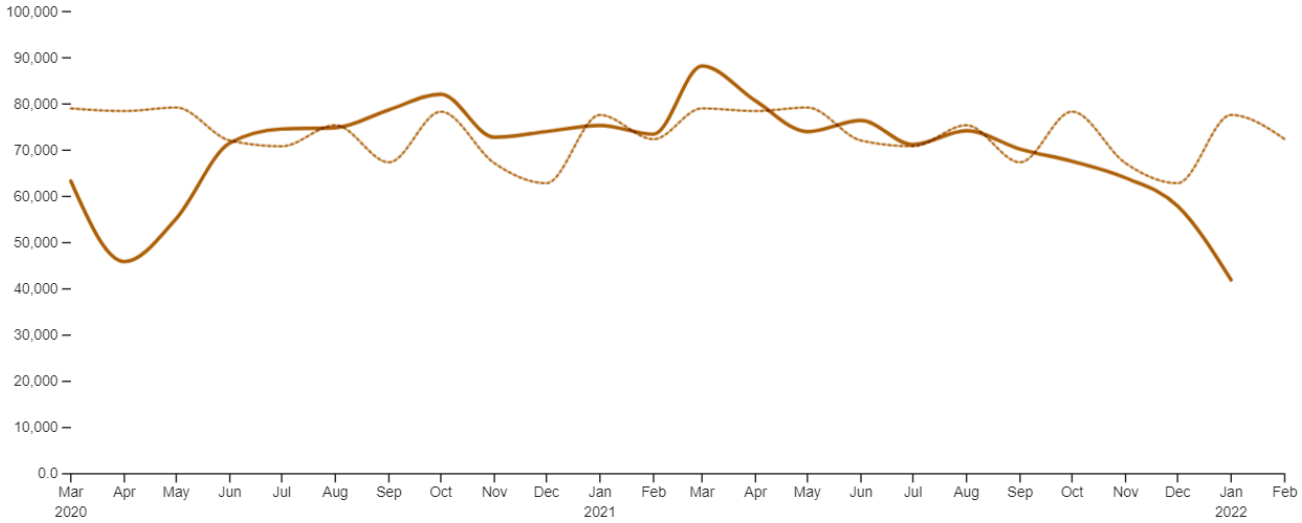
The average rate of contraceptive services provided per 1,000 female beneficiaries is **~20% lower** during the PHE period.

Note: Data for recent months are likely to be adjusted upward due to claims lag. The top figure displays the monthly count of services, and the bottom figure displays the monthly service use rate per 1,000 beneficiaries. The PHE period rate may not be directly comparable to the pre-PHE average rate since, for some states, there are increased suspensions of eligibility redeterminations during the PHE, which may inflate the denominator Medicaid population.

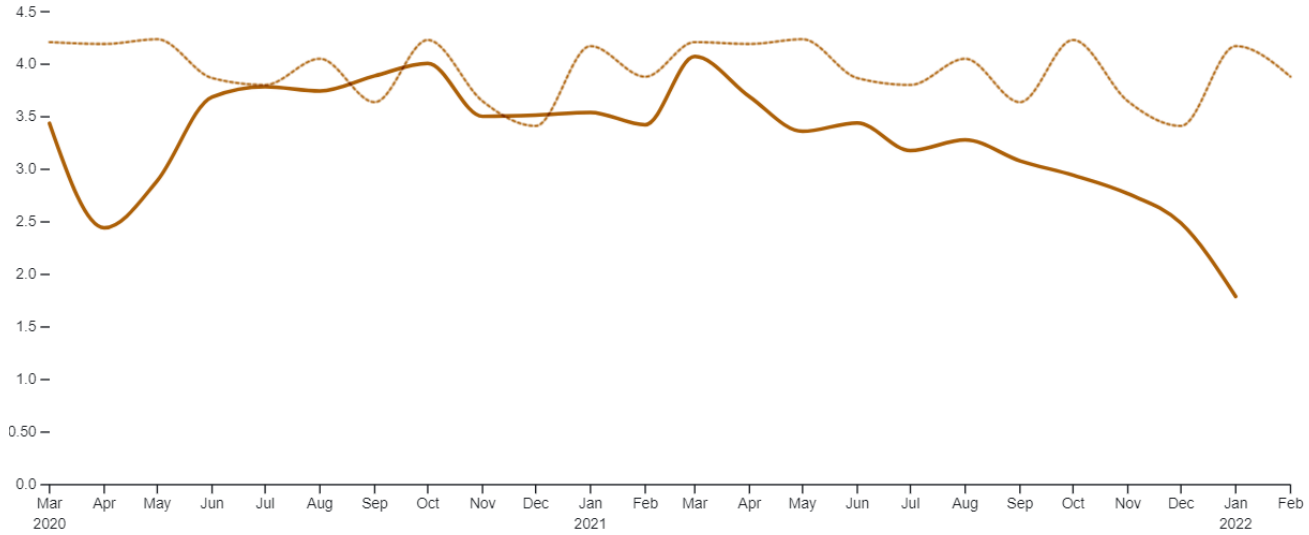
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the volume of long-acting reversible contraceptives (LARC) provided during the PHE is close to pre-PHE levels, but the decline in the rate of services grew, likely due to increased enrollment.

Number of LARCs provided among female Medicaid and CHIP beneficiaries, ages 15-44



Number of LARCs provided per 1,000 female Medicaid and CHIP beneficiaries, ages 15-44



Services: Any contraceptive
— **PHE period** (March 2020 – January 2022)
···· **Pre-PHE average** (average values for month in years that predate the PHE)

Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~5% fewer** (84,000) LARCs provided to women ages 15 to 44.

The average rate of LARCs provided per 1,000 female beneficiaries is **~17% lower** during the PHE period.

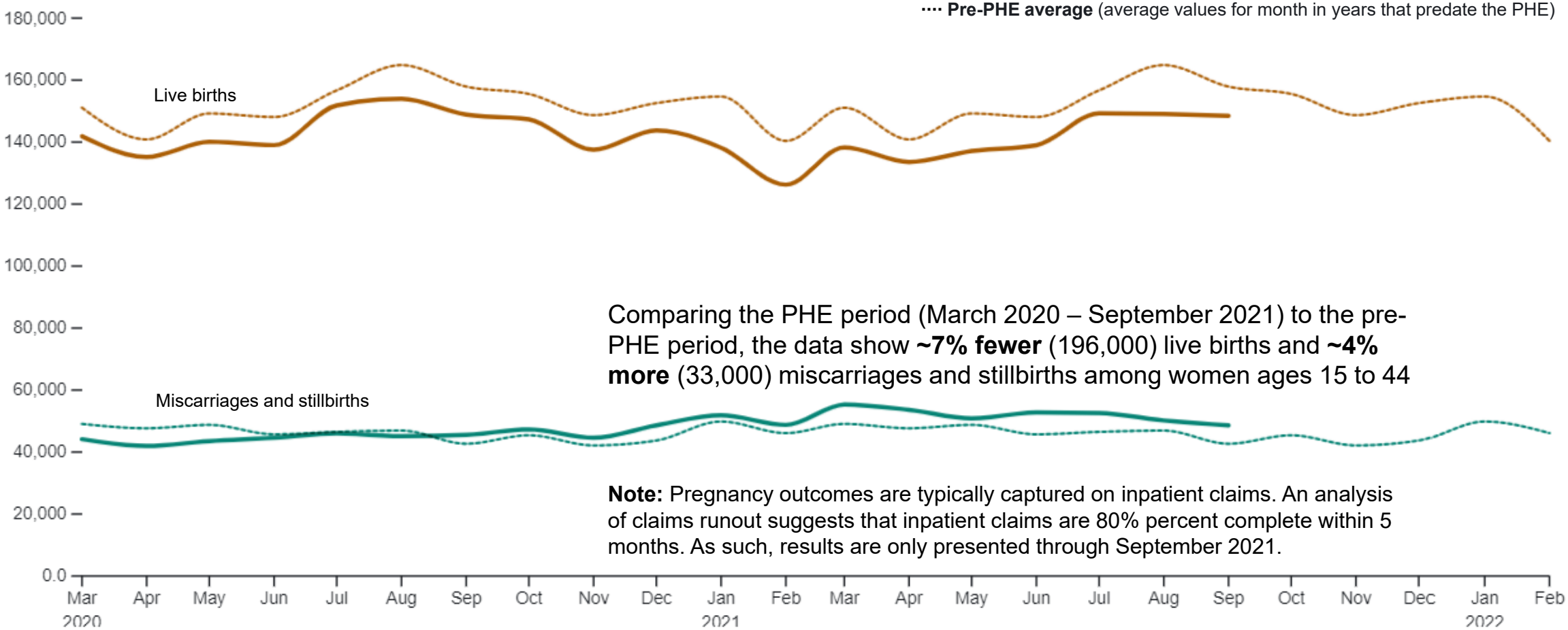
Note: Data for recent months are likely to be adjusted upward due to claims lag. The top figure displays the monthly count of services, and the bottom figure displays the monthly service use rate per 1,000 beneficiaries. The PHE period rate may not be directly comparable to the pre-PHE average rate since, for some states, there are increased suspensions of eligibility redeterminations during the PHE, which may inflate the denominator Medicaid population.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the volume of live births was lower during the PHE as compared to the pre-PHE period, whereas the volume of miscarriages and stillbirths was slightly above pre-PHE levels

Number of pregnancies among female Medicaid and CHIP beneficiaries, ages 15-44

Pregnancy outcomes: Live births, Miscarriages / stillbirths
— **PHE period** (March 2020 – September 2021)
···· **Pre-PHE average** (average values for month in years that predate the PHE)



Comparing the PHE period (March 2020 – September 2021) to the pre-PHE period, the data show **~7% fewer** (196,000) live births and **~4% more** (33,000) miscarriages and stillbirths among women ages 15 to 44

Note: Pregnancy outcomes are typically captured on inpatient claims. An analysis of claims runout suggests that inpatient claims are 80% percent complete within 5 months. As such, results are only presented through September 2021.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because inpatient data are incomplete for at least 5 months, results are only presented through September 31, 2020. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

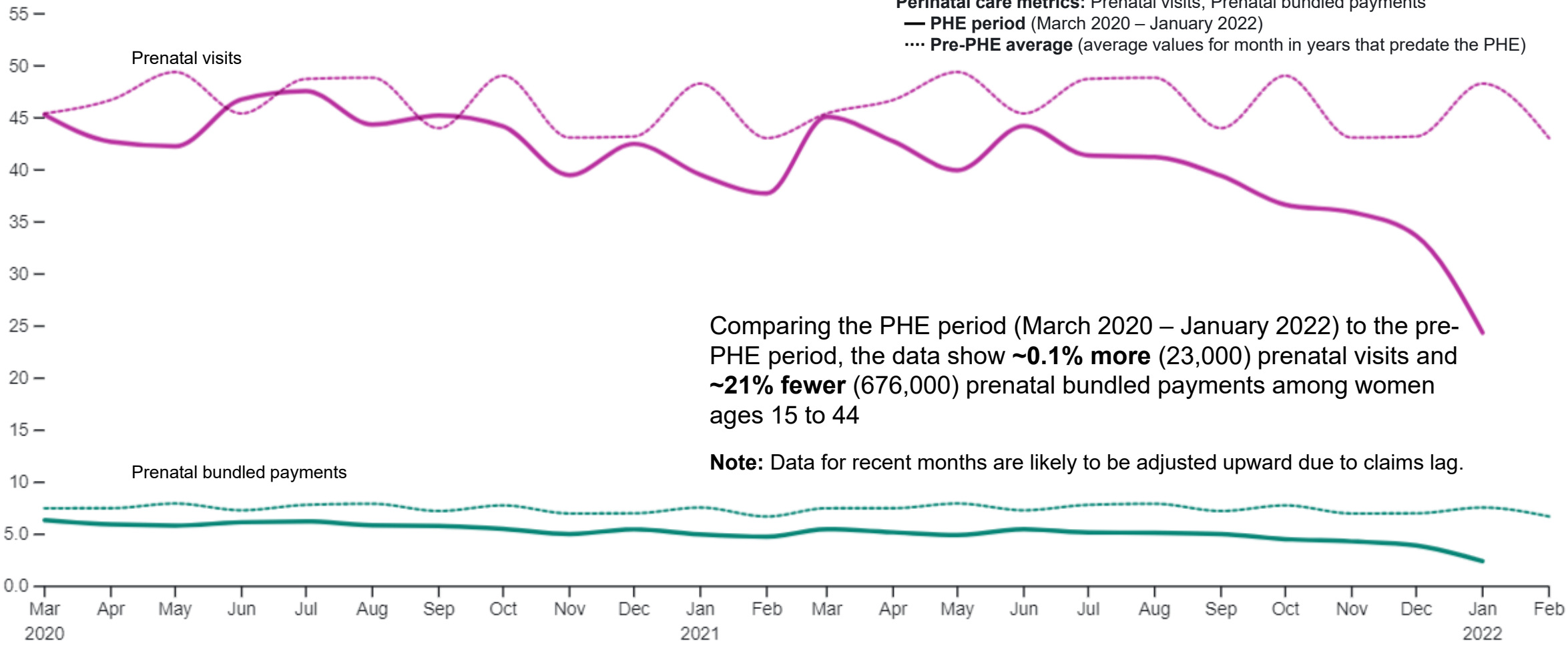
Counting prenatal and postpartum services

- Maternity care services can be billed either separately for each service or as a “bundle” of services with a bundled payment procedure code.
- There are two types of bundled payment codes: (1) those that include standard prenatal care and the mother’s charges for an uncomplicated delivery and postpartum care, and (2) those that include only the mother’s charges for an uncomplicated delivery and postpartum care. Both types of codes are used in all states, but there is considerable variation across states in how frequently they are used.
- In states that frequently use bundled payment codes that include prenatal services or postpartum services, researchers cannot assess the quality or use of prenatal and postpartum care.[1] As a result, the following perinatal care measures are likely an undercount of prenatal and postpartum services among women ages 15 to 44 in states where perinatal services are billed together as bundled payments.

1. More information about the use of bundled payment codes to bill for maternity services in TAF is available at: Bundled Payments for Prenatal Care (Medicaid.gov DQ Atlas).

Preliminary data show the rate of prenatal visits declined in April 2020 and approached pre-PHE levels in early 2021, whereas the rate of prenatal bundled payments remained below pre-PHE levels through January 2022

Number of perinatal care services per 1,000 female Medicaid and CHIP beneficiaries, ages 15-44



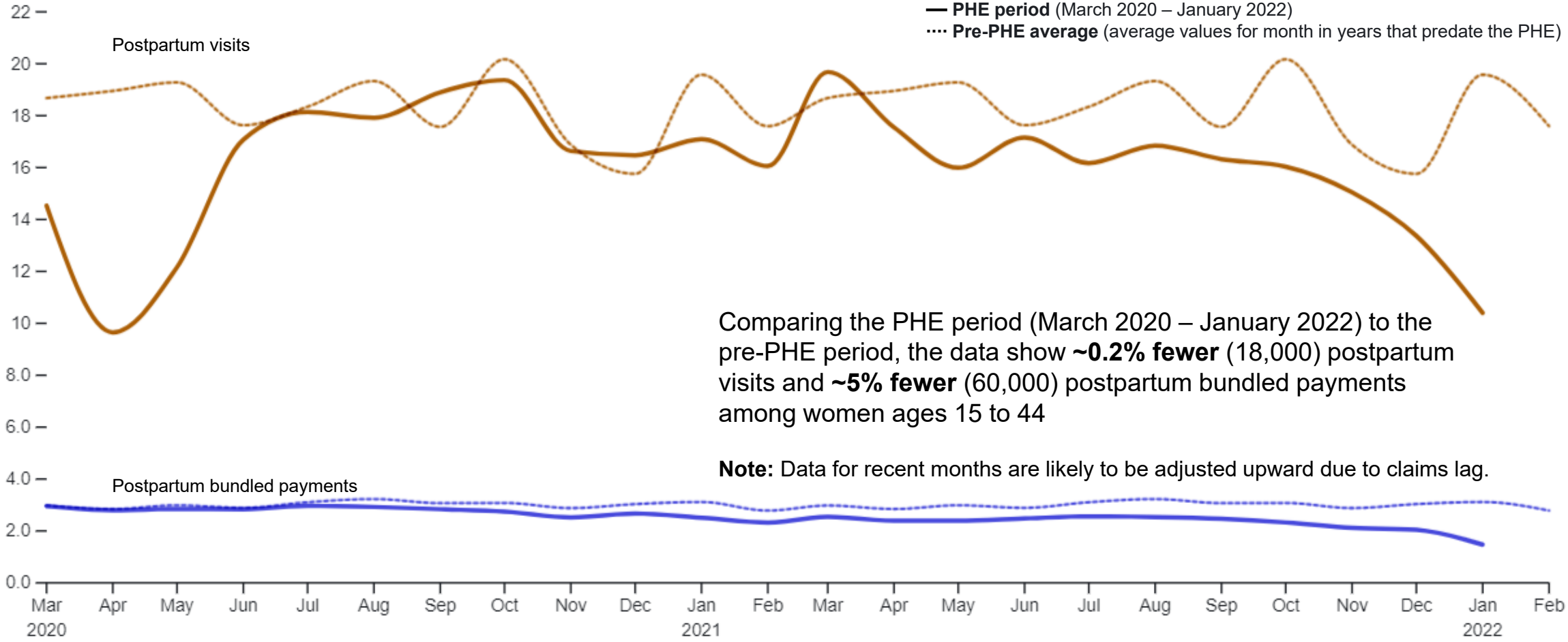
Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~0.1% more** (23,000) prenatal visits and **~21% fewer** (676,000) prenatal bundled payments among women ages 15 to 44

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020. This measure is likely an undercount of prenatal services among women ages 15 to 44 in states where perinatal services are billed together as bundled payments.

Preliminary data show the rate of postpartum visits declined in April 2020 and rebounded through March 2021, whereas the rate of postpartum bundled payments remained steady, though overall both are slightly below pre-PHE levels

Number of perinatal care services per 1,000 female Medicaid and CHIP beneficiaries, ages 15-44



Comparing the PHE period (March 2020 – January 2022) to the pre-PHE period, the data show **~0.2% fewer** (18,000) postpartum visits and **~5% fewer** (60,000) postpartum bundled payments among women ages 15 to 44

Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020. This measure is likely an undercount of prenatal services among women ages 15 to 44 in states where perinatal services are billed together as bundled payments.

Appendix: State-level Average Monthly Rate Tables

Appendix Table 1. Average monthly rate of COVID-19 treatment and COVID-19 hospitalizations per 100,000 beneficiaries

State	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE
United States	**574.22**	**372.56**	**27.49**	**3.25**
Alaska	491.60	388.86	18.07	2.95
Alabama	427.64	420.26	15.29	2.30
Arkansas	549.81	517.25	20.51	2.89
Arizona	594.82	312.85	38.07	3.90
California	467.65*	234.38*	21.82*	1.87*
Colorado	483.63	250.97	26.88	4.06
Connecticut	809.63	595.68	34.50	3.57
District of Columbia	802.33*	1,083.42*	34.43	4.73
Delaware	591.95	407.87	19.11	2.76
Florida	497.33	358.02	30.90	4.35
Georgia	550.14	369.74	25.04	3.64
Hawaii	247.69	204.18	14.61	1.26
Iowa	641.77	378.16	21.14	2.61
Idaho	624.22	367.44	25.05	2.59
Illinois	540.43	254.95	37.94	3.22
Indiana	572.25	290.72	27.74	2.21
Kansas	534.54	282.20	18.48	2.91
Kentucky	800.39	563.67	27.08	3.04
Louisiana	915.06	671.80	34.54	3.81
Massachusetts	793.26	423.50	43.96	2.67
Maryland	633.91	377.31	28.45	3.45
Maine	367.81	298.40	16.70	1.10
Michigan	579.91	351.85	22.42	3.69
Minnesota	651.58	341.12	34.59	3.27
Missouri	539.73*	311.53*	28.57*	3.46*
Mississippi	876.05	702.26	37.68	3.64
Montana	501.22	289.77	29.25	3.01
North Carolina	465.14	382.31	22.30	3.87
North Dakota	537.72	312.83	33.54	4.81
Nebraska	607.51	359.67	30.01	3.24
New Hampshire	557.77	518.56	18.10	1.51
New Jersey	967.15	484.56	41.87	3.10
New Mexico	730.32	520.29	32.65	4.11

State	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE
Nevada	480.85	210.79	37.33	4.48
New York	698.60	475.46	37.30	4.45
Ohio	617.77	299.60	37.19	3.51
Oklahoma	674.51	480.32	27.07	4.42
Oregon	375.51	258.43	18.28	1.88
Pennsylvania	595.59	299.55	29.01	3.63
Puerto Rico	345.20*	340.87*	5.29*	2.29*
Rhode Island	548.12	357.48	13.34	1.92
South Carolina	448.41	455.20	15.71	2.99
South Dakota	696.62	439.23	34.03	3.36
Tennessee	543.75	390.17	19.07	2.67
Texas	586.40	466.22	23.40	4.15
Utah	515.86	284.69	21.05	3.04
Virginia	566.29	386.92	24.19	1.97
Virgin Islands	156.42*	79.17*	9.84*	1.12*
Vermont	335.45	345.33	9.61	1.08
Washington	397.96	275.83	18.37	1.63
Wisconsin	459.52	292.85	25.08	2.48
West Virginia	505.39	347.63	27.60	2.17
Wyoming	651.02	384.14	33.35	3.30

Note: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022.

* indicates state's data include at least one unusable data value.

Appendix Table 2. Average monthly rate of COVID-19 tests or testing related services and services delivered through telehealth per 100,000 beneficiaries

State	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of services delivered through telehealth per 100,000 Medicaid and CHIP beneficiaries during the PHE	Average monthly rate of services delivered through telehealth per 100,000 beneficiaries under age 19 during the PHE
United States	**3,988.98**	**3,546.06**	**10,260.77**	**8,487.86**
Alaska	5,704.14	5,172.15	10,055.43	7,998.41
Alabama	4,287.23	4,687.41	4,605.06	4,553.39
Arkansas	3,276.07*	4,377.74*	6,677.35*	9,462.27*
Arizona	3,752.12	3,240.81	20,230.96	19,048.90
California	2,900.93*	2,284.95*	9,055.45	8,478.34
Colorado	2,910.36	2,555.96	10,501.50	9,862.05
Connecticut	6,820.20	5,860.14	19,691.80	20,218.24
District of Columbia	4,869.42*	5,261.58*	38,416.19	18,599.40
Delaware	3,205.65	3,128.30	13,619.57	8,934.20
Florida	2,930.77	2,723.42	7,972.57	8,713.49
Georgia	3,343.27	3,237.56	7,896.16	7,257.83
Hawaii	2,427.98	2,155.16	6,851.52	3,768.78
Iowa	3,893.92	3,471.44	8,882.19	6,172.06
Idaho	3,699.83	2,744.30	13,656.95	8,914.07
Illinois	3,060.68	2,057.37	5,389.26	4,313.70
Indiana	3,435.07	2,936.42	10,511.89	7,611.29
Kansas	3,077.99	2,685.54	11,169.53	9,704.62
Kentucky	5,712.18	5,259.34	13,511.26	10,239.45
Louisiana	6,172.91	5,089.87	11,382.90	12,116.24
Massachusetts	5,053.03	4,958.75	26,454.93	23,813.17
Maryland	4,816.22	4,075.54	15,255.31	13,835.09
Maine	3,812.57	4,181.85	20,640.52	19,393.39
Michigan	4,430.89	3,191.20	13,554.14	8,566.00
Minnesota	4,814.74	3,974.44	20,057.79	13,262.06
Missouri	3,578.19*	2,810.78*	6,125.72*	4,128.61*
Mississippi	5,568.44	5,716.79	7,128.94	6,990.97
Montana	2,499.35	2,155.97	11,106.22	7,959.67
North Carolina	4,221.53	4,661.72	7,542.13	8,642.88
North Dakota	2,788.51	2,448.34	7,415.04	5,645.54
Nebraska	3,288.28	3,076.46	9,303.93	6,180.83
New Hampshire	5,055.05	5,680.28	23,893.53	18,127.47
New Jersey	7,095.02	5,347.38	9,145.84	3,746.85

State	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of services delivered through telehealth per 100,000 Medicaid and CHIP beneficiaries during the PHE	Average monthly rate of services delivered through telehealth per 100,000 beneficiaries under age 19 during the PHE
New Mexico	5,373.81	4,199.67	11,711.27	10,682.45
Nevada	2,714.78	1,930.66	8,863.15	5,830.17
New York	5,282.95	4,671.32	6,520.81	4,124.87
Ohio	4,666.00	3,371.96	15,172.26	9,807.35
Oklahoma	3,585.17	3,708.52	9,468.15	8,786.48
Oregon	3,418.27	2,620.92	16,270.92	10,614.74
Pennsylvania	3,501.97	3,010.57	9,211.62	7,050.20
Puerto Rico	4,655.89*	4,511.66*	6,901.49	5,204.90
Rhode Island	3,815.58	3,334.04	24,235.82	25,311.02
South Carolina	3,609.47	4,216.18	4,309.25	5,162.01
South Dakota	3,381.07	3,183.18	4,574.76	3,107.96
Tennessee	4,783.80	4,648.40	7,377.90	6,544.12
Texas	3,710.88	3,978.93	8,494.74	8,451.34
Utah	2,915.68*	2,455.76*	5,038.23*	2,398.14*
Virginia	4,020.46	3,694.93	10,207.28	8,762.42
Virgin Islands	1,734.27*	1,026.97*	1,193.06*	434.74*
Vermont	856.78	903.67	3,644.02	1,258.91
Washington	4,117.37	3,375.68	9,880.96	7,484.14
Wisconsin	3,559.91	3,028.68	9,211.30	6,584.73
West Virginia	4,351.05	4,173.29	9,034.61	4,820.17
Wyoming	3,166.53	2,761.19	8,178.41	5,350.37

Note: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v7 in DataConnect using final action claims. They are based on March T-MSIS submissions with services through the end of February. Recent dates of service have very little time for claims runout, and we expect large changes in the results after each monthly update. Because data for February are incomplete, results are only presented through January 31, 2022. The PHE period includes data for March 2020 through January 2022.

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