



# All-State Medicaid & CHIP Call

February 9, 2021





# 2021 Federally Facilitated Exchange (FFE) Special Enrollment Period



# Agenda

- Overview of 2021 Special Enrollment Period (SEP)
- Key Implications for Medicaid and CHIP
- Account Transfer (AT) Processing
  - Receiving and Processing ATs (Reminders)
  - Processing Real-Time Outbound Account Transfers
  - Processing ATs for Beneficiaries Already Enrolled
  - Dual Medicaid/CHIP & QHP Enrollment
- Planning Ahead

# 2021 Special Enrollment Period in Response to the COVID-19 Emergency

- In accordance with the Executive Order issued on January 28, 2021 by President Biden, CMS determined that the COVID-19 emergency presents exceptional circumstances for consumers in accessing health insurance and will provide a Special Enrollment Period (SEP) for individuals and families to apply and enroll in the coverage they need.
- This SEP will be available to consumers in the 36 states served by Marketplaces that use the HealthCare.gov platform, and CMS will conduct outreach activities to encourage those who are eligible to enroll in health coverage.
- Starting on February 15, 2021 and continuing through May 15, 2021, Marketplaces using the HealthCare.gov platform will operationalize functionality to make a SEP available to all Marketplace-eligible consumers who are submitting a new application or updating an existing application.
- These consumers will newly be able to access the SEP through a variety of channels: through HealthCare.gov directly, the Marketplace call center, or direct enrollment channels.

# 2021 SEP – Outreach Strategies

- To promote the SEP and ensure that a broad and diverse range of consumers are aware of this implementation, CMS will conduct an outreach campaign in cooperation with community and stakeholder organizations, focused on education and awareness of this new opportunity to enroll in English, Spanish and other languages.
- CMS outreach efforts will use a mix of paid advertising and direct outreach to consumers. Outreach efforts will include considerable awareness-building efforts to encourage the uninsured and those who come to HealthCare.gov to explore coverage to continue the process and enroll. CMS plans to spend \$50 million on outreach and education, using a mix of tactics to increase awareness, including advertisements on broadcast, digital, and an earned media.

# Key Implications for Medicaid/CHIP Agencies

1. Likely increase in application volume from both state-submitted applications and account transfers
2. Potential increase in applicant/beneficiary inquiries and state call center volume

# General Reminders: Account Transfer Types

- States served by the FFE will continue to receive Outbound Account Transfers (from FFE to state) as they do throughout the year. States will receive:
  - **Assessments/Determinations** of eligibility for MAGI-based Medicaid and CHIP (based on state election)
  - **Non-MAGI Referrals** for individuals who answer “yes” to specific screening questions that indicate they may be eligible on a basis other than MAGI - i.e., disability
  - **Inconsistencies and Pends** for individuals who attest to MAGI income and other factors that would make them potentially eligible for Medicaid/CHIP but for whom the FFE cannot verify eligibility
  - **Full Determination Requests:**
    - In assessment states, full determination requests are sent to the state for a final MAGI-based determination and for determinations of eligibility for non-MAGI groups.
    - In determination states, full determination requests are only sent to states to complete a determination for non-MAGI coverage. The FFE has already made the final determination for MAGI-based coverage.

# State Responsibilities: Processing Medicaid/CHIP Assessments

## **In Assessment States:**

The FFE transfers the account, for individuals assessed as potentially eligible, to the state agency for a final eligibility determination.

The FFE also transfers accounts for individuals whose information was not verified by the FFE and for those not assessed as eligible, but who have requested that their accounts be transferred to the state agency for a full Medicaid/CHIP determination.

## State Agency Responsibilities:

- Notify the FFE of receipt of the electronic account (acknowledgement)
- Do not request information from applicant if already included in the electronic account and accept findings related to specific eligibility criteria made by the FFE, without further verification
- Promptly determine eligibility for MAGI-based coverage and non-MAGI coverage, if appropriate, without requiring a new application
- Notify the applicant of the eligibility determination and enroll, if eligible
- Notify the FFE of final determination of the individual's eligibility or ineligibility (outbound response)



# State Responsibilities: Processing Medicaid/CHIP Determinations

## **In Determination States:**

The FFE transfers the electronic account for individuals determined eligible for MAGI based Medicaid through the Hub to the state agency. The state accepts the determination as final.

The FFE also transfers accounts for individuals whose information was not verified by the FFE and for those not determined as eligible, but who have requested that their accounts be transferred to the state agency for a full Medicaid/CHIP determination for non-MAGI coverage.

## State Agency Responsibilities:

- Notify the FFE of receipt of the electronic account (acknowledgement)
- Promptly enroll individual in Medicaid or CHIP and send notice, as appropriate
- Collect additional information to resolve other inconsistencies and pends, and complete a final determination, as needed. Notify the applicant of the eligibility determination and enroll, if eligible
- Determine eligibility on a non-MAGI basis, if appropriate, send notice, and begin coverage, if eligible
- Notify the FFE of final determination of the individual's eligibility or ineligibility (outbound response)

# Processing Real-Time Outbound Account Transfers

- Since Fall 2019, the FFE has sent outbound ATs to states in real time, instead of in nightly batches.
- Multiple versions of an application may be sent to the state in an outbound AT if an applicant returns to the FFE to update their application in the same day.
- States must fully process all ATs received in subsequent days, after the initial submission date, as they may contain information that constitutes a change in circumstance that may affect eligibility and must be addressed consistent with 42 CFR 435.916(d) and 457.343.

# Processing Account Transfers for Beneficiaries Already Enrolled in Medicaid/CHIP

- It is possible that existing Medicaid beneficiaries may end up applying at the FFE, especially if they are unsure of their current enrollment status
- If these individuals are assessed or determined eligible for Medicaid or CHIP, the FFE will transfer these accounts for states to process
- States will need to de-duplicate applications sent via the AT process to identify individuals that are known to the state either as a current enrollee or applicant.
  - Process any updated information in the more recent AT as a change in the beneficiary's circumstances

# Dual Medicaid/CHIP & QHP Enrollment

- If an existing Medicaid/CHIP beneficiaries ends up applying for coverage at the FFE during the 2021 SEP, it is possible that he or she could be determined by the FFE as eligible for coverage in a QHP with APTC.
- This may result in dual Medicaid/CHIP and QHP/APTC coverage for the individual.
- Individuals determined or assessed ineligible for Medicaid or CHIP by an Exchange who enroll in a QHP with APTC will not be liable to pay back APTC, according to IRS guidance (see Question 30 in the link below).

# Planning Ahead

- Plan for increased application and call center volume
  - Resource: *Ensuring Timely and Accurate Eligibility Determinations (Slide Deck)*  
<https://www.medicaid.gov/state-resource-center/downloads/mac-learning-collaboratives/timely-accurate-eligibility.pdf>
- Consider temporary policy or operational changes to facilitate timely determinations of eligibility
  - Update state verification policies
  - Temporarily accept FFE assessments as determinations
- Closely monitor systems regularly to identify issues sending and receiving account transfers
  - Report planned system outages to max.gov
  - Contact your CClIO IT Project Manager for assistance, if needed

# Medicaid and CHIP COVID-19 Summaries



***Preliminary Medicaid &  
CHIP Data Snapshot***

**Services through July 31, 2020**

# Medicaid & CHIP Content Overview

**Medicaid and CHIP Population:** As of August 2020, over 95.4 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 for at least one day. About 44% of beneficiaries were children, which translates to nearly 41.5 million beneficiaries. Approximately 55% of beneficiaries were female, 44% were male, and 9% were over the age of 65. 14% of the population is dually-eligible for Medicare and Medicaid. 34% of the population is white, 23% of the population is of unknown race, 21% is Hispanic, 17% is black, 4% is Asian, and 2% is 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 & 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 September 2020, which include services through the end of August 2020. Because data for August are mostly incomplete, results are only presented through July 31, 2020. For additional information regarding state variability in data quality, please refer to the [Medicaid DQ Atlas](#).

# What You Should Know When Using The Data

**Claims Lag:** You should use caution when interpreting our 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 & CHIP Inpatient claims received by months after service was delivered (based on March 2018 service date)						
Months after service	1	2	3	4	5	6
<b>Fee-for-service Claims Submission, %</b>						
Inpatient	21.8	62.5	76.4	83.4	88.5	92.3
Long-term care	14.9	82.0	89.3	92.3	95.4	96.8
Other services	26.3	70.2	83.0	89.4	92.3	95.1
Prescription drug	64.0	97.9	98.5	98.8	98.9	99.0
<b>Managed Care Encounters Submission, %</b>						
Inpatient	6.3	48.8	68.7	77.5	81.4	84.7
Long-term care	3.6	33.6	57.4	71.1	77.8	81.4
Other services	9.8	55.8	77.6	85.3	88.4	90.8
Prescription drug	34.6	83.6	93.2	96.3	97.4	97.6



# 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 all other services claims within only 3 months, while other states take nearly a year.

Percent of Medicaid & CHIP Inpatient Hospital claims received by months after service was delivered (based on March 2018 service date)						
Months after service	1	2	3	4	5	6
<b>Fastest claims submission, Inpatient Hospital Claims %</b>						
Colorado	50.2	76.2	83.1	87.6	89.6	91.0
Rhode Island	43.5	65.8	70.2	72.6	78.8	80.1
Wyoming	39.9	73.6	84.2	89.1	92.2	93.9
Connecticut	37.3	86.1	92.1	95.6	96.9	97.9
<b>Longest claims submission, Inpatient Hospital Claims %</b>						
Puerto Rico	0.0	15.6	68.7	83.9	87.6	89.3
Massachusetts	0.0	5.2	20.3	40.2	50.2	69.1
Hawaii	0.2	16.9	58.8	76.4	82.6	86.5
Illinois	1.6	10.5	35.3	51.6	62.0	69.0

# 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 and encounter Other Services claims 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 & CHIP Other Services claims received by months after service was delivered (based on March 2018 service date)						
Months after service	1	2	3	4	5	6
<b>Fastest claims submission, Other Services Claims %</b>						
Colorado	58.0	86.9	91.6	95.1	96.1	97.2
Nebraska	49.7	83.4	90.9	93.5	94.8	96.4
South Dakota	40.3	84.6	92.8	95.8	97.0	98.4
Arkansas	39.1	80.8	87.8	90.4	93.2	96.1
<b>Longest claims submission, Other Services Claims %</b>						
Hawaii	5.0	43.8	76.6	85.7	88.3	89.7
Illinois	4.9	33.2	48.7	60.3	63.3	74.2
Missouri	2.9	46.4	79.7	86.0	88.2	90.0
Puerto Rico	1.1	48.2	87.7	95.2	98.5	99.2

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# COVID-19 Treatment and Outcomes



***Preliminary Medicaid &  
CHIP Data Snapshot***

**Services through July 31, 2020**

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# What You Should Know When Using the Data

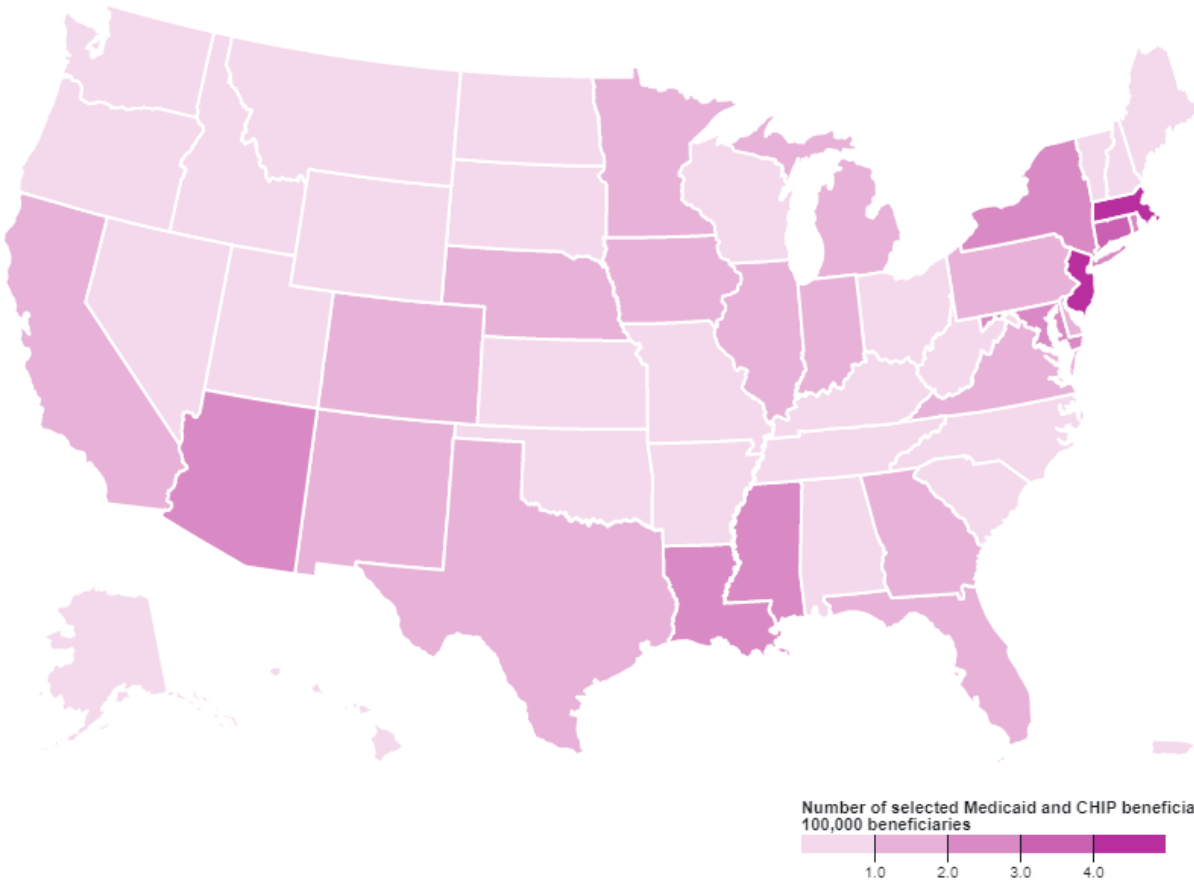
- These estimates reflect COVID-19 treatment and outcomes that are covered by Medicaid and CHIP.
- Services covered by other insurance programs, such as Medicare, are not included in these results.
- In 2019, there were 12.3 million dually eligible beneficiaries enrolled in both Medicare and Medicaid.<sup>1</sup>
- These results are unlikely to reflect the full scope of COVID-related treatments for dually eligible beneficiaries, as Medicare pays first for Medicare-covered services that are also covered by Medicaid because Medicaid is generally the payer of last resort.<sup>2</sup>
- 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." <https://www.cms.gov/files/document/medicaremedicaidualenrollmenteverenrolledtrendsdatabrief.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

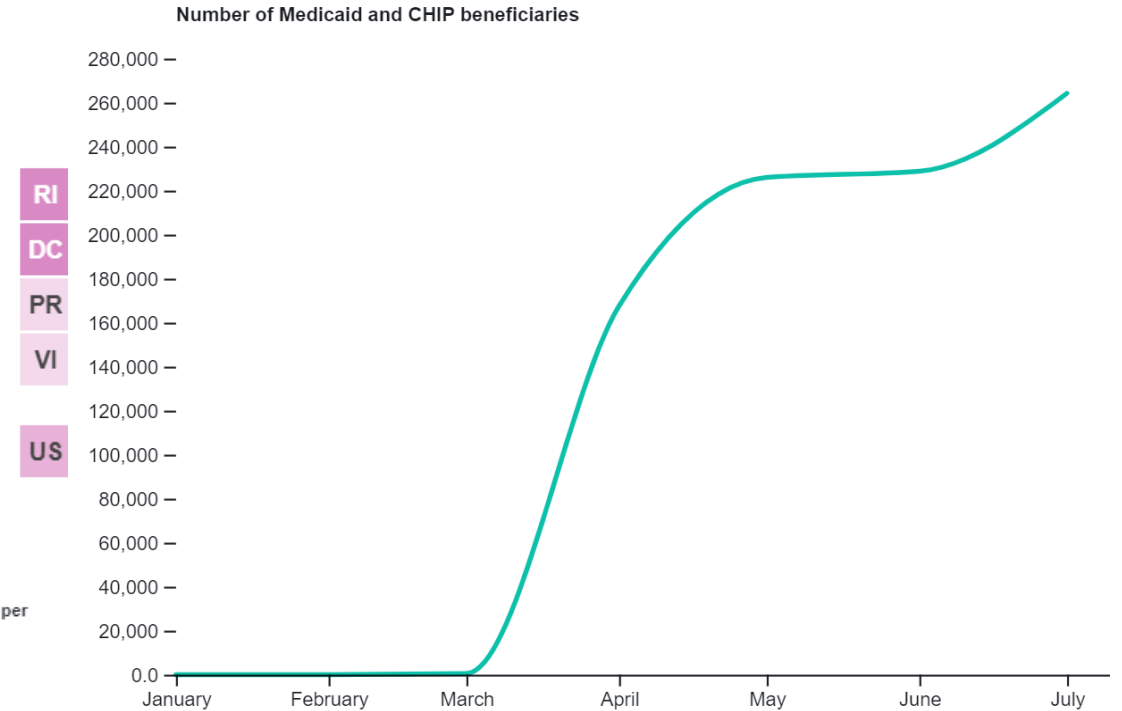
Average monthly rate of COVID-19 treatment per 100,000 beneficiaries in 2020



Beneficiaries treated for COVID-19 in 2020: **733,746**

COVID-19 treatment rate per 100,000 beneficiaries in 2020: **769.2**

Number of Medicaid and CHIP beneficiaries treated for COVID-19 in 2020, by month

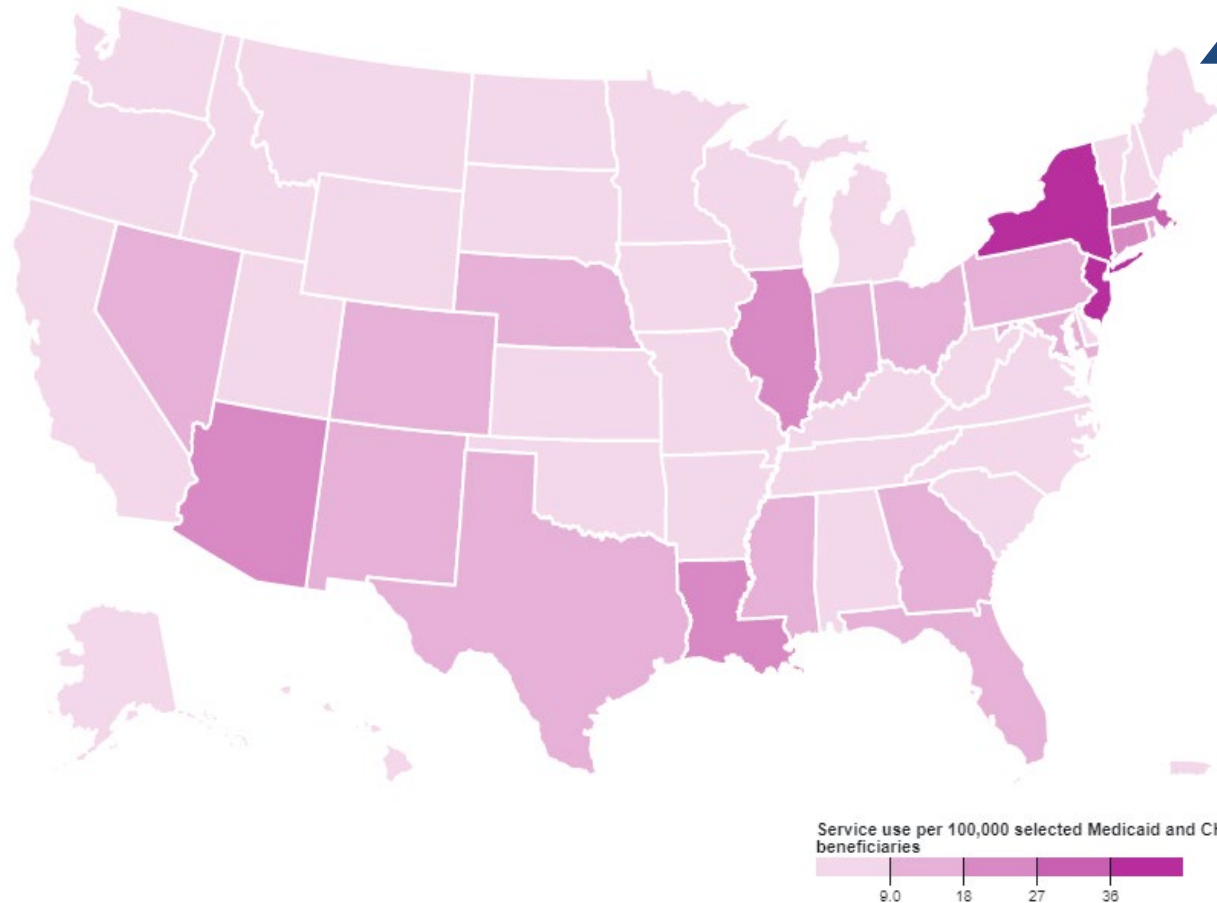


**Note:** Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid & CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among 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 v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.

# Medicaid and CHIP beneficiaries COVID-19 acute care use

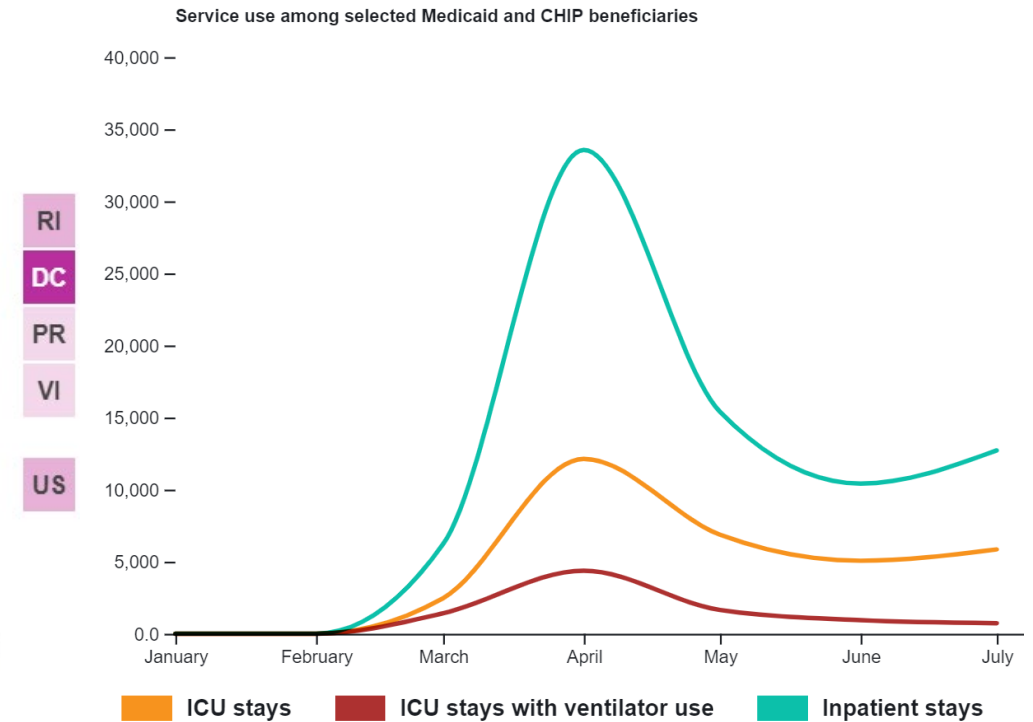
Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries in 2020 were highest in a few key states



Number of COVID-19 hospitalizations in 2020: **79,305**

COVID-19 hospitalizations per 100,000 beneficiaries in 2020: **83.1**

Number of acute care services for Medicaid and CHIP beneficiaries treated for COVID-19 in 2020, by month



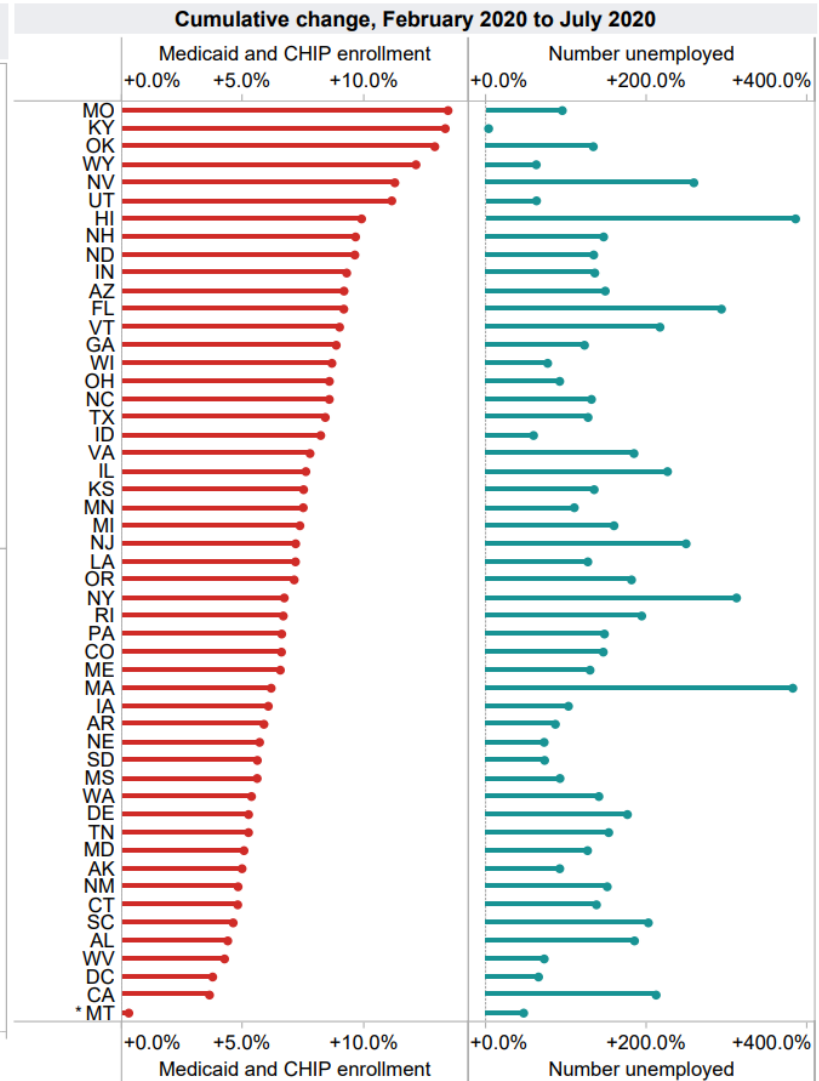
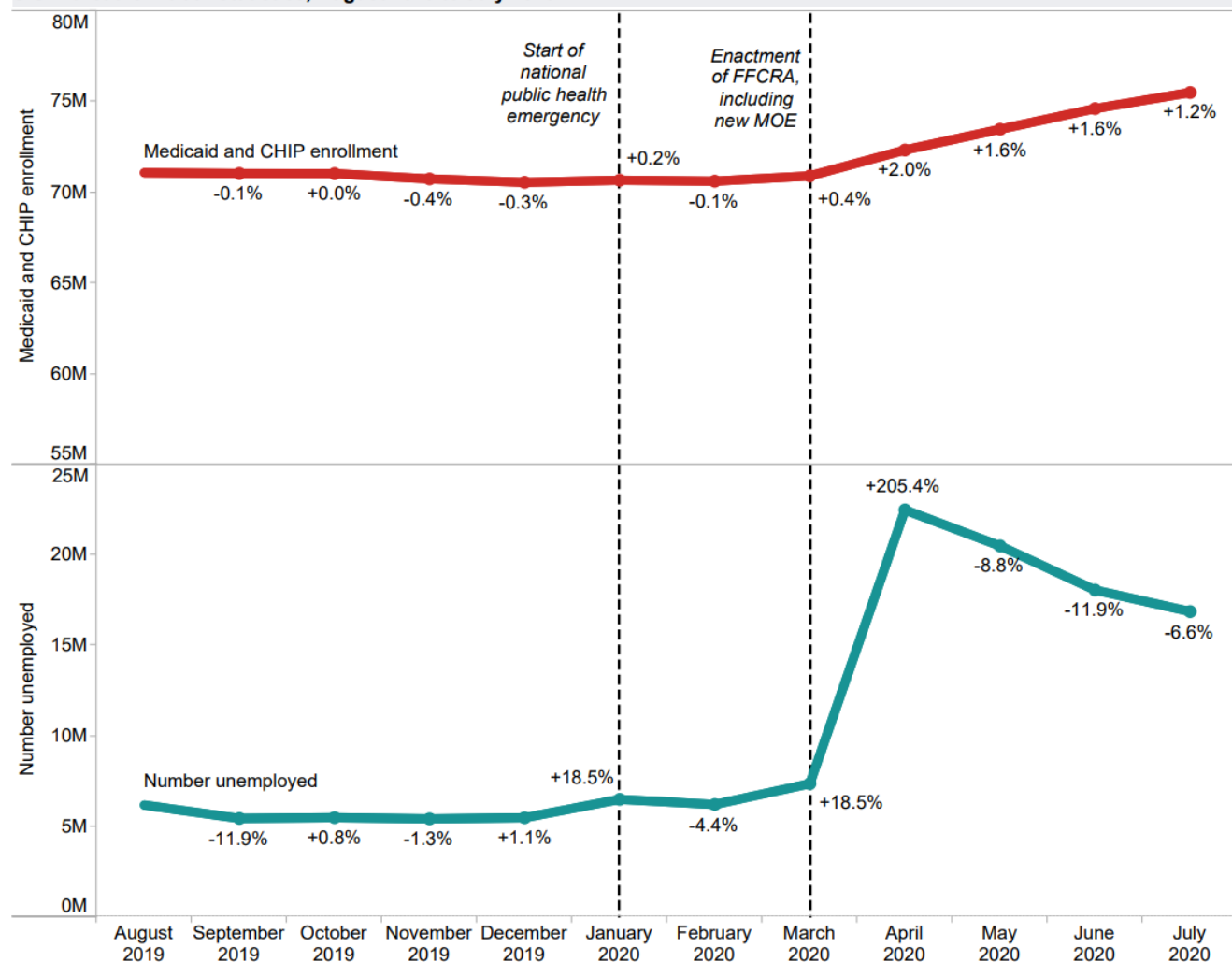
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# Medicaid and CHIP enrollment continues to steadily increase compared to declining unemployment rates

Figure 4. Medicaid and CHIP enrollment from the CMS Performance Indicator Data compared to unemployment data from the U.S. Bureau of Labor Statistics, August 2019 to July 2020



**Sources:** (1) Medicaid and CHIP Eligibility and Enrollment Performance Indicators as of September 30, 2020 and (2) State Employment and Unemployment Data (Monthly) from the U.S. Bureau of Labor Statistics as of September 30, 2020.  
**Note:** This analysis includes data from 50 states and the District of Columbia. "FFCRA" refers to the Families First Coronavirus Response Act. "MOE" refers to the FFCRA's maintenance of effort requirement, which makes available a temporary 6.2 percentage point increase to each state or territory's federal medical assistance percentage (FMAP) during the emergency. As a condition of receiving the FMAP increase, states must meet several requirements pertaining to eligibility and maintenance of enrollment.  
**Data quality:** In Montana, Medicaid and CHIP enrollment began to rise in May 2020, following monthly enrollment declines in early 2020. As of October 2, 2020, Montana had not yet provided an explanation for its Medicaid and CHIP enrollment declines in early 2020.



# Service Use Among Medicaid & CHIP Beneficiaries Age 18 and Under during the COVID-19 Public Health Emergency



***Preliminary Medicaid & CHIP Data Snapshot***

**Services through July 31, 2020**

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

- Medicaid and CHIP covered nearly 41.5 million children between January and August 2020
- The programs cover three quarters of children living in poverty<sup>1</sup>
- Approximately four in ten children covered under the programs have a special health care need that requires health services<sup>2</sup>

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/>

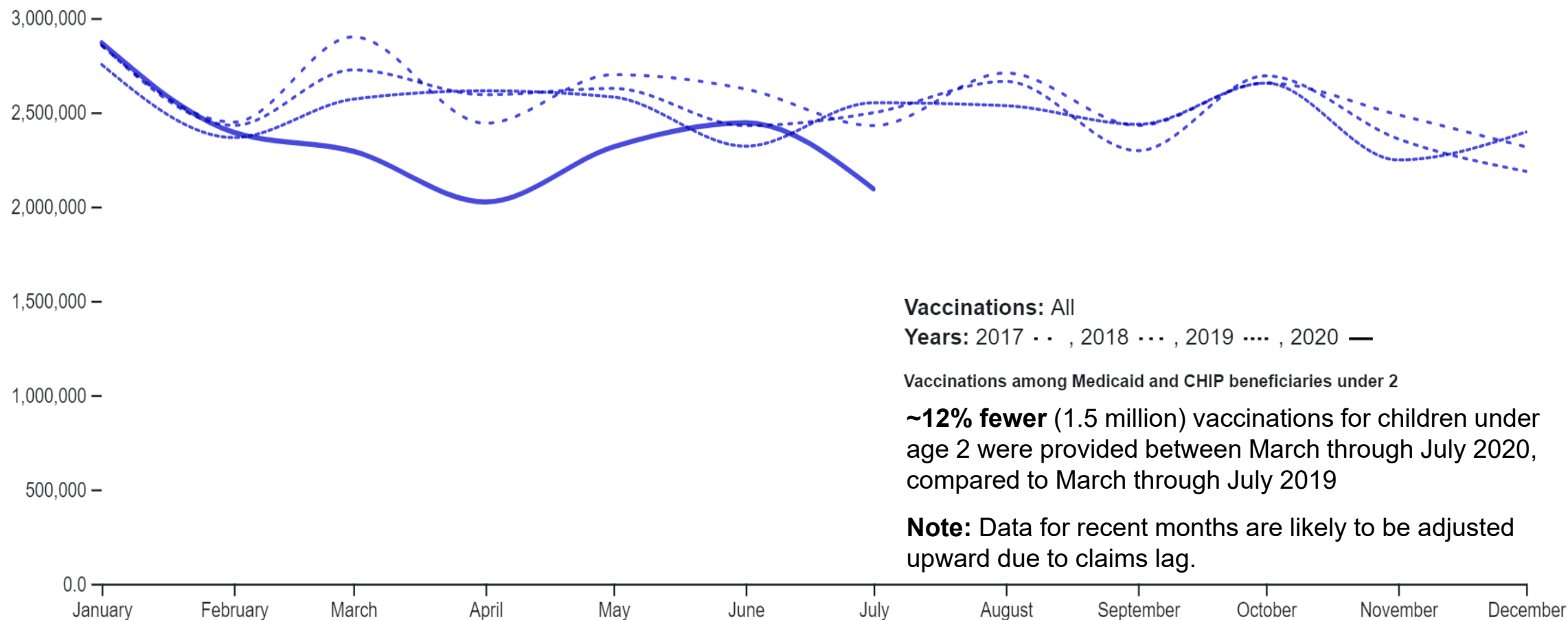
# Service use among children during COVID-19: Key highlights

Preliminary data suggest that, during the PHE:

- Primary, preventive, and mental health services declined among children age 18 and under starting in March 2020. Although rates are starting to rebound, millions of services still need to be delivered to make up for those missed between March and July 2020.
- Service delivery via telehealth for children increased dramatically, but not enough to offset this decline in services, especially for mental health services. Of all services examined in this analysis, mental health services rates have rebounded the least between March and July 2020.
- There is considerable state variation in service use rates, with some states returning to or surpassing February 2020 levels of care by June 2020
- The COVID-19 treatment rate for children is low, with <0.2% receiving treatment for COVID-19 under Medicaid or CHIP and fewer than 2,200 hospitalizations so far in 2020

# Preliminary data show vaccinations among beneficiaries under age 2 declined through April and returned to prior year's level in June

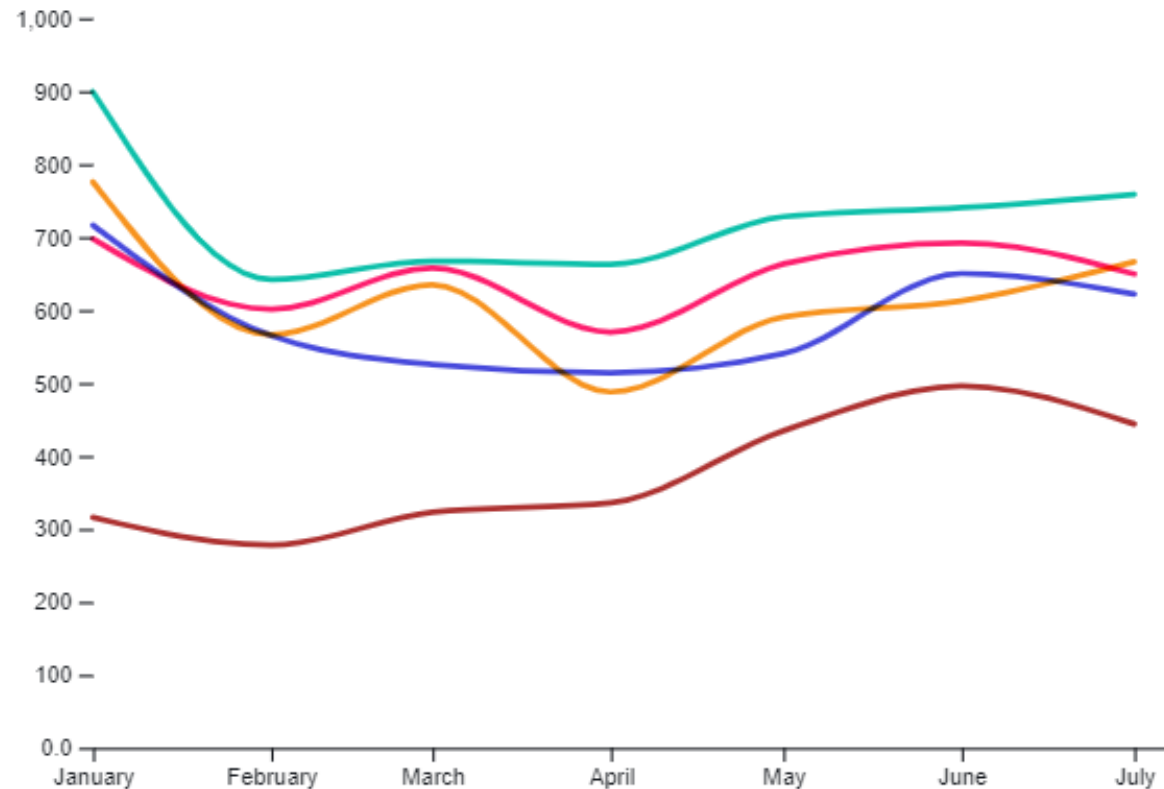
3,500,000 – Vaccination rates among beneficiaries under age 2 dropped from 587 per 1,000 in February to about 496 per 1,000 beneficiaries in April and increased to about 595 per 1,000 beneficiaries in June



**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.

# Preliminary data show state variation in vaccination rates, with some states returning to or surpassing February rates by July after a drop in services in April

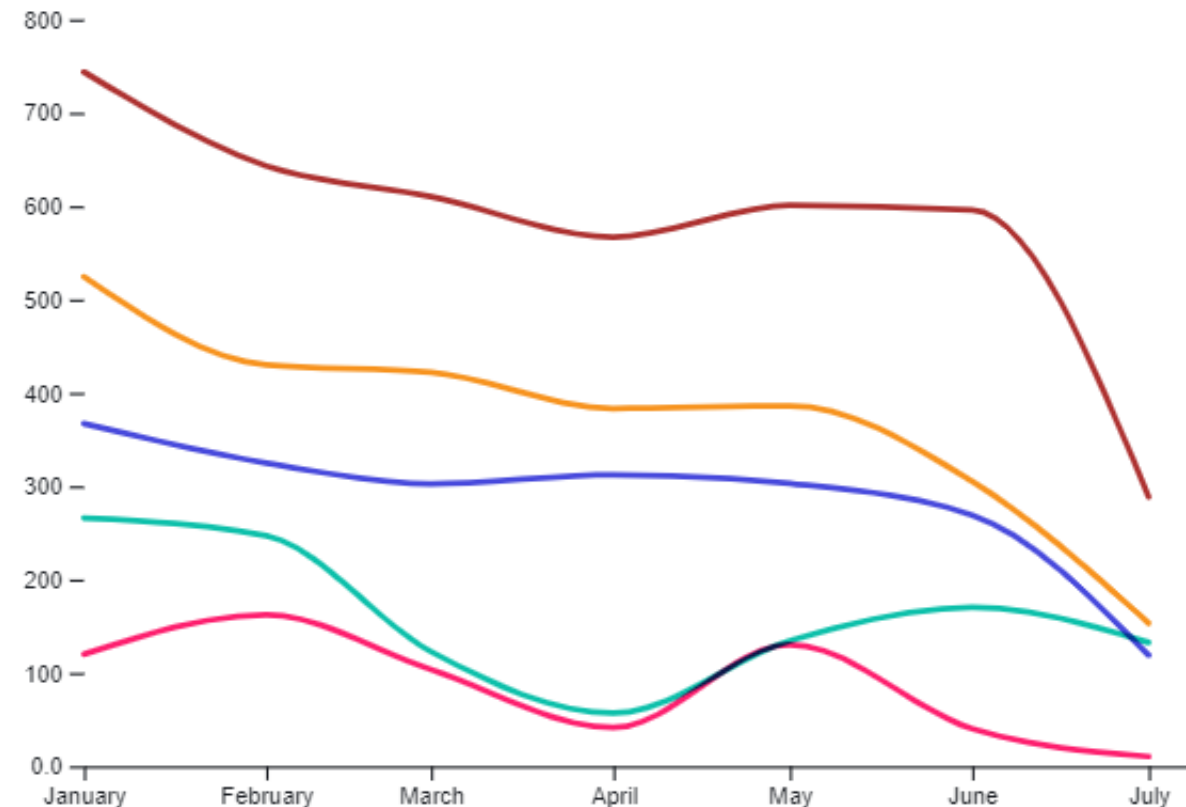
Vaccinations per 1,000 Medicaid and CHIP beneficiaries under 2



ME, ND, OK, VT, and WY had the greatest percent increase in vaccinations among children under 2 from February 2020 to July 2020 (data incomplete)

■ Maine ■ North Dakota ■ Oklahoma ■ Vermont ■ Wyoming

Vaccinations per 1,000 Medicaid and CHIP beneficiaries under 2



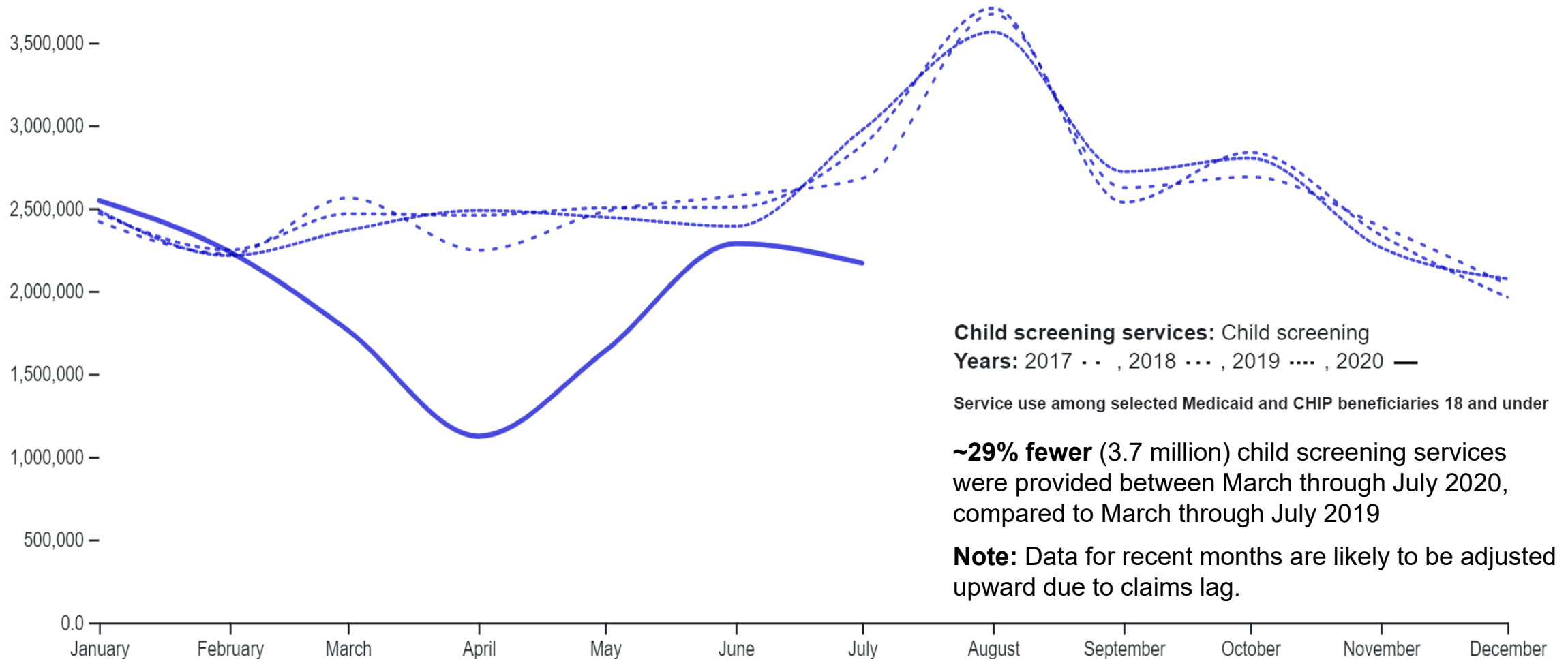
HI, MO, NV, PR, and VI had the greatest percent decrease in vaccinations among children under 2 from February 2020 to July 2020 (data incomplete)

■ Hawaii ■ Missouri ■ Nevada ■ Puerto Rico ■ Virgin Islands

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# Preliminary data show the number of child screening services declined substantially in April and increased through July, nearing prior years' rates

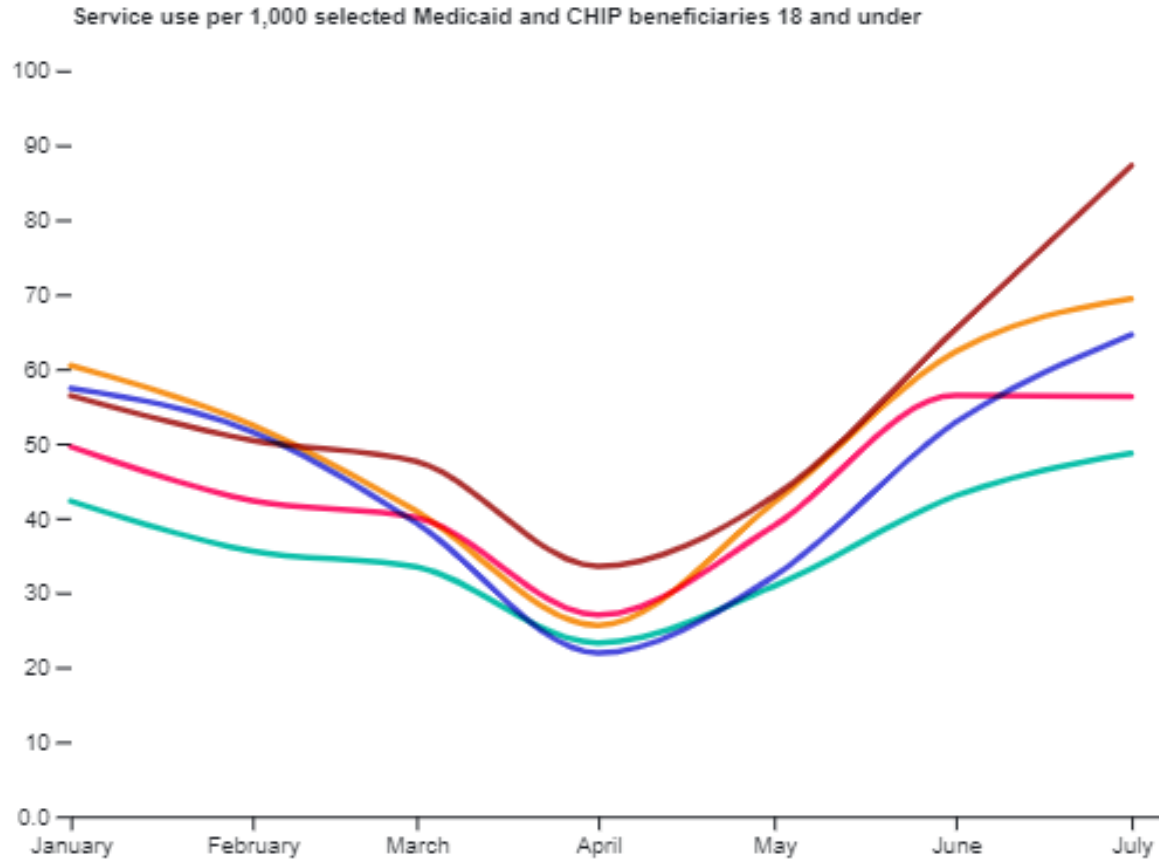
Screening rates among children dropped from 61 per 1,000 beneficiaries in February to a low of 30 per 1,000 beneficiaries in April and increased to 57 per 1,000 beneficiaries in July



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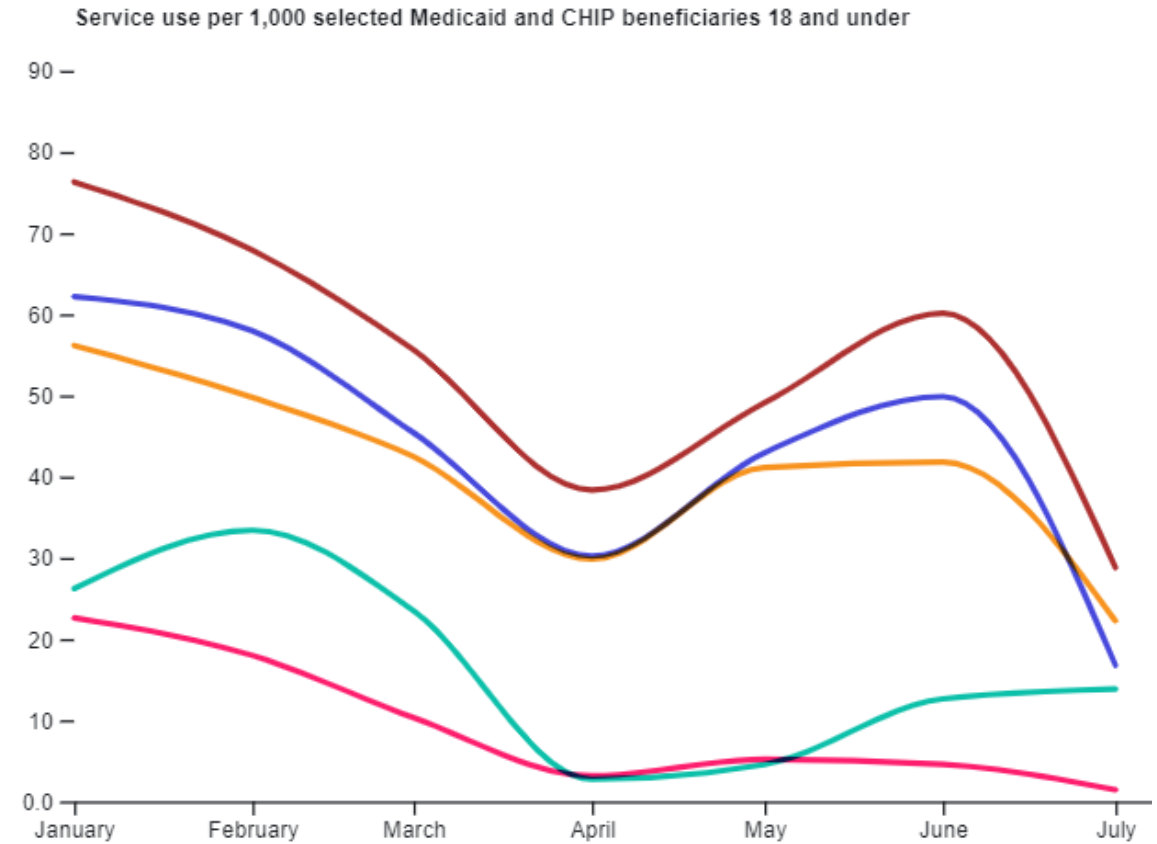


# Preliminary data show child screening rates declined in April and started to rise in May and June, and in some states, July rates are above where they were in February



IL, IN, NE, SD, and WY had the greatest percent increase in screenings among children under 19 from February 2020 to July 2020 (data incomplete)

■ Illinois ■ Indiana ■ Nebraska ■ South Dakota ■ Wyoming



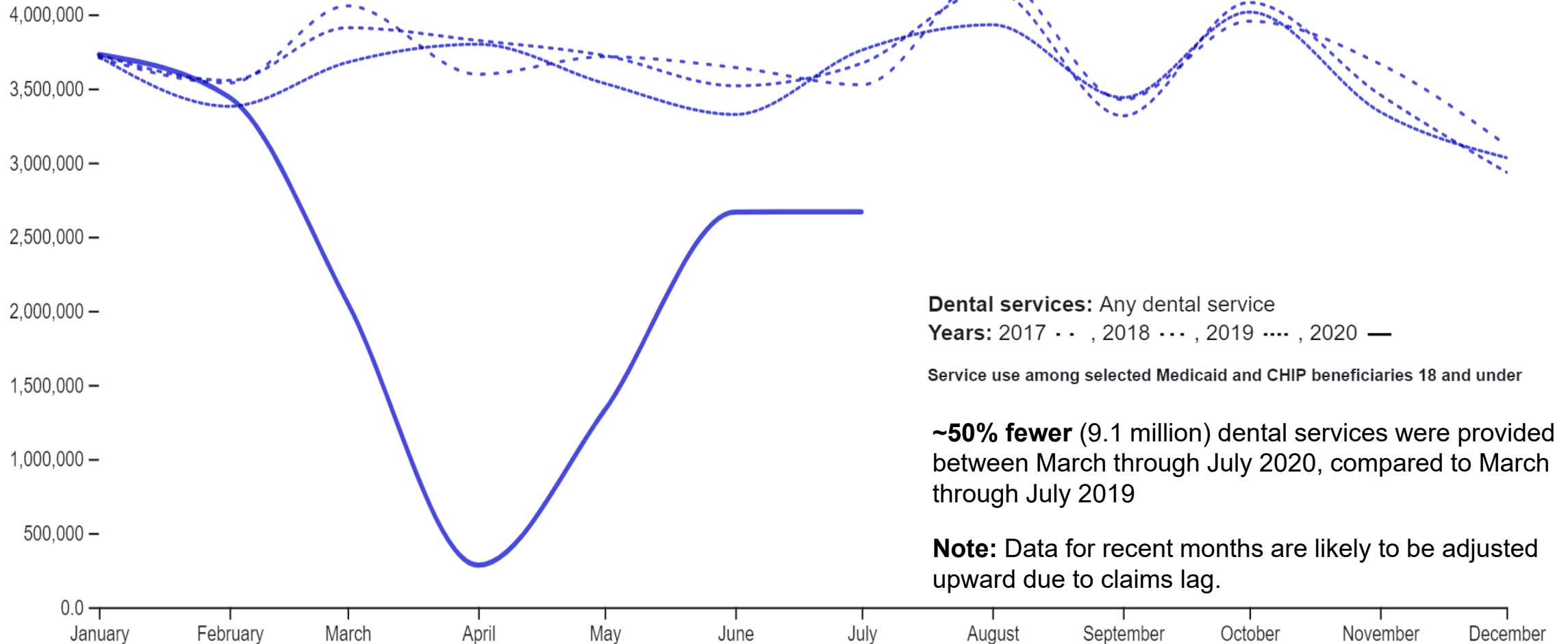
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# Preliminary data show the number of dental services for children declined substantially in April, increased through July, but are still below prior years' rates

4,500,000 – Dental service rates among children dropped from 93 per 1,000 in February to a low of 8 per 1,000 beneficiaries in April and increased to about 71 per 1,000 beneficiaries in July



**Dental services:** Any dental service  
**Years:** 2017 . . , 2018 . . . , 2019 . . . . , 2020 —

Service use among selected Medicaid and CHIP beneficiaries 18 and under

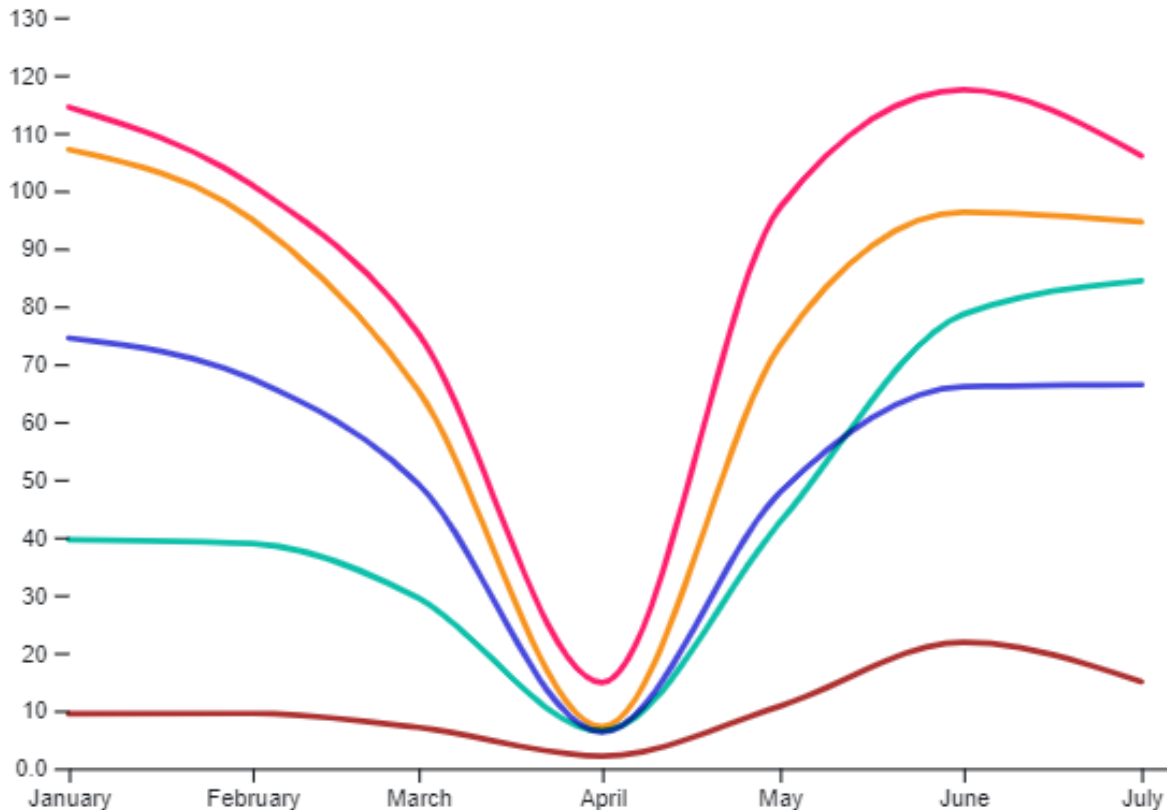
**~50% fewer** (9.1 million) dental services were provided between March through July 2020, compared to March through July 2019

**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 v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.

# Preliminary data show dental service rates among children declined for all states in April, and in a few states, rates had returned to February levels by July

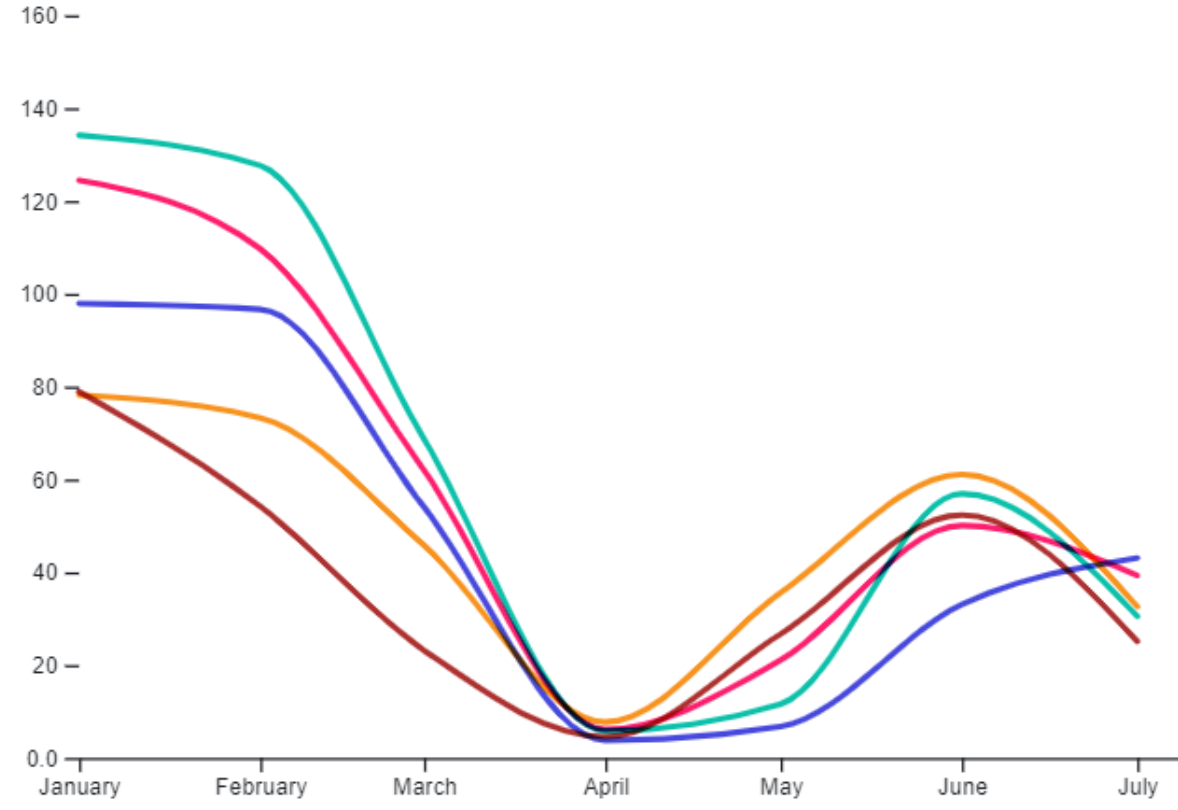
Service use per 1,000 selected Medicaid and CHIP beneficiaries 18 and under



ND, OK, VI, VA, and WY had the greatest percent increase in dental examinations among children under 19 from February 2020 to July 2020 (data incomplete)

North Dakota Oklahoma Virgin Islands Virginia Wyoming

Service use per 1,000 selected Medicaid and CHIP beneficiaries 18 and under



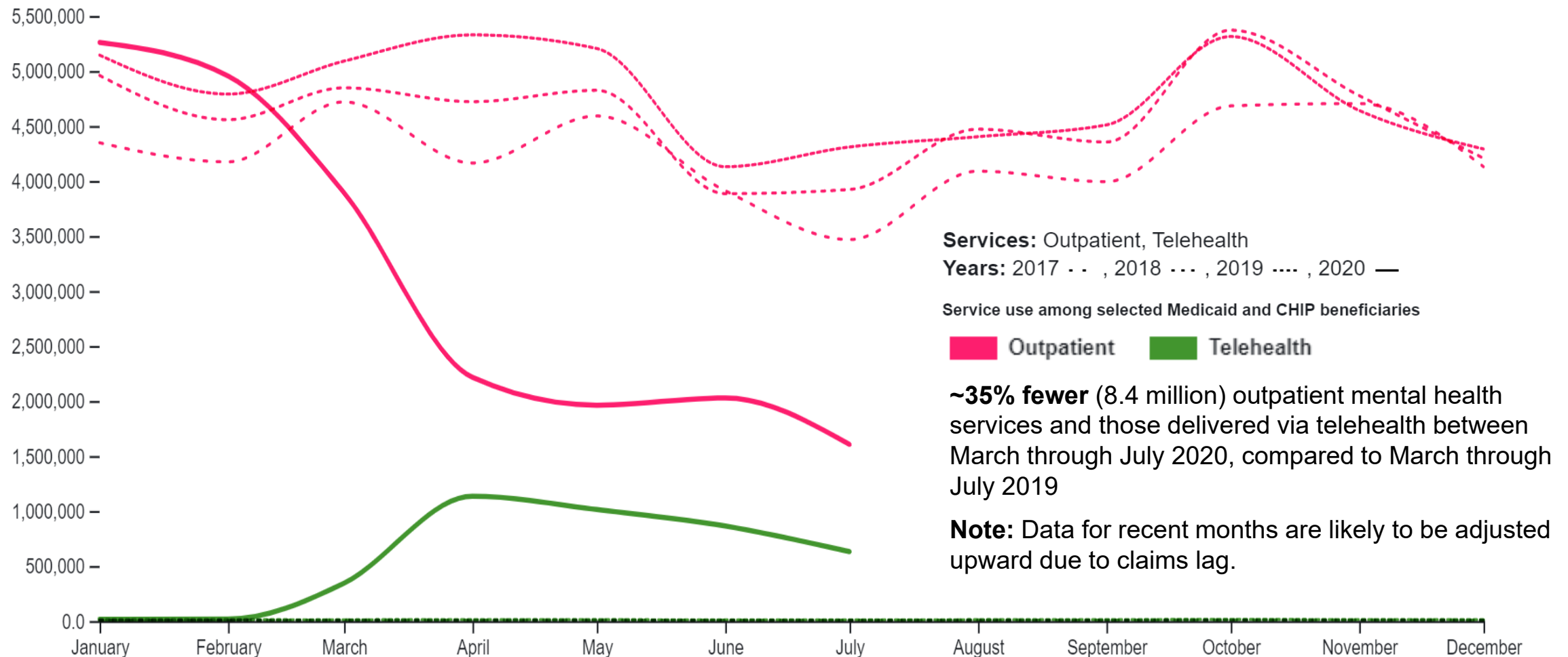
DC, FL, MO, NJ, and RI had the greatest percent decrease in dental examinations among children under 19 from February 2020 to July 2020 (data incomplete)

District of Columbia Florida Missouri New Jersey Rhode Island

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020. There is significant variation in how quickly states submit claims to CMS. It is possible that this variation in claims lag is responsible for the differences in utilization across states. Please refer to Slides 3 to 5 for additional information.

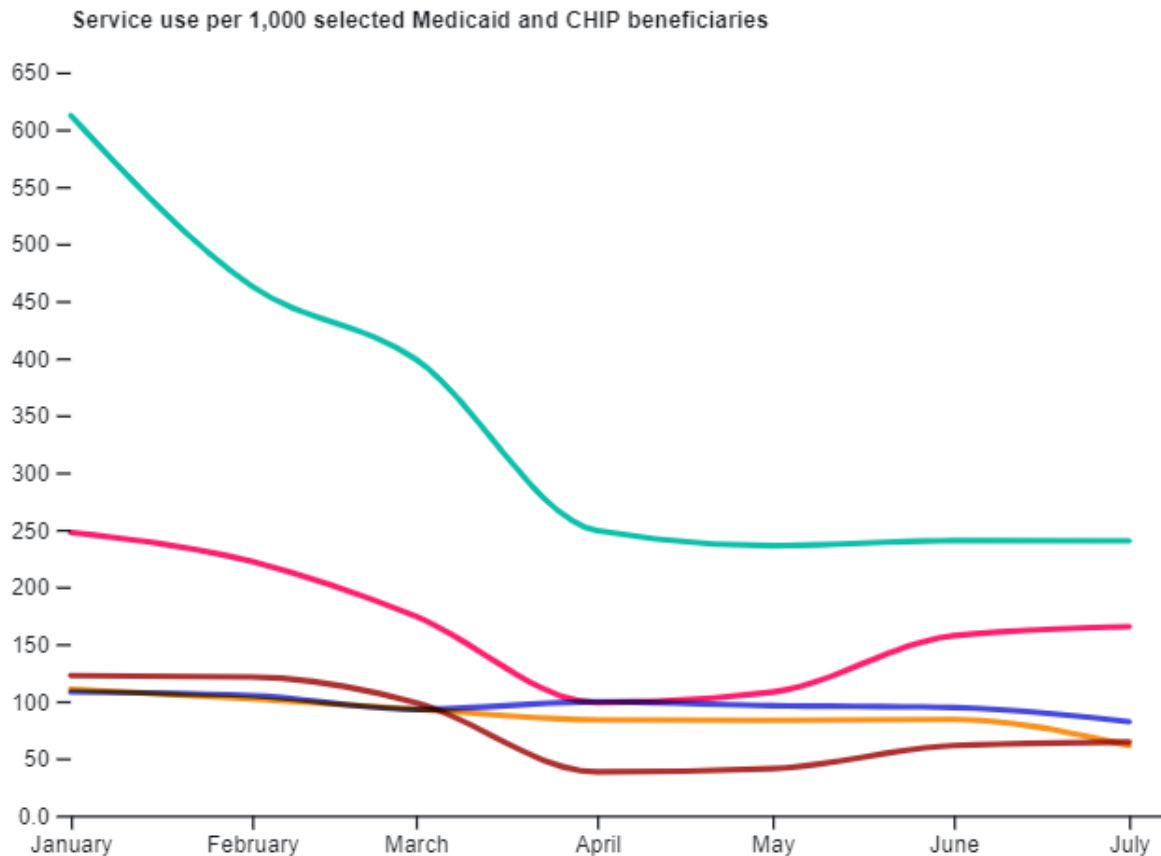
# Preliminary data show outpatient mental health services for children declined starting in March and are still well below prior years' levels. Telehealth increased starting in March, but not enough to offset this decline.

6,000,000 – Outpatient mental health services and services delivered via telehealth among children dropped from 134 per 1,000 in February to about 59 per 1,000 beneficiaries in July



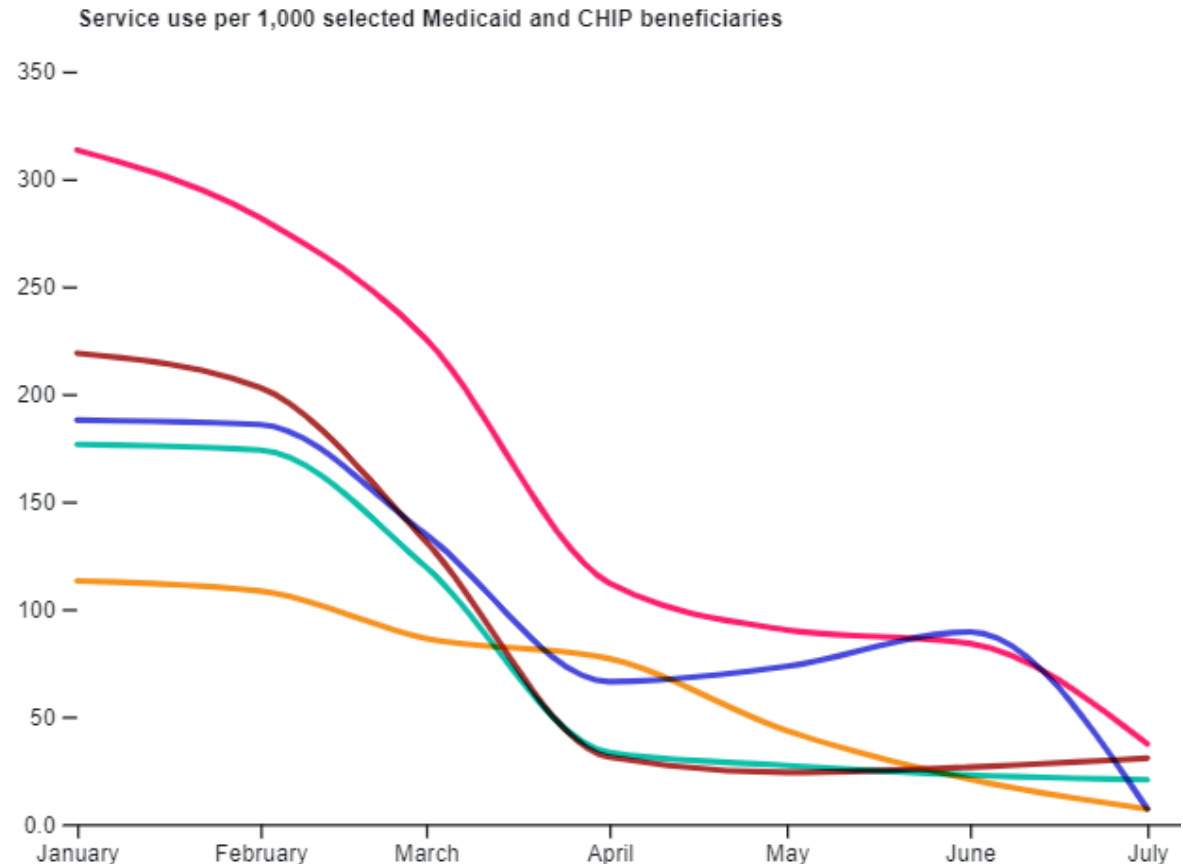
**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for August are incomplete, results are only presented through July 31, 2020.

# Preliminary data show outpatient mental health service use among children declined in all states through July, but the rate of decline varied across states



NJ, NY, ND, VT, and WY had the smallest percent decrease in mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

■ New Jersey ■ New York ■ North Dakota ■ Vermont ■ Wyoming

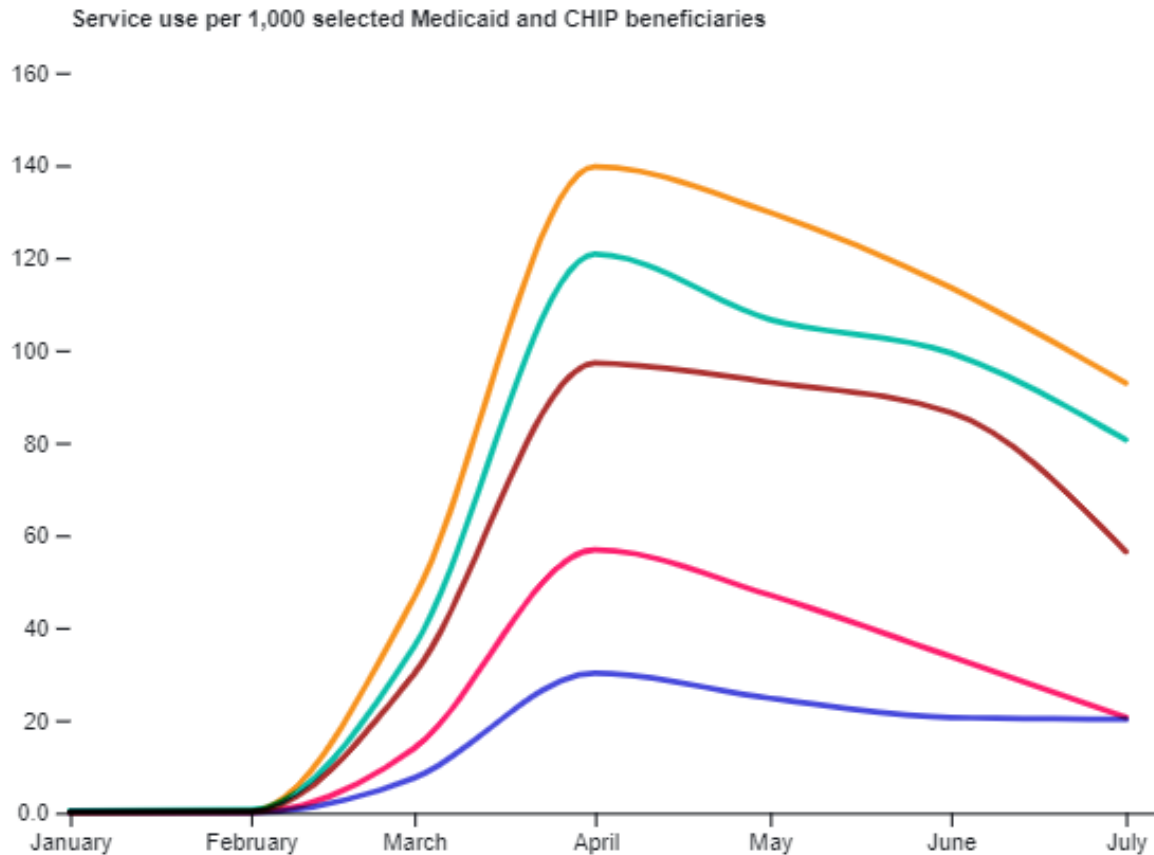


AK, CA, CT, DE, and MA had the greatest percent decrease in mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

■ Alaska ■ California ■ Connecticut ■ Delaware ■ Massachusetts

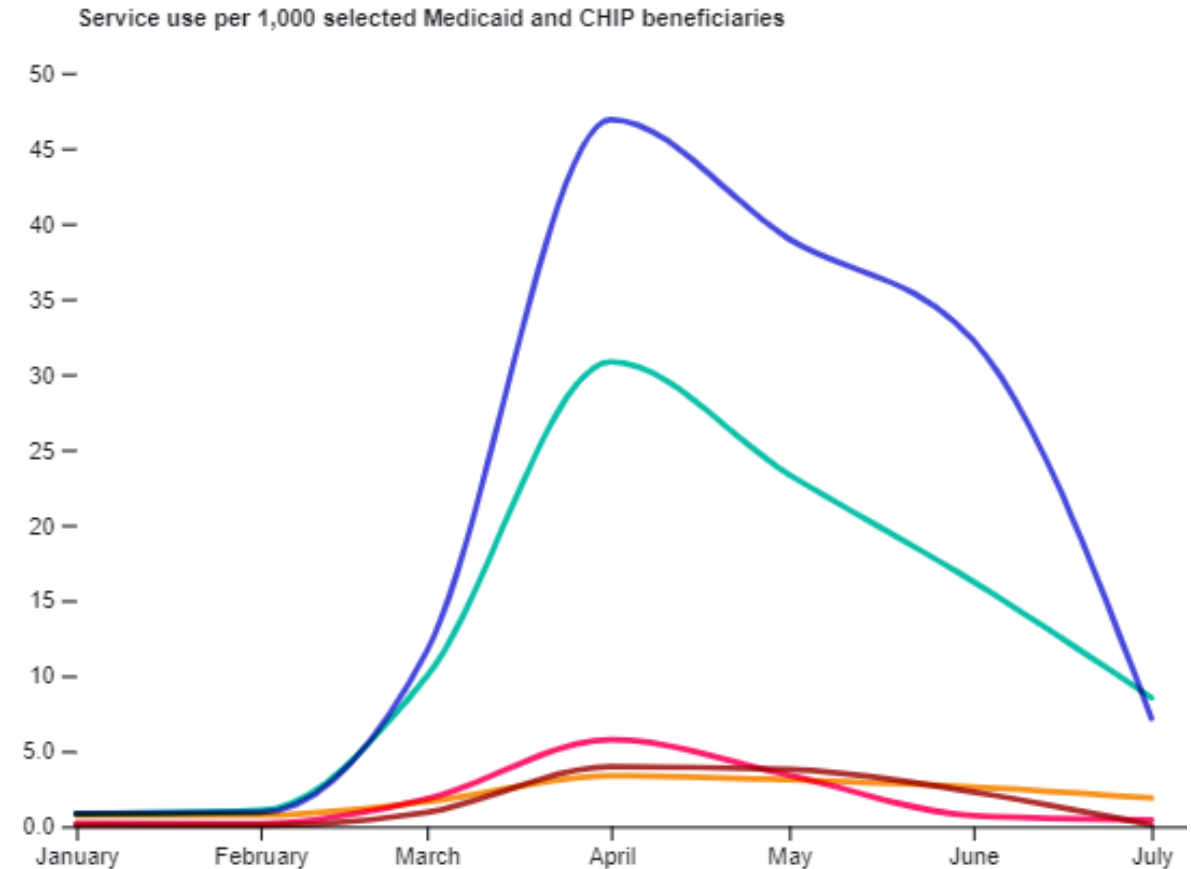
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# Preliminary data show, among children, mental health services delivered through telehealth increased in all states in April and tapered off in July, but the rate of increase from February varied across states



AL, CT, MD, NH, and RI had the greatest percent increase in telehealth mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

Alabama Connecticut Maryland New Hampshire Rhode Island



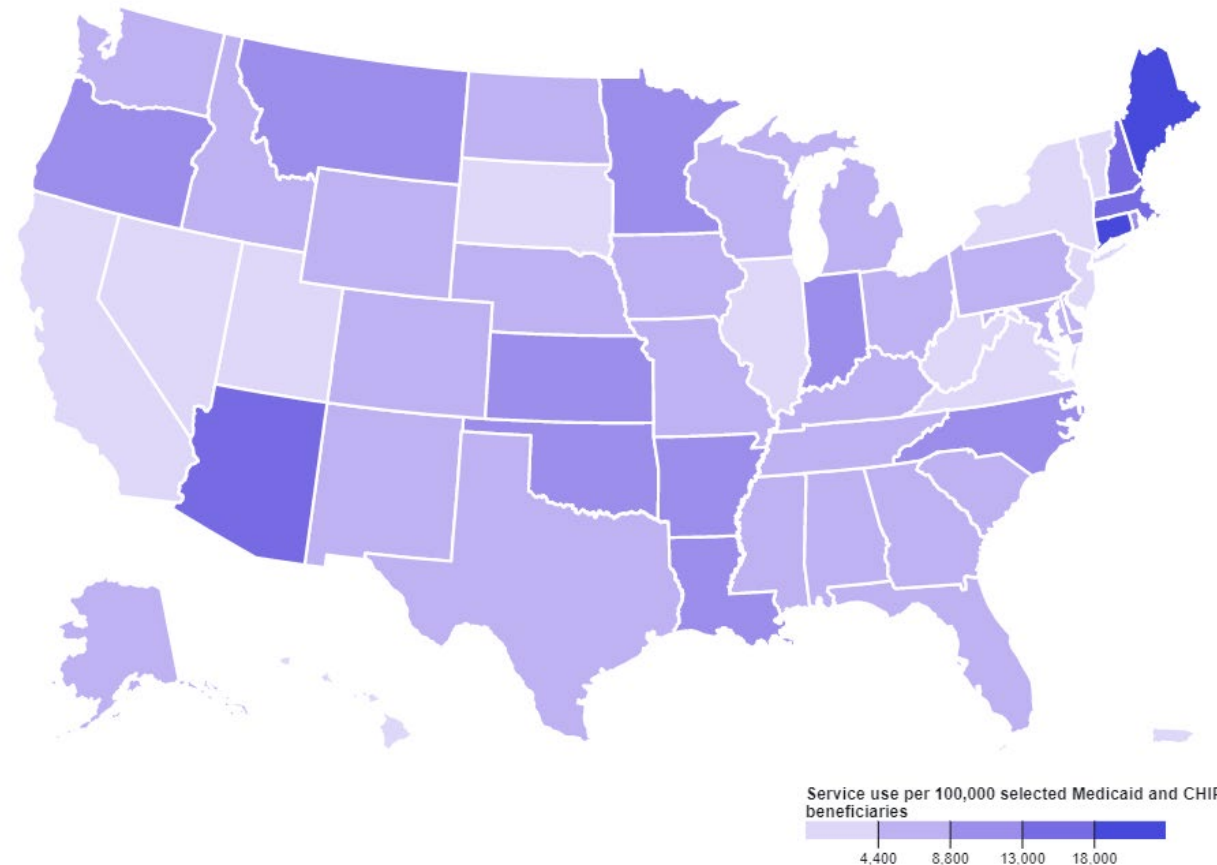
AK, AZ, IL, MO, and PA had the smallest percent increase in telehealth mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

Alaska Arizona Illinois Missouri Pennsylvania

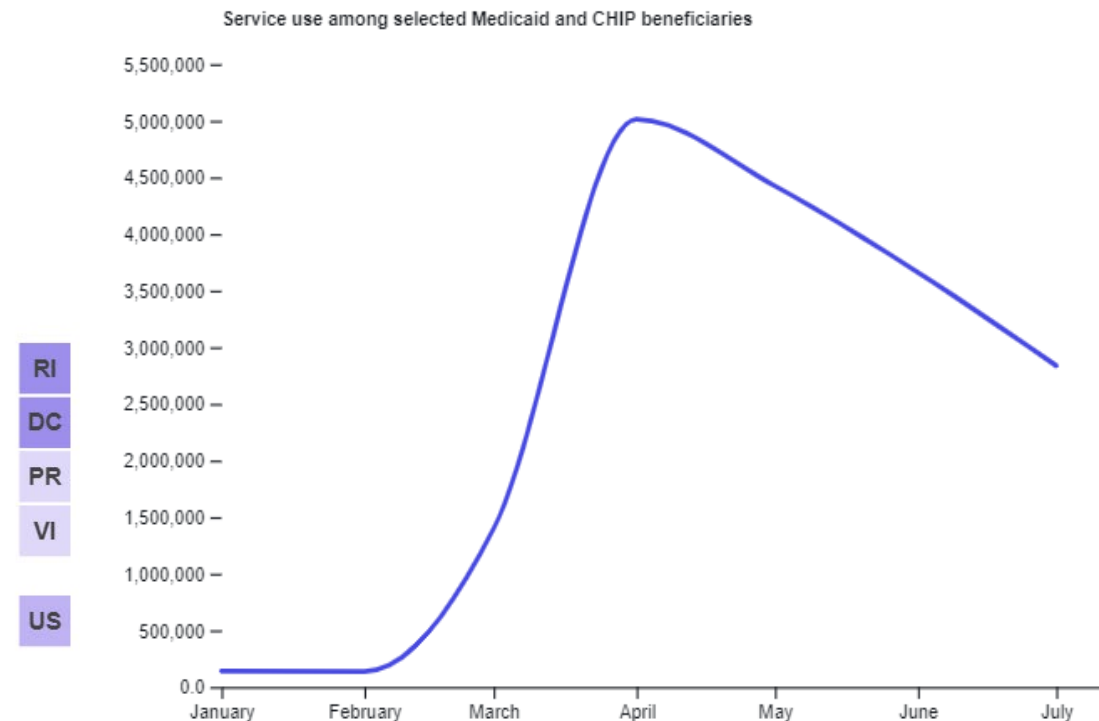
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# Preliminary data show rates of services delivered through telehealth among beneficiaries under age 19 peaked in April and were generally highest in the northeast

Average monthly rate of services delivered via telehealth per 100,000 beneficiaries under age 19 in 2020



Number of services delivered via telehealth among Medicaid and CHIP beneficiaries under age 19 in 2020

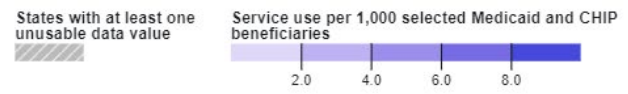
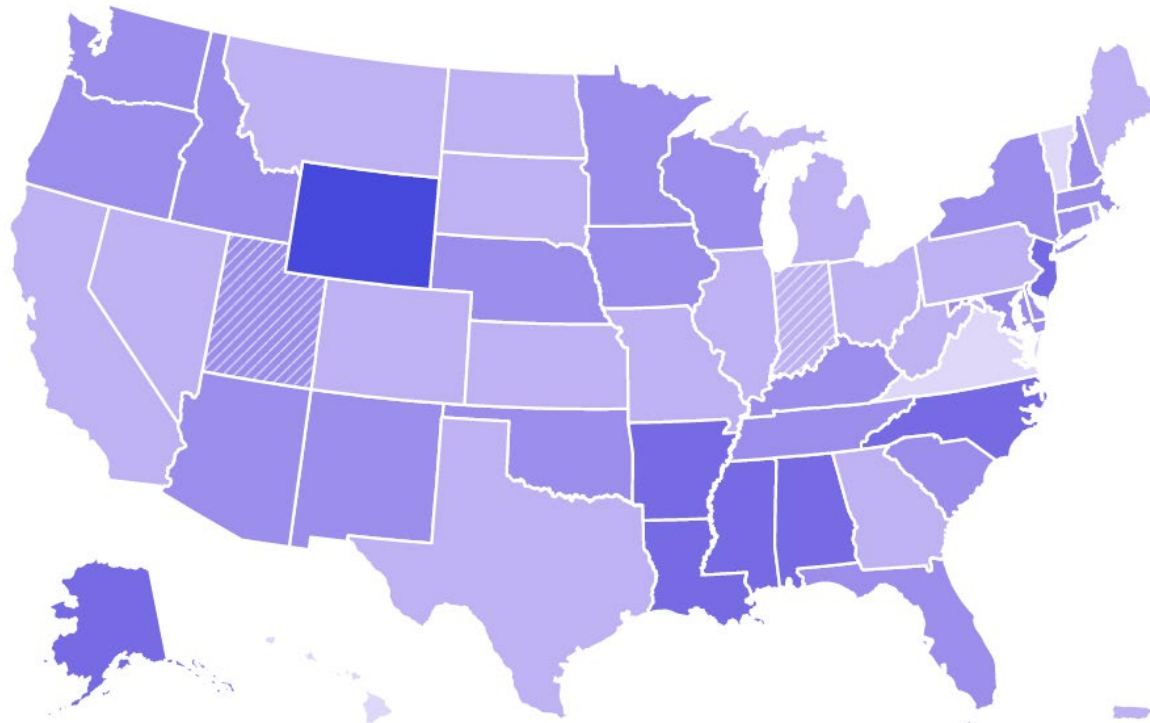


**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

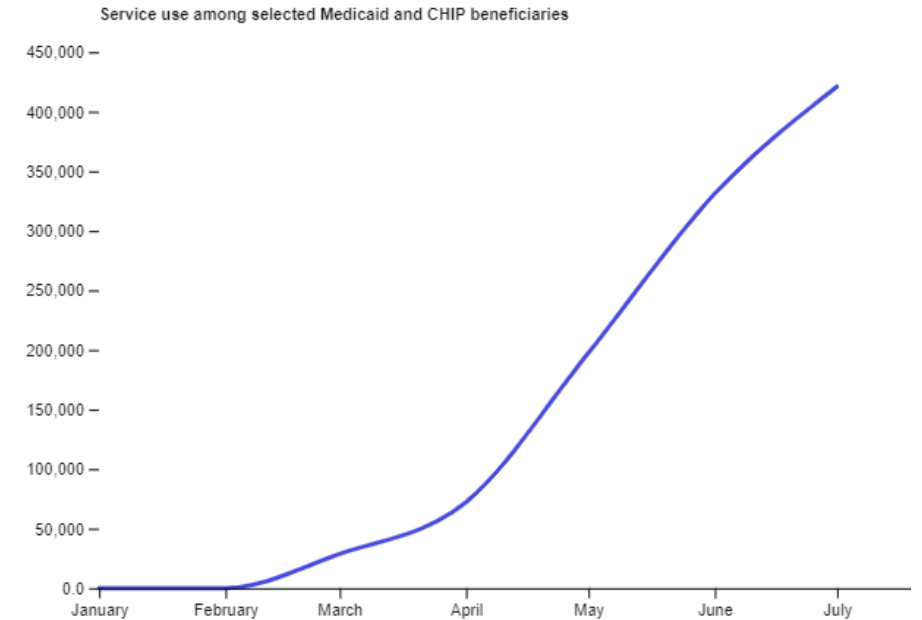
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# More than 1.1 million Medicaid and CHIP beneficiaries under age 19 received a test for COVID-19 in 2020

Average monthly rate of COVID-19 tests or testing-related services per 100,000 beneficiaries under age 19 in 2020



Number of COVID-19 tests or testing-related services among Medicaid and CHIP beneficiaries under age 19 in 2020



- RI
- DC
- PR
- VI
- US

COVID-19 test or testing-related service

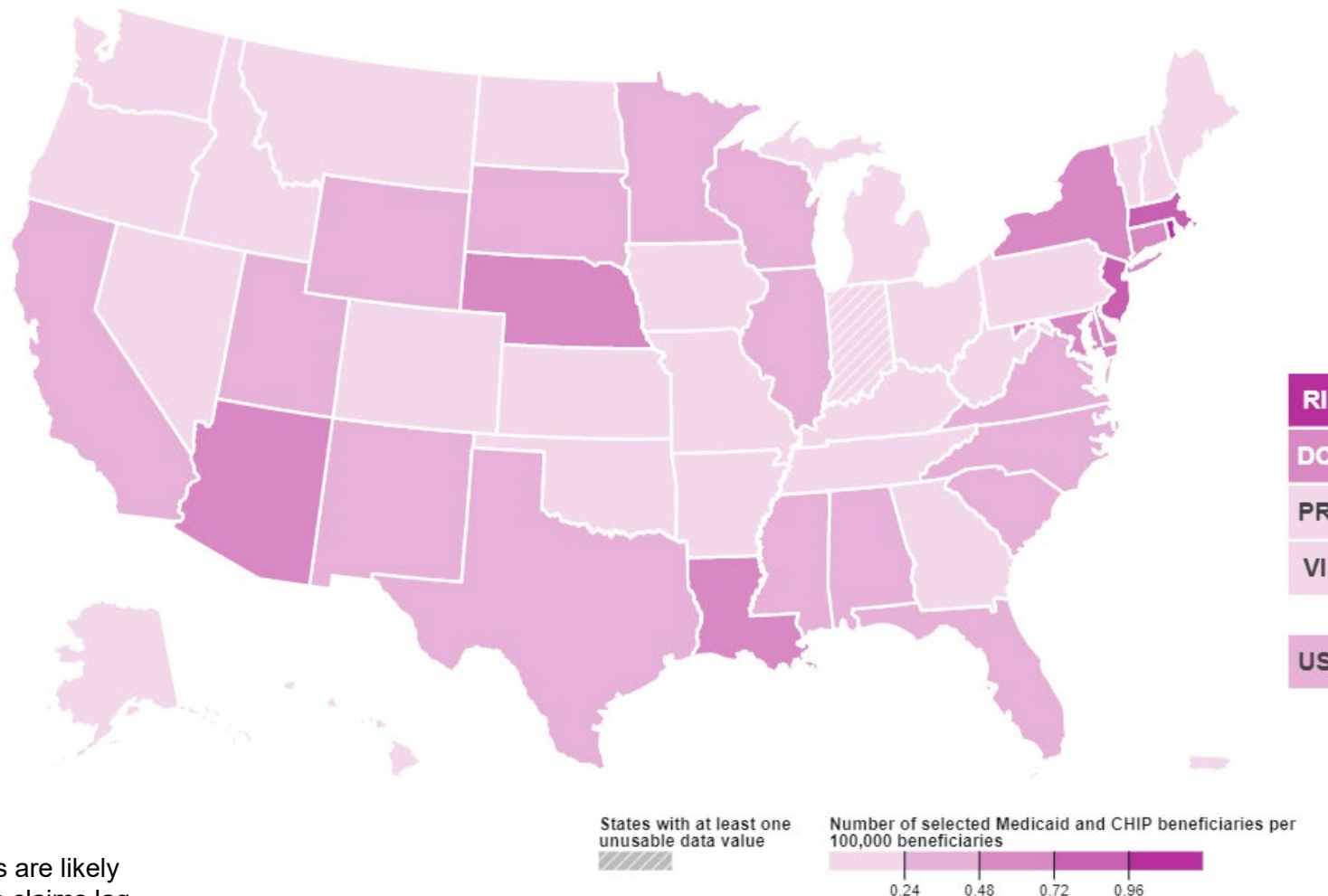
**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.



# Less than 130,000 Medicaid and CHIP beneficiaries under age 19 received treatment for COVID-19 in 2020

Average monthly treatment rate for COVID-19 per 100,000 beneficiaries under age 19 in 2020

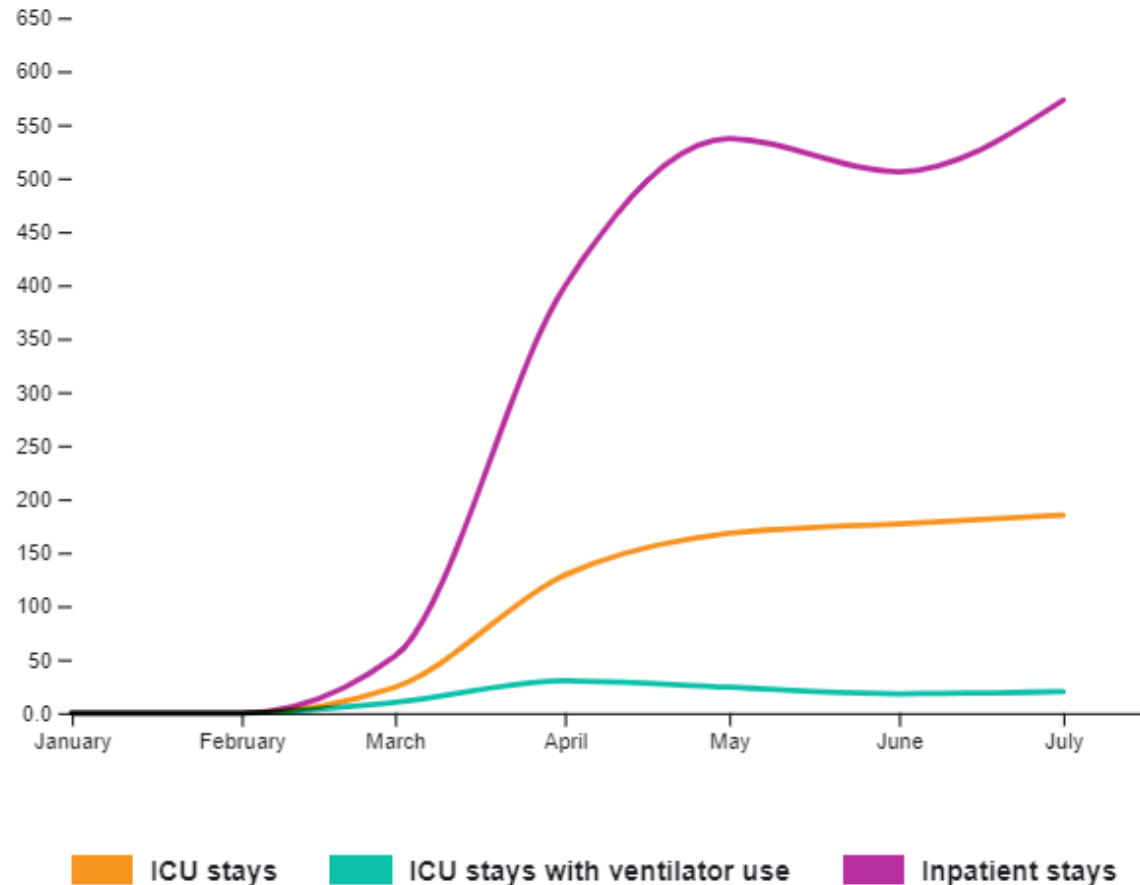


**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.

# Fewer than 2,100 of over 41 million Medicaid and CHIP beneficiaries under age 19 (<0.01%) have been hospitalized for COVID-19

Number of COVID-19 acute care services for beneficiaries 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 v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.



# Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries during the COVID-19 Public Health Emergency



*Preliminary Medicaid & CHIP Data Snapshot*

Services through July 31, 2020

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# Services Delivered via Telehealth in Medicaid & 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
Evaluation and management services	Routine office visits provided via video
Virtual check-ins	Remote evaluations of recorded video or images submitted by an established patient followed by a brief (5-10 minute) check-in with a physician or other provider via telephone or other telecommunications device to decide whether an office visit or other service is needed
Asynchronous electronic communication	Communication with an established patient through a patient portal or other online method, resulting in a digital evaluation and management service
Remote patient monitoring	Use of digital technologies to collect and transmit health data from individuals to health care providers
Critical care or interprofessional consults	Consultative services provided through digital technologies
Other telehealth visits	Any other services provided via telehealth

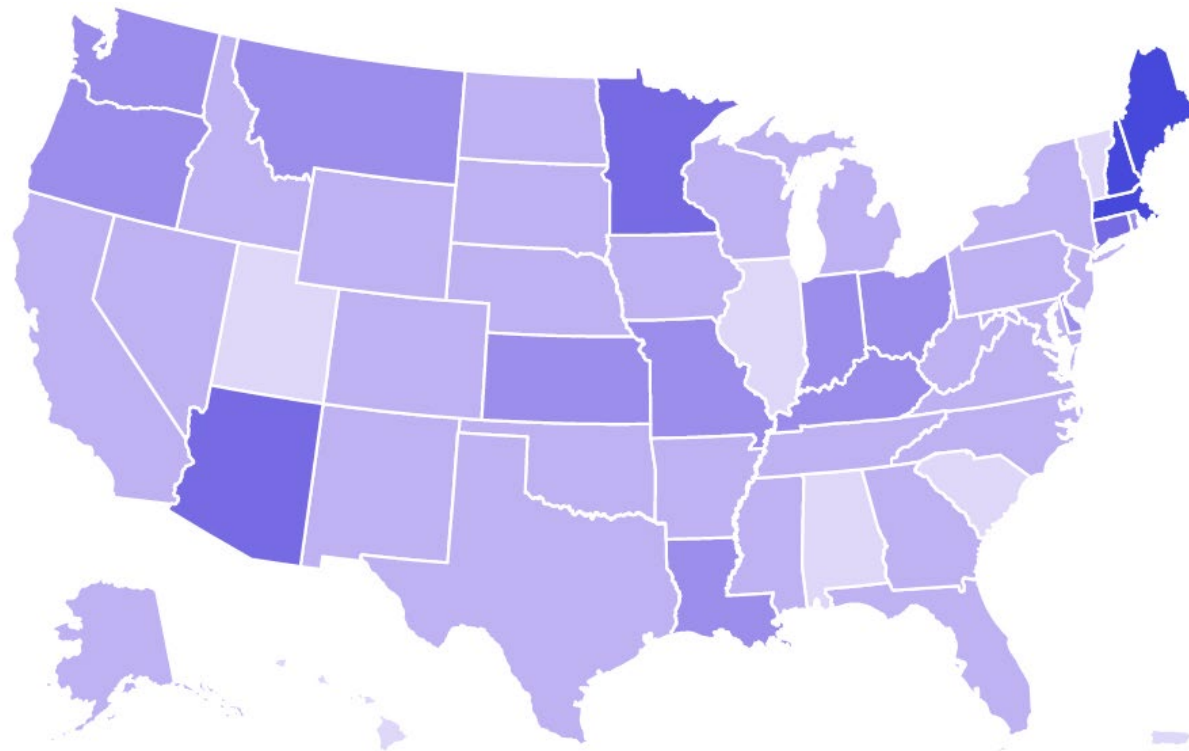
# Use of telehealth during COVID-19: Key highlights

Preliminary data suggest that, during the PHE:

- Services delivered through telehealth spiked in April and fell from May through July among all age groups
- Across the US, the rate of telehealth use per 100,000 beneficiaries was highest among adults ages 19 to 64, and rates were similar among children under age 19 and adults age 65 and older
- There was considerable variation in the use of telehealth across states and across ages within states

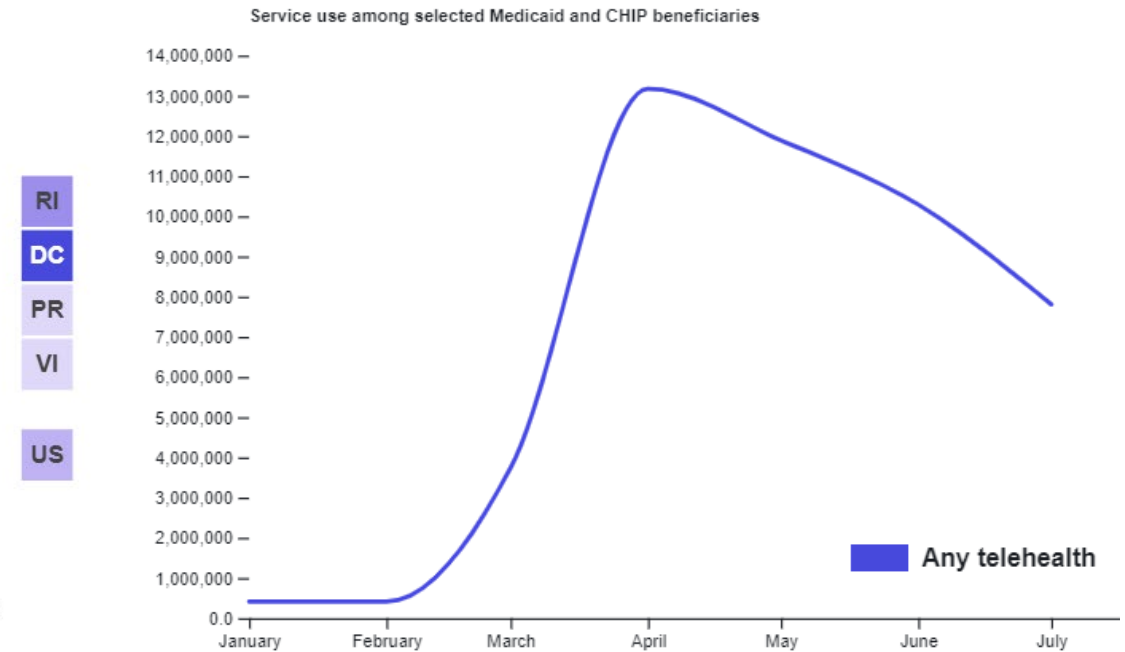
# Preliminary data show rates of services delivered through telehealth peaked in April, fell through July, and were highest in a few key states

Average monthly rate of services delivered via telehealth per 100,000 Medicaid and CHIP beneficiaries in 2020



**46,897,937** services delivered through telehealth from March through July 2020, an increase of **2,846%** compared to March through July 2019

Number of services delivered via telehealth among Medicaid and CHIP beneficiaries in 2020



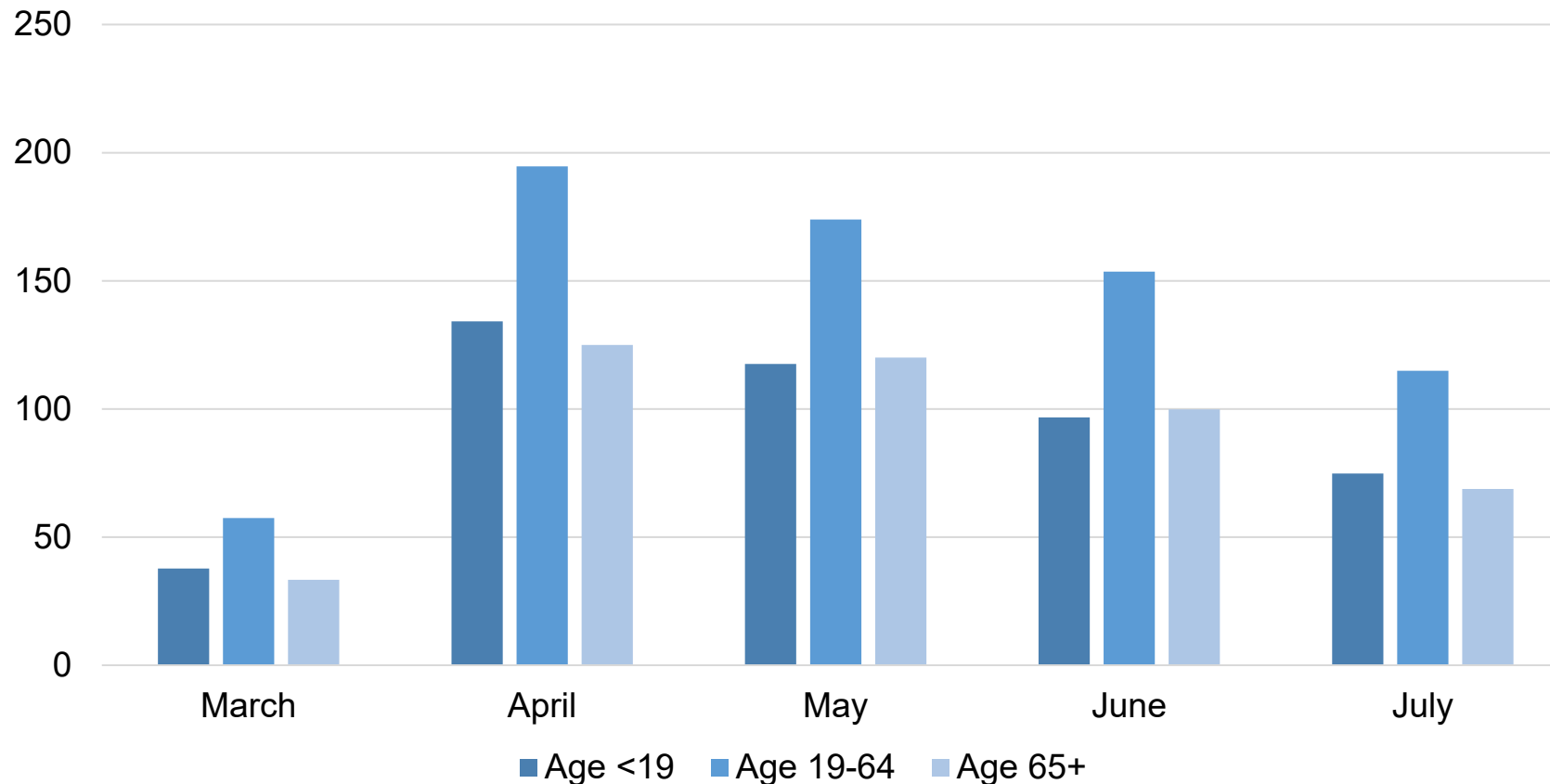
**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

Service use per 100,000 selected Medicaid and CHIP beneficiaries

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.

# Preliminary data suggest that services delivered via telehealth were highest among working age adults, followed by children and older adults

Services delivered via telehealth per 1,000 beneficiaries in 2020

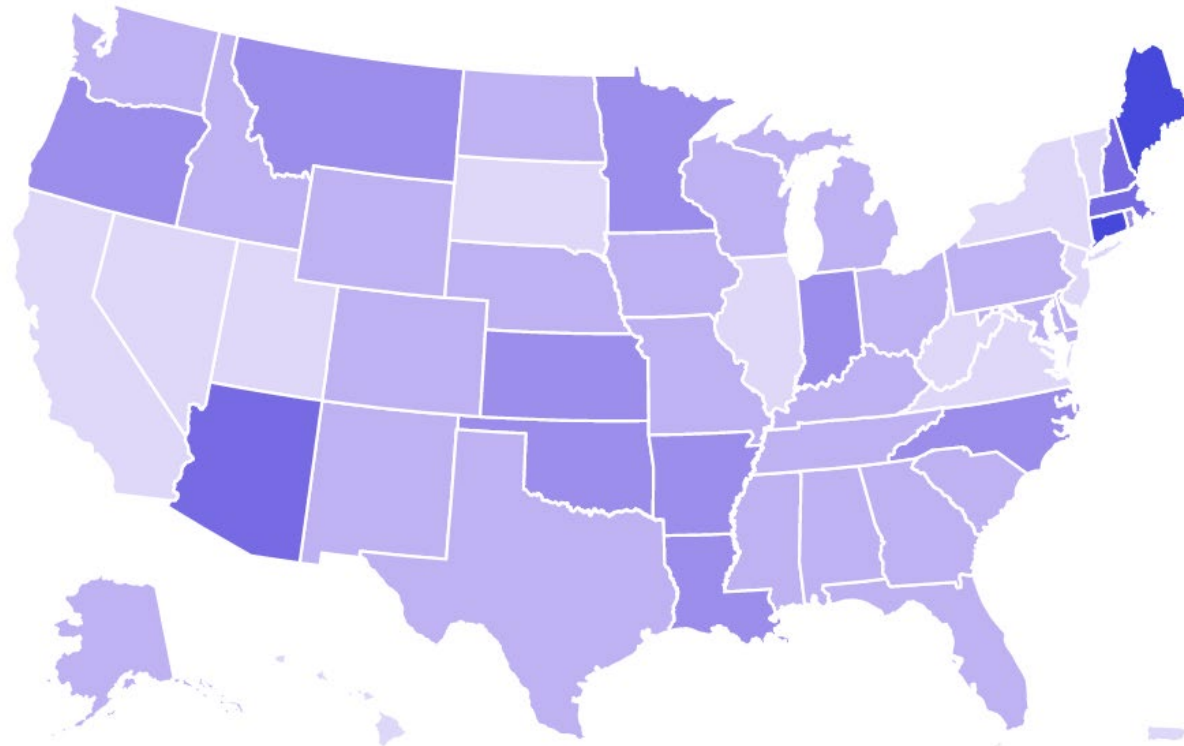


**Note:** Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid & CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. Many beneficiaries age 65 and older are likely to be dually eligible for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



# Preliminary data show rates of services delivered through telehealth among beneficiaries under age 19 peaked in April and were generally highest in the northeast

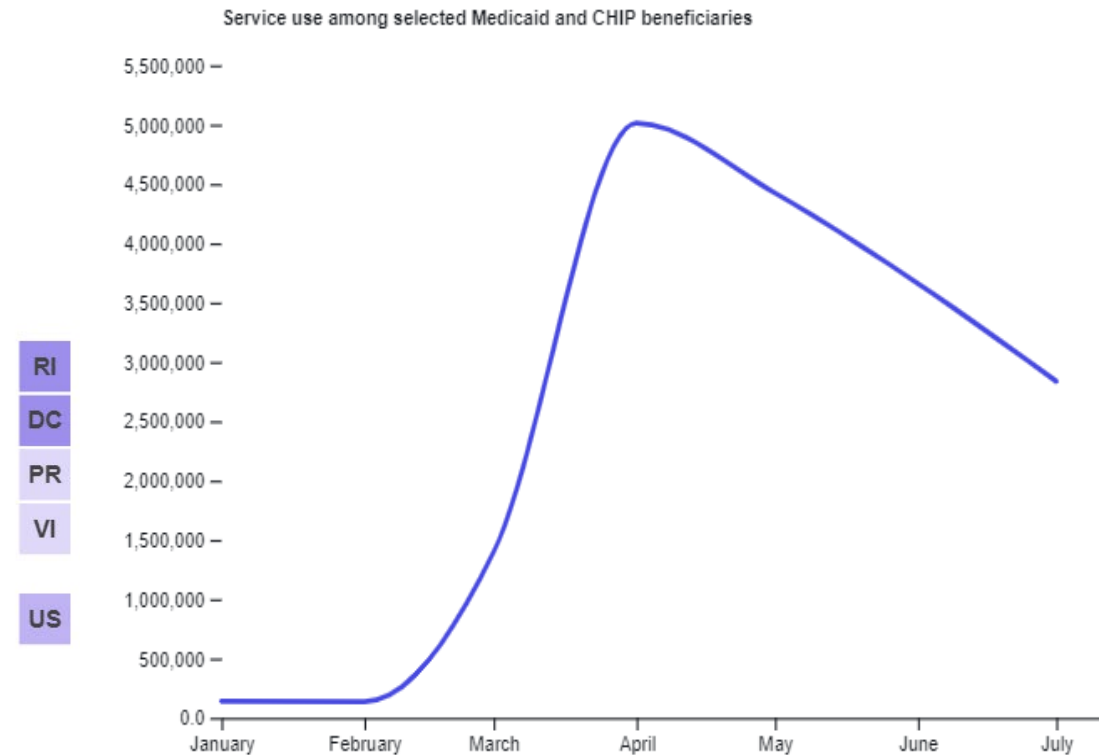
Average monthly rate of services delivered via telehealth per 100,000 beneficiaries under age 19 in 2020



Service use per 100,000 selected Medicaid and CHIP beneficiaries

4,400	8,800	13,000	18,000
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Number of services delivered via telehealth among Medicaid and CHIP beneficiaries under age 19 in 2020

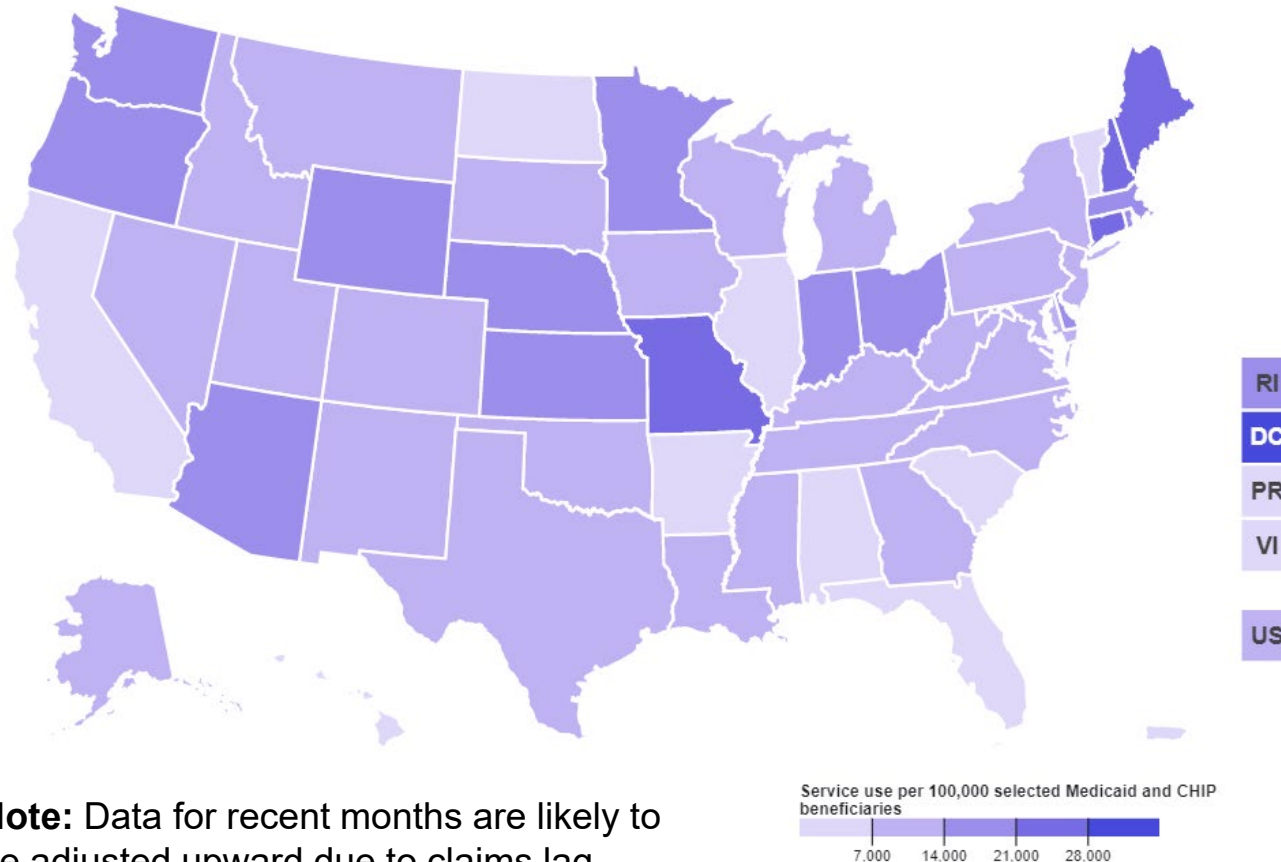


**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

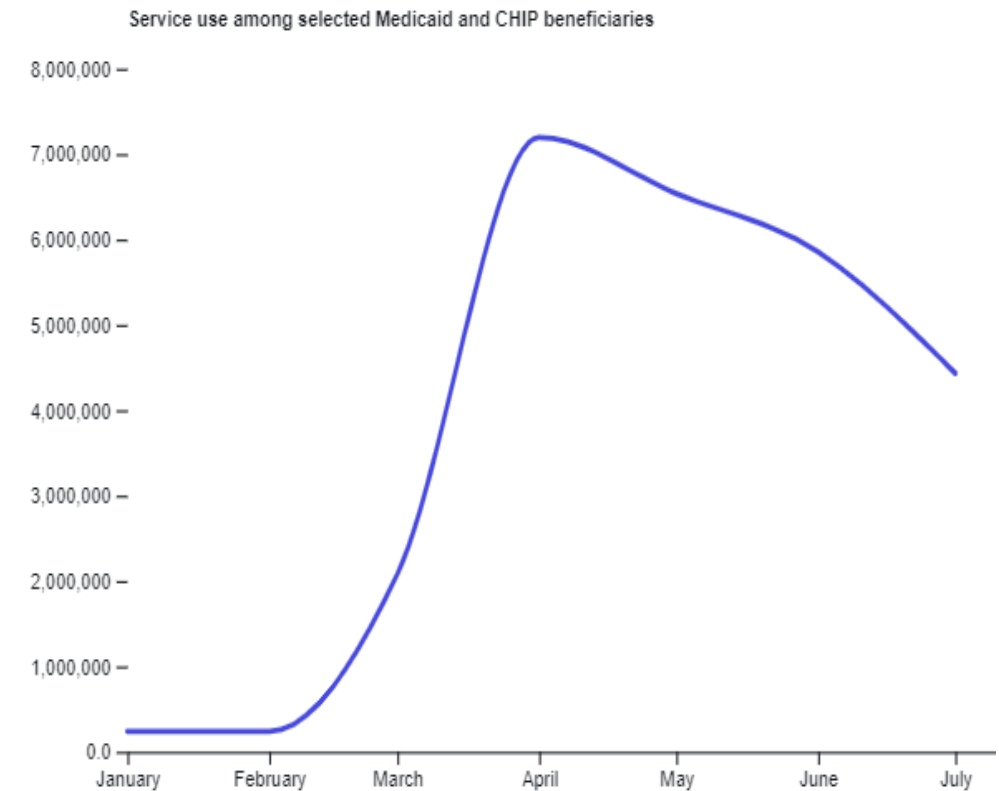
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# Preliminary data show rates of services delivered through telehealth per 100,000 were highest among beneficiaries ages 19 to 64 across nearly all states

Average monthly rate of services delivered via telehealth per 100,000 beneficiaries ages 19 to 64 in 2020



Number of services delivered via telehealth among Medicaid and CHIP beneficiaries ages 19 to 64 in 2020

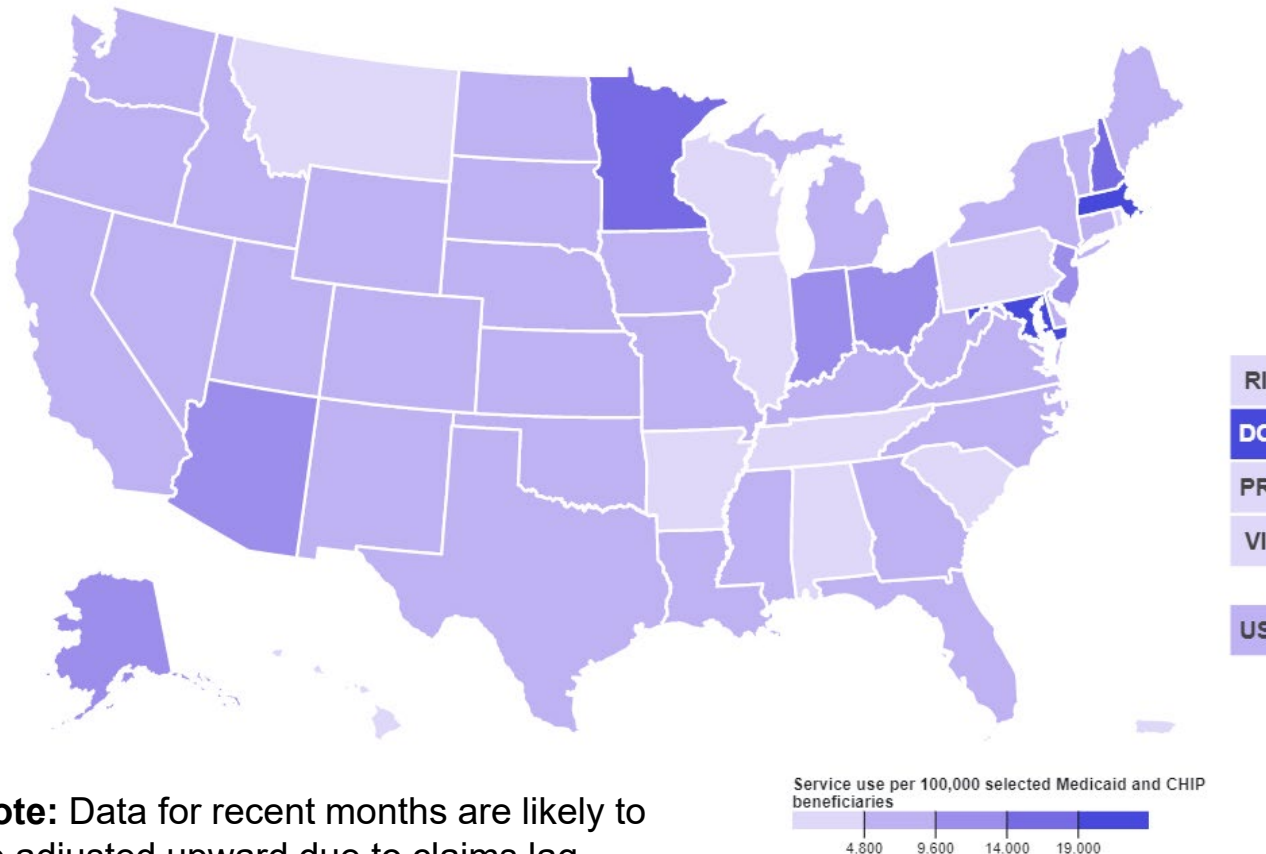


**Note:** Data for recent months are likely to be adjusted upward due to claims lag.

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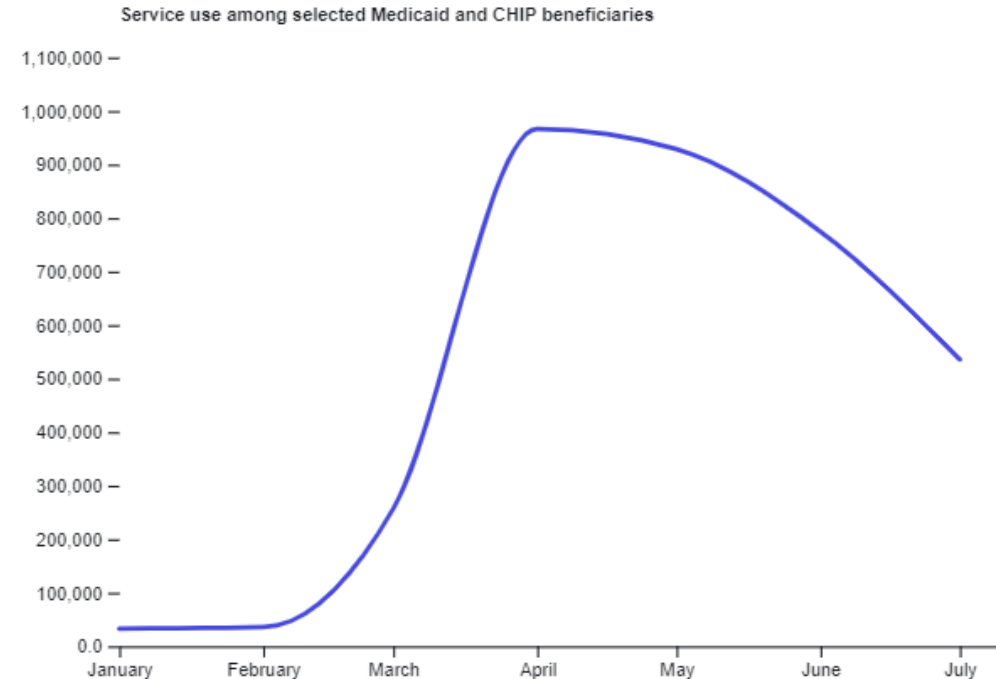
# Preliminary data show rates of services delivered through telehealth (paid for by Medicaid) per 100,000 beneficiaries age 65 and older varied by state

Average monthly rate of services delivered via telehealth per 100,000 beneficiaries age 65 and older in 2020



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

Number of services delivered via telehealth among Medicaid and CHIP beneficiaries age 65 and older in 2020



**Note:** These results are for Medicaid & 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. Therefore, the results may underestimate telehealth utilization in this population.

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020.



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



***Preliminary Medicaid &  
CHIP Data Snapshot***

**Services through July 31, 2020**

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# 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.<sup>1</sup>
- Individuals suffering from mental health conditions or SUD face many challenges accessing care and often do not seek treatment.<sup>2,3</sup>
- 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.<sup>4</sup>

<sup>1</sup>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>.

<sup>2</sup>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.

<sup>3</sup>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.

<sup>4</sup>Mathematica analysis of 2019 TAF data. October 2020.

# Mental Health and Substance Use Disorders during COVID-19

- Preliminary evidence suggests that there has been a sharp increase in the number of adults reporting adverse mental or behavioral health conditions during the COVID-19 pandemic compared to prior years.<sup>1</sup>
- Similarly, preliminary evidence indicates that there has also been an increase in drug-related mortality during the COVID-19 pandemic.<sup>2</sup>

<sup>1</sup> 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.mm6932a1>[external icon](#)

<sup>2</sup> American Medical Association (AMA). "Issue brief: Reports of increases in opioid- and other drug-related overdose and other concerns during COVID pandemic." October 31, 2020. Available at: <https://www.ama-assn.org/system/files/2020-11/issue-brief-increases-in-opioid-related-overdose.pdf>

# Service use among adults during COVID-19: Key highlights

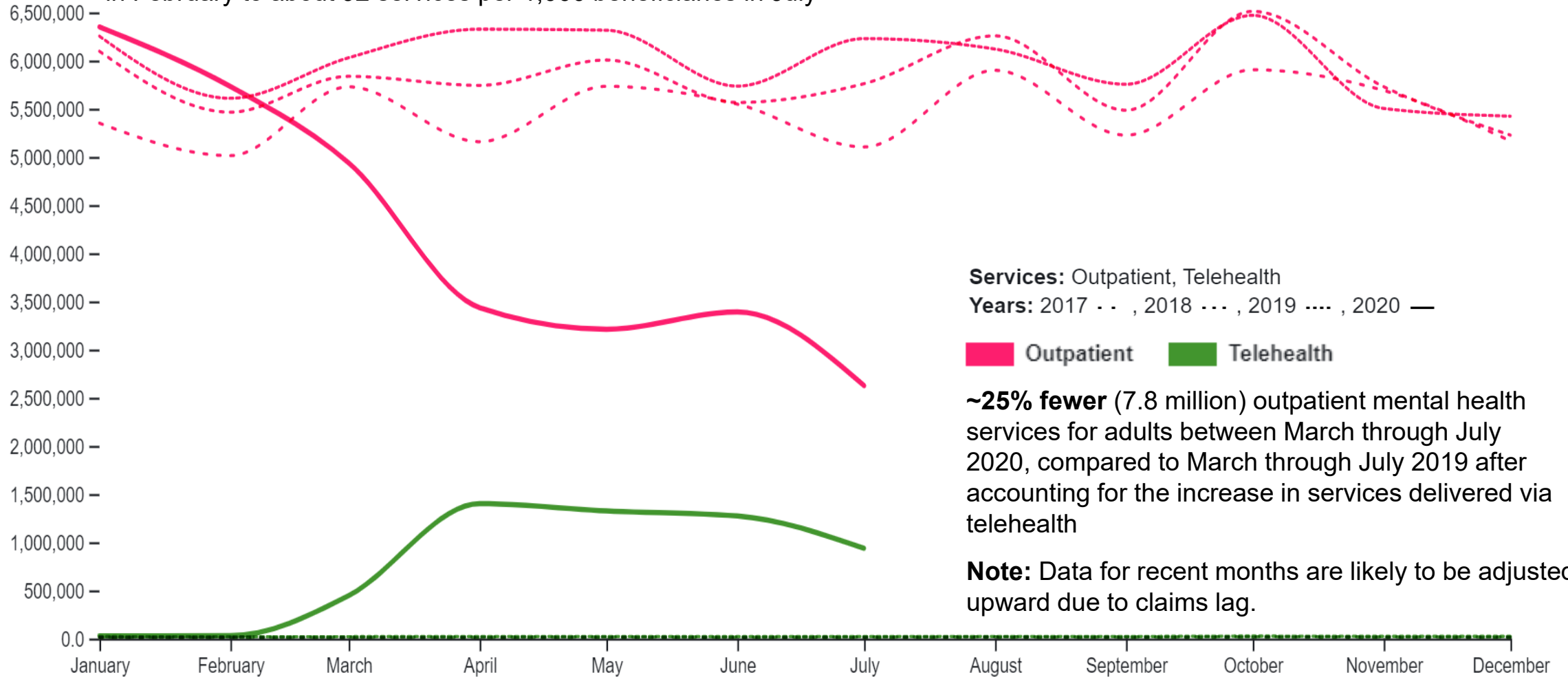
Preliminary data suggest that, during the PHE:

- Mental health services and SUD services for adults ages 19 to 64 and children under age 19 dropped substantially in April and have continued to decline through July in nearly all states.
- Compared to prior years' rates, there is a notable gap in services for mental health conditions and SUDs.
- Service delivery via telehealth for adults age 19 to 64 and children under 19 increased dramatically, but not enough to offset the decline in in-person services.
- Intensive SUD services for adults are often delivered in inpatient or partial hospitalization settings, which poses a unique challenge for care delivery during the PHE.



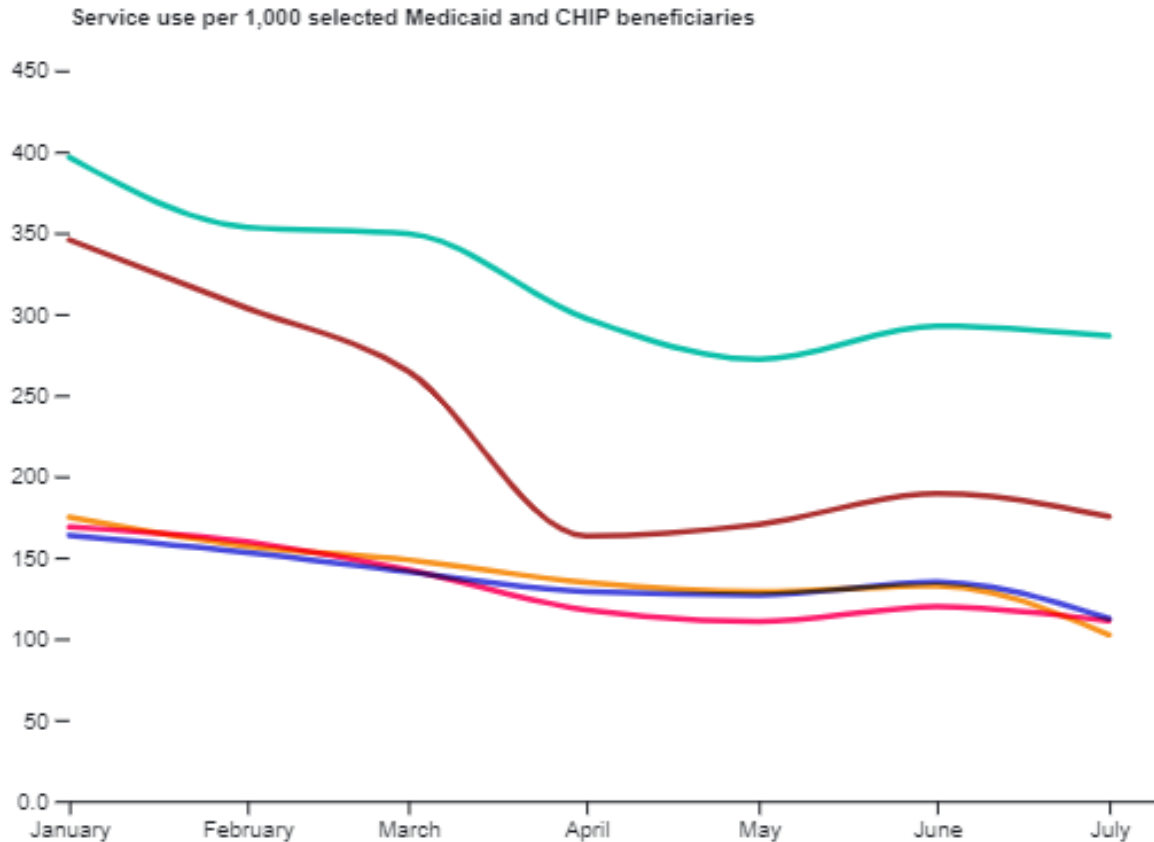
# Preliminary data show outpatient mental health services for adults age 19 to 64 declined starting in March and continued through July. Telehealth increased starting in March, but not enough to offset this decline.

7,000,000 – Outpatient mental health services and services delivered via telehealth among adults dropped from 159 per 1,000 beneficiaries in February to about 92 services per 1,000 beneficiaries in July



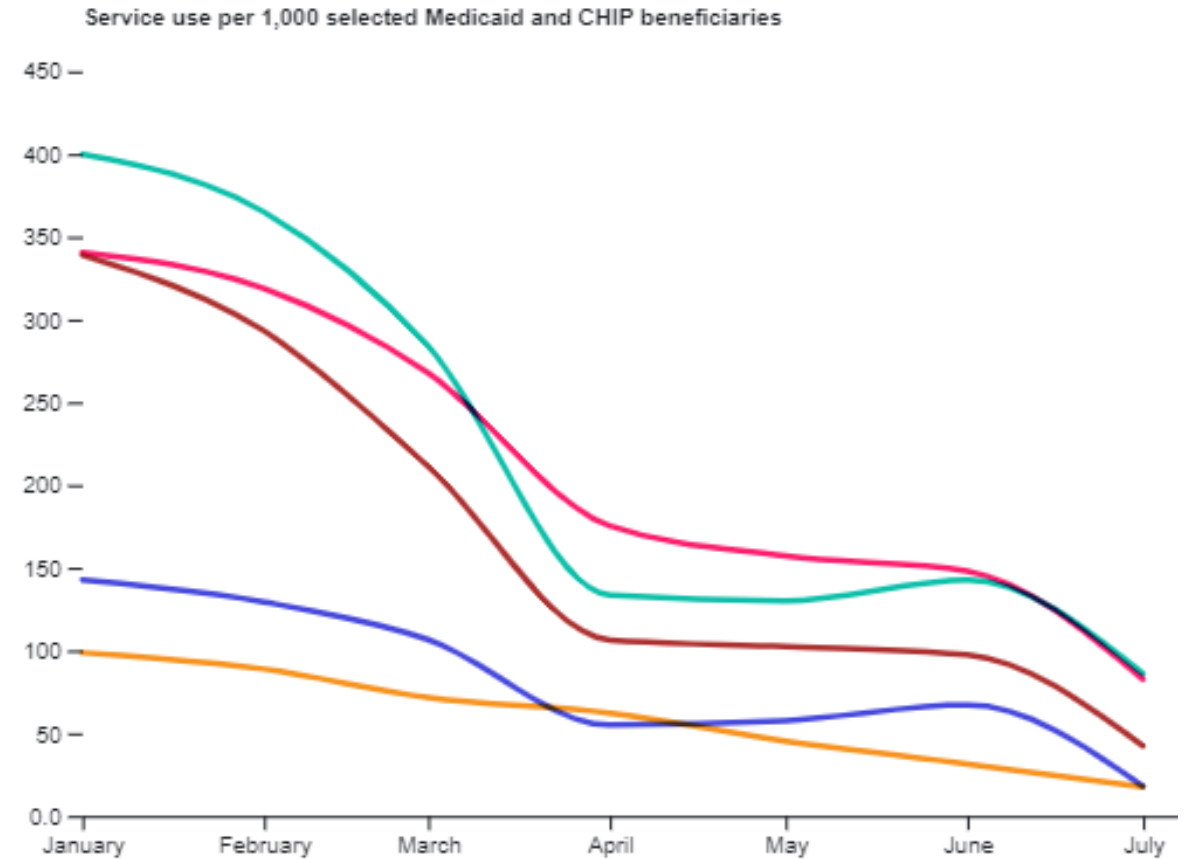
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# Preliminary data show outpatient mental health service use among adults age 19 to 64 declined in all states through July, but the rate of decline varied across states



NJ, NY, OK, SD, and WA had the smallest percent decrease in mental health services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

■ New Jersey ■ New York ■ Oklahoma ■ South Dakota ■ Washington

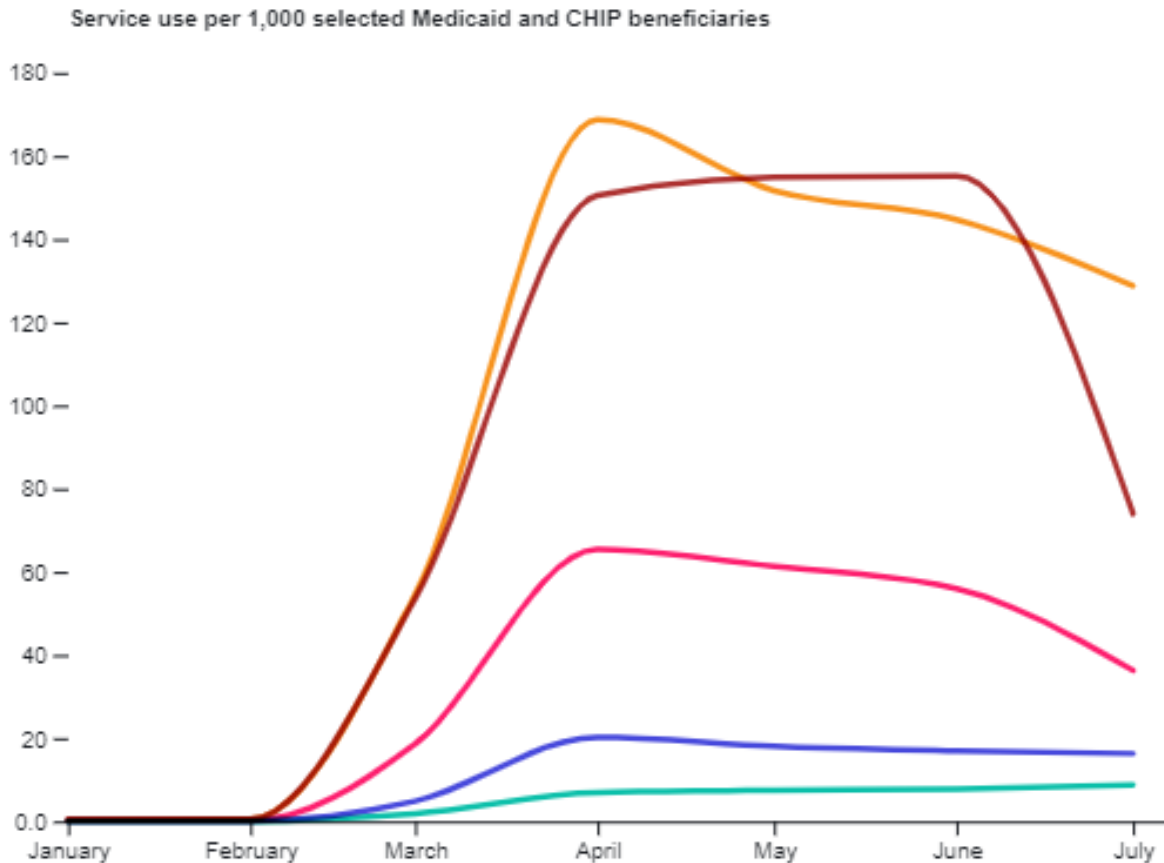


AK, CA, MA, MN, and RI had the greatest percent decrease in mental health services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

■ Alaska ■ California ■ Massachusetts ■ Minnesota ■ Rhode Island

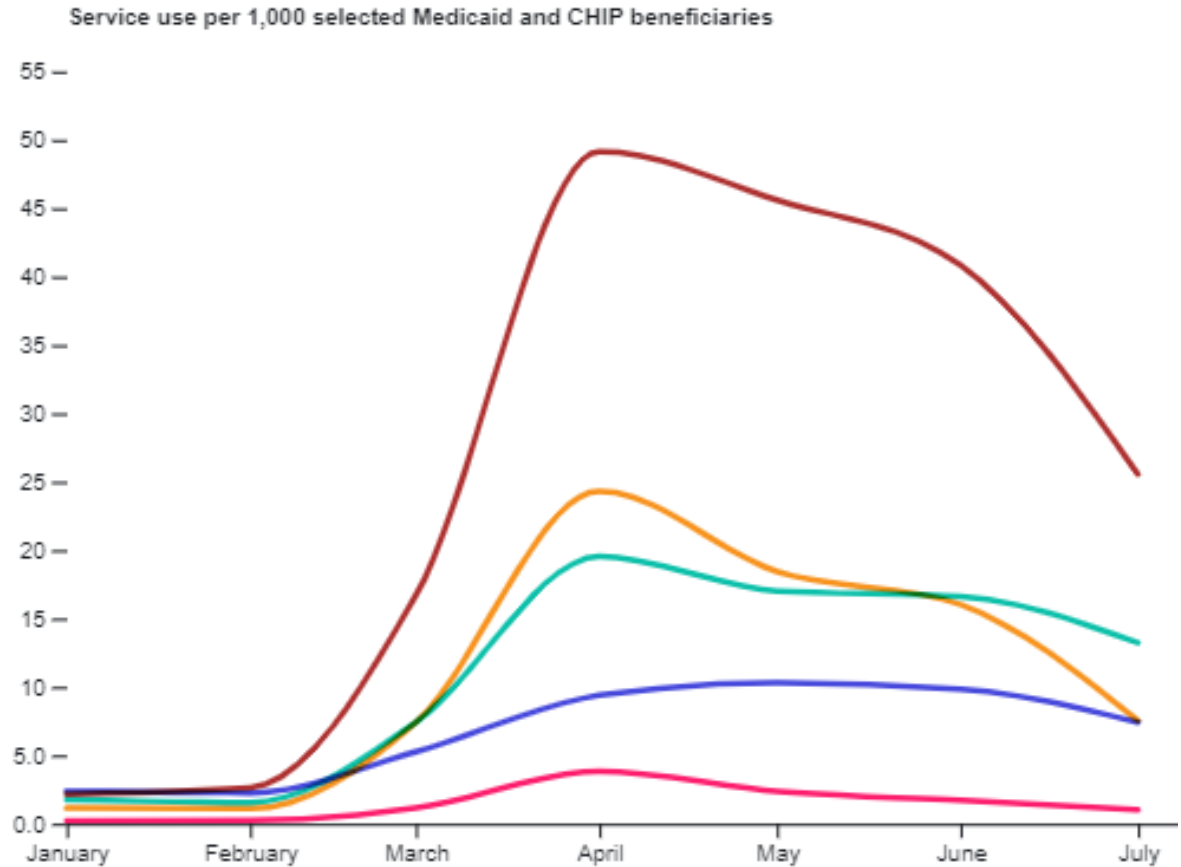
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# Preliminary data show, among adults age 19 to 64, mental health services delivered through telehealth increased in nearly all states in April and tapered off in July, but the rate of increase from February varied across states



AL, CT, MA, PR, and RI had the largest percent increase in telehealth mental health services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

Alabama Connecticut Massachusetts Puerto Rico Rhode Island



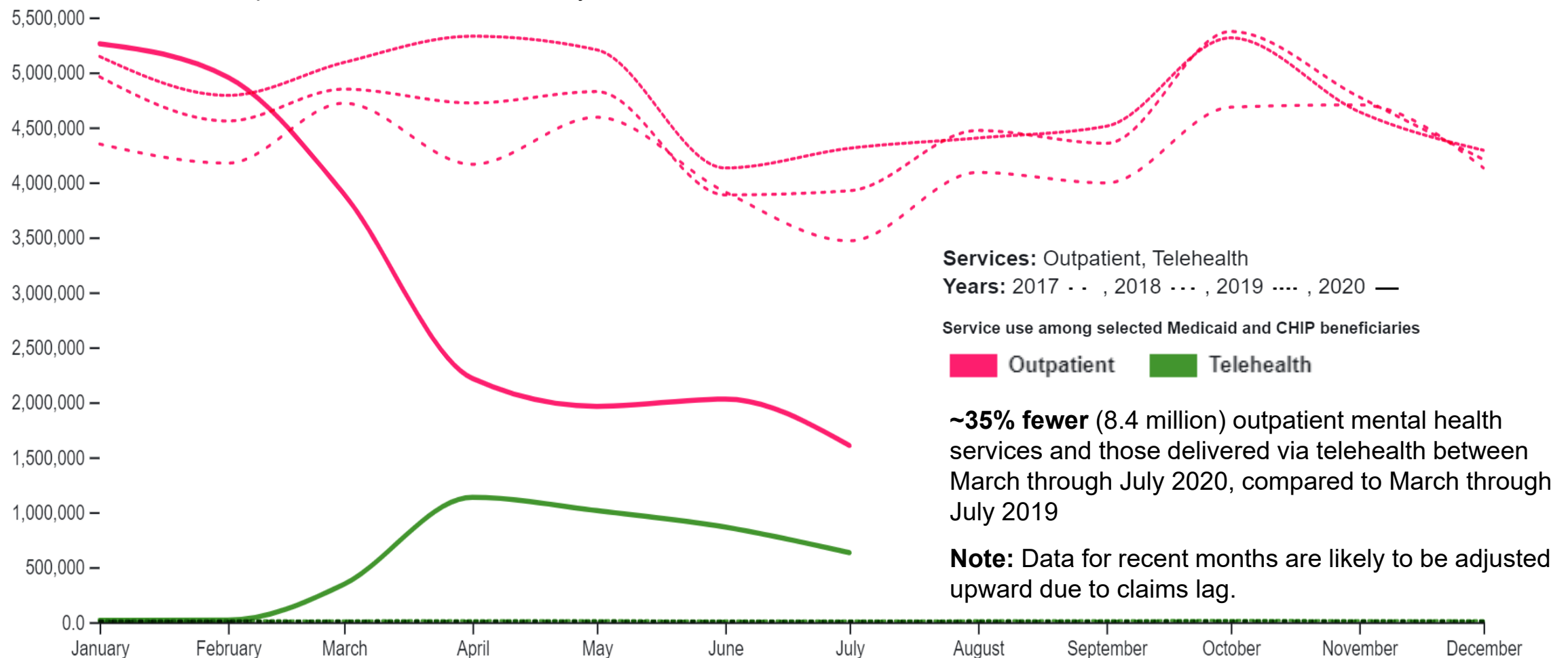
AZ, MO, NV, NJ, and PA had the smallest percent increase in telehealth mental health services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

Arizona Missouri Nevada New Jersey Pennsylvania

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020. There is significant variation in how quickly states submit claims to CMS. It is possible that this variation in claims lag is responsible for the differences in utilization across states. Please refer to Slides 3 to 5 for additional information.

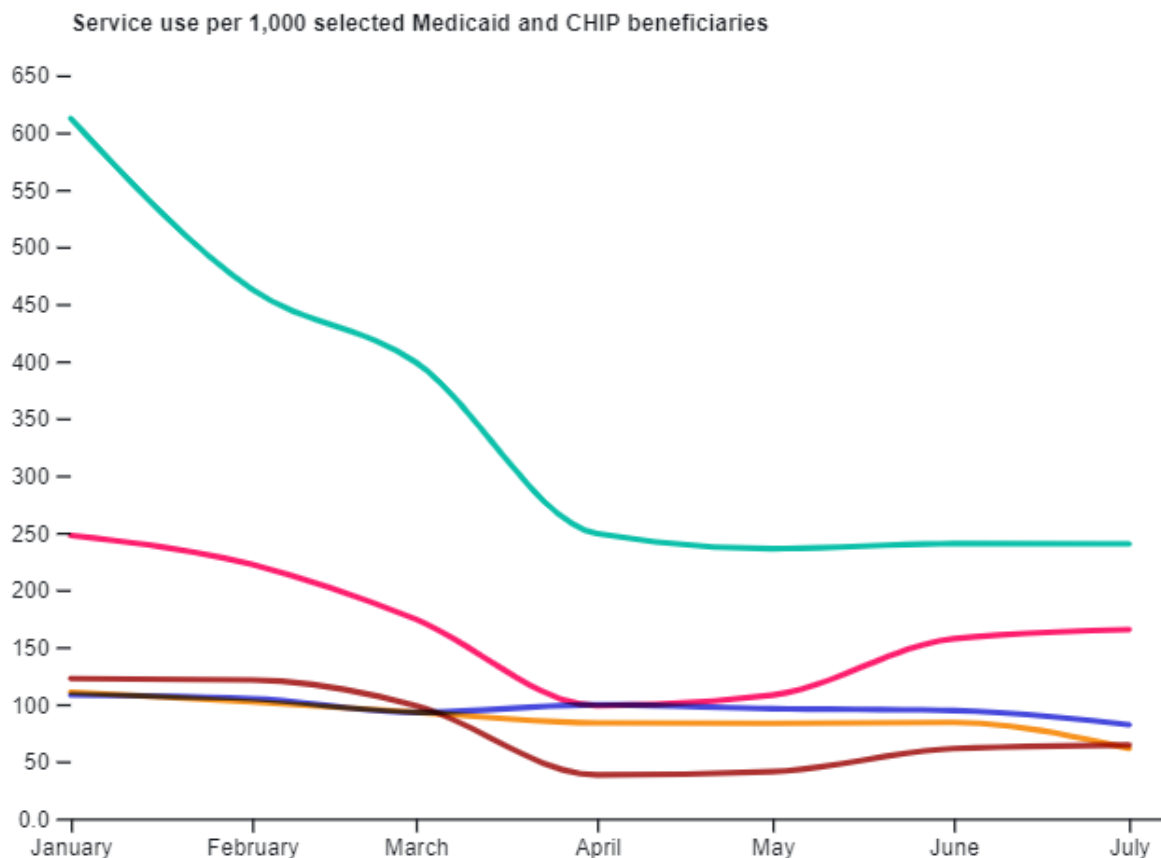
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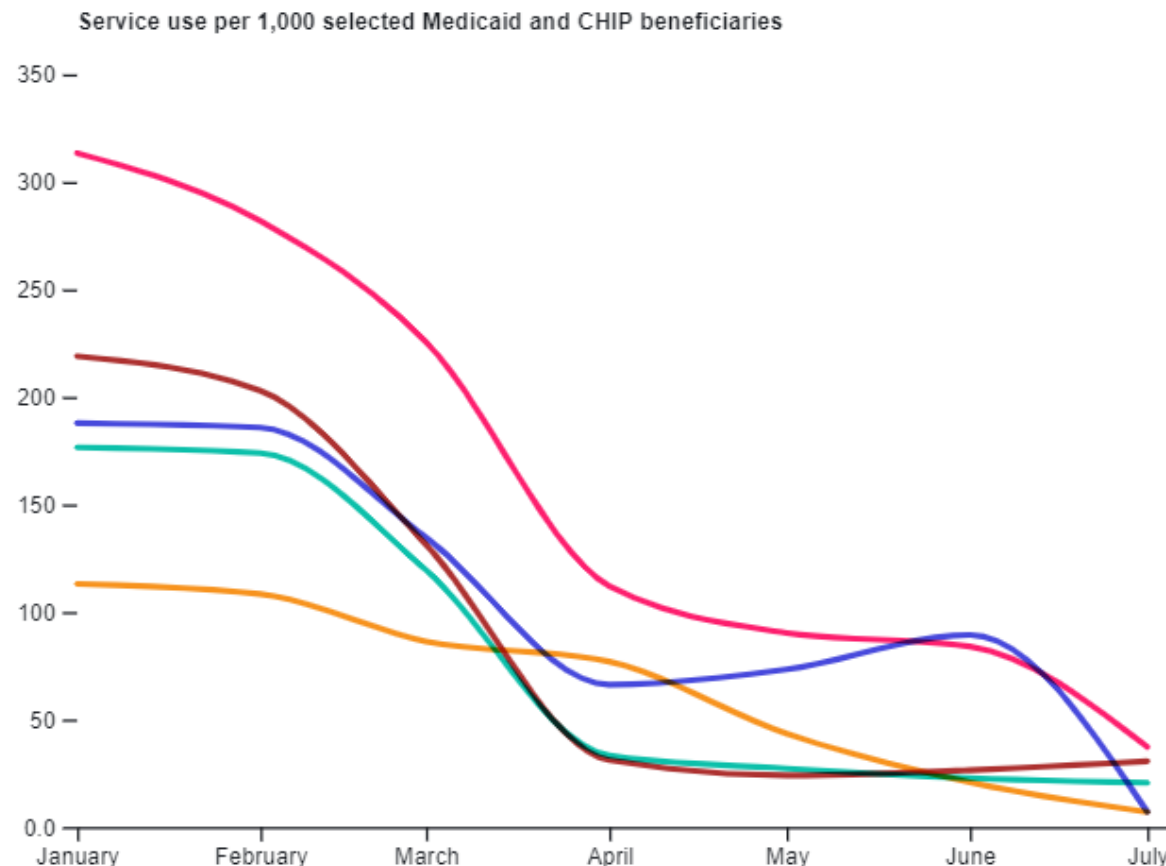
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# Preliminary data show outpatient mental health service use among children declined in all states through July, but the rate of decline varied across states



NJ, NY, ND, VT, and WY had the smallest percent decrease in mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

■ New Jersey ■ New York ■ North Dakota ■ Vermont ■ Wyoming

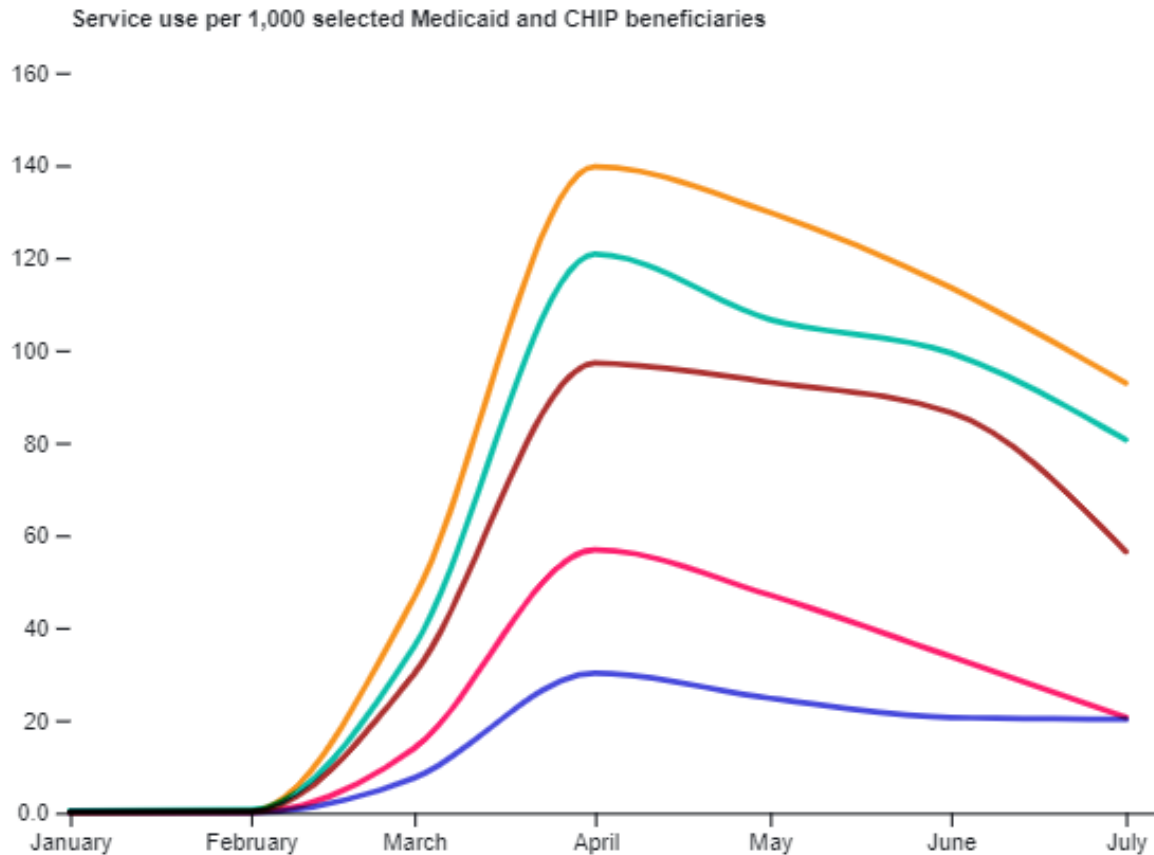


AK, CA, CT, DE, and MA had the greatest percent decrease in mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

■ Alaska ■ California ■ Connecticut ■ Delaware ■ Massachusetts

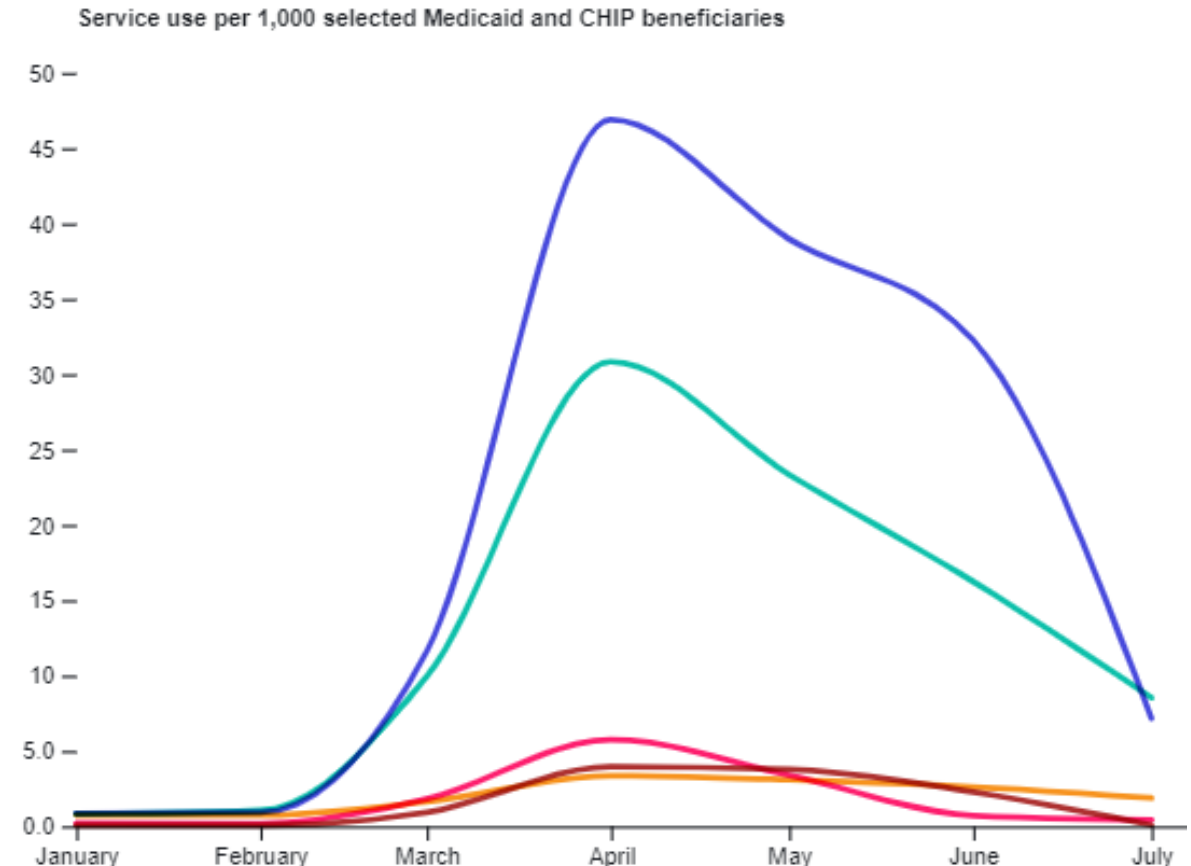
**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for August are incomplete, results are only presented through July 31, 2020. There is significant variation in how quickly states submit claims to CMS. It is possible that this variation in claims lag is responsible for the differences in utilization across states. Please refer to Slides 3 to 5 for additional information.

# Preliminary data show, among children, mental health services delivered through telehealth increased in all states in April and tapered off in July, but the rate of increase from February varied across states



AL, CT, MD, NH, and RI had the greatest percent increase in telehealth mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

Alabama Connecticut Maryland New Hampshire Rhode Island



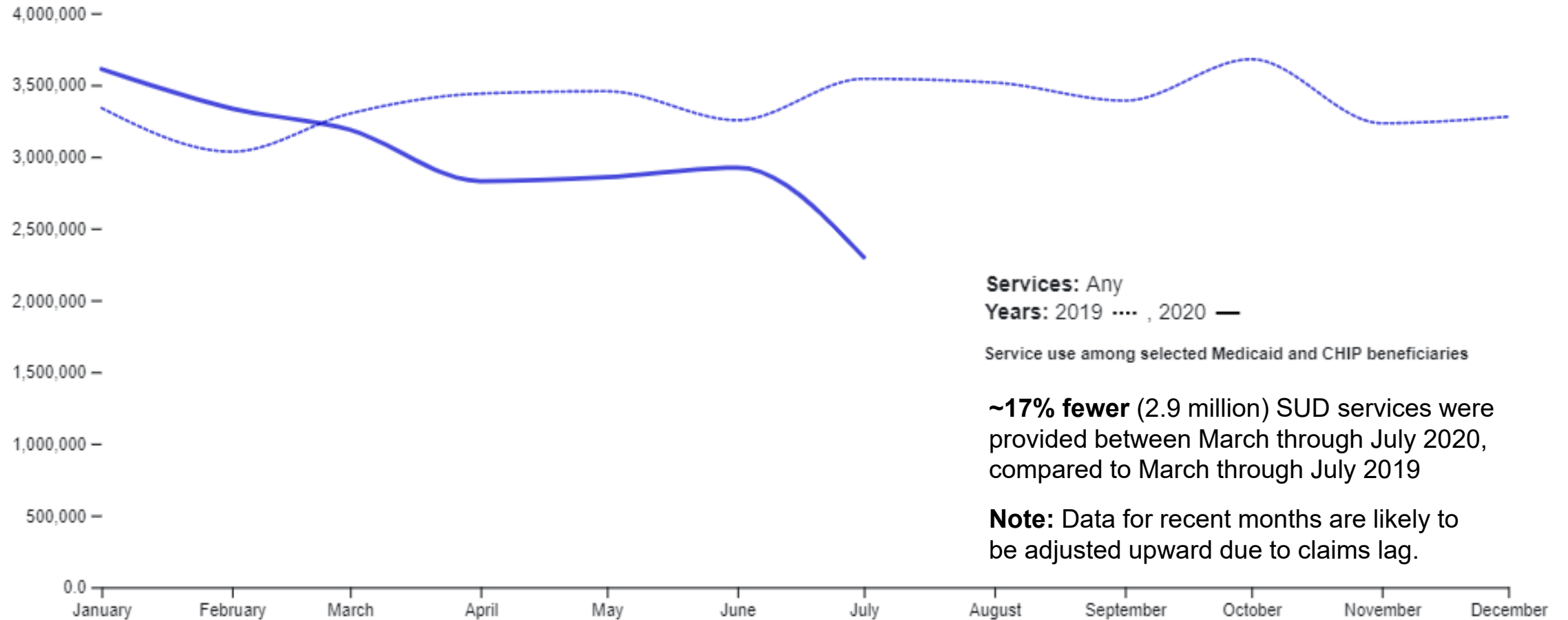
AK, AZ, IL, MO, and PA had the smallest percent increase in telehealth mental health services among children under 19 from February 2020 to July 2020 (data incomplete)

Alaska Arizona Illinois Missouri Pennsylvania

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020. There is significant variation in how quickly states submit claims to CMS. It is possible that this variation in claims lag is responsible for the differences in utilization across states. Please refer to Slides 3 to 5 for additional information.

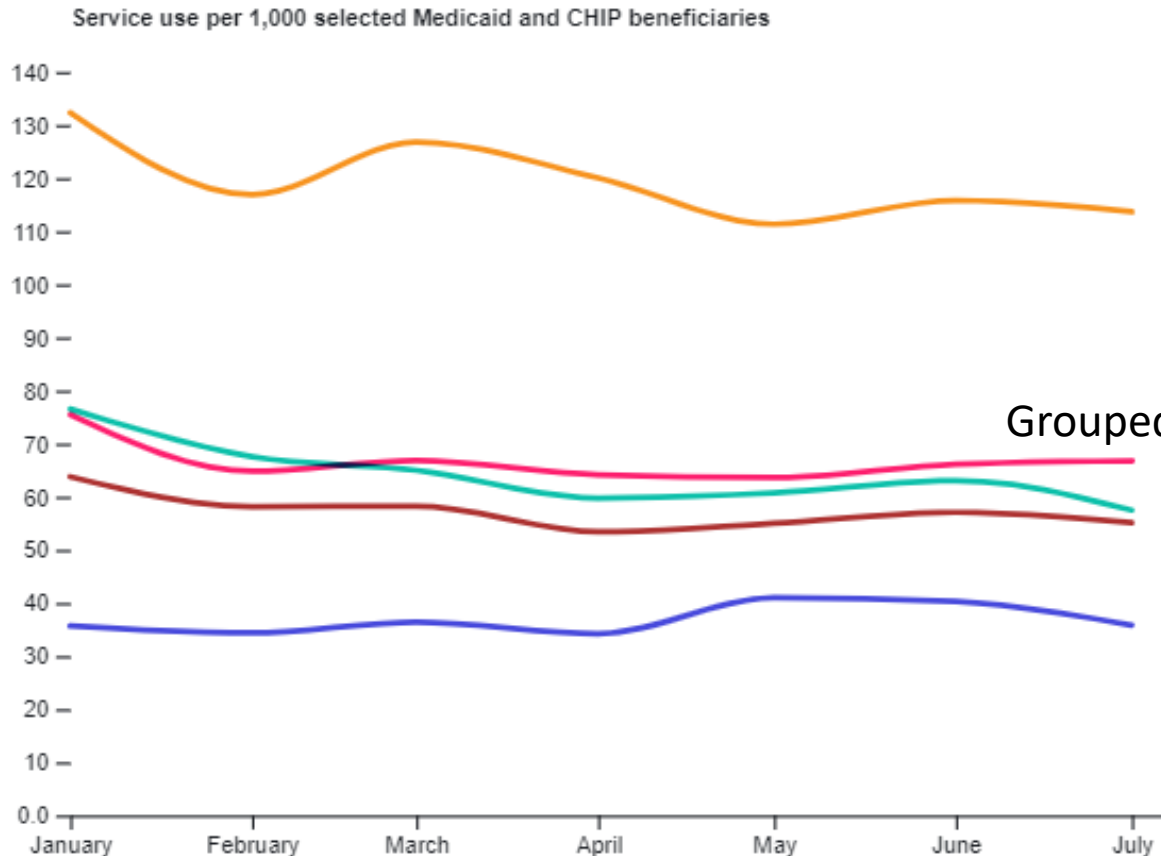
# Preliminary data show SUD services for adults age 19 to 64 declined starting in March and are still below 2019 levels through July

SUD services for adults ages 19 to 64 dropped from about 92 per 1,000 beneficiaries in February to 60 per 1,000 beneficiaries in July



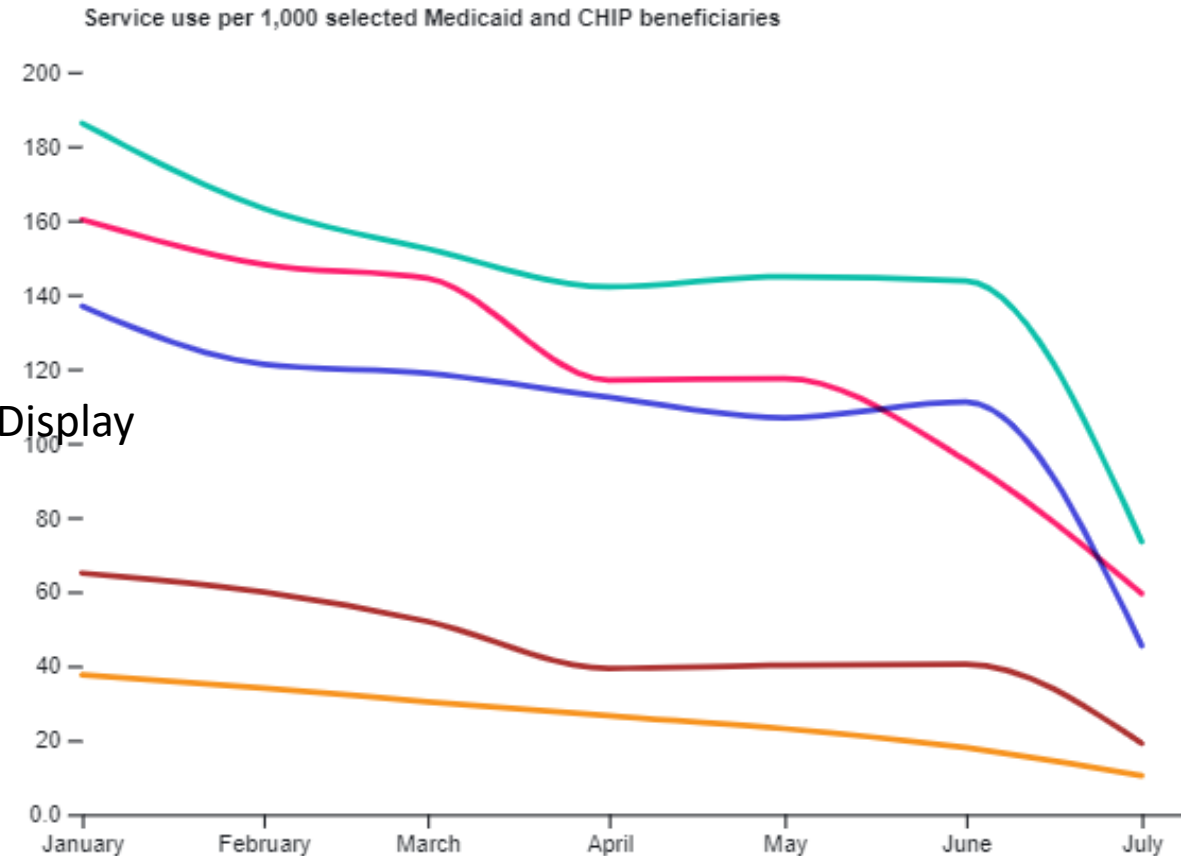
**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for August are incomplete, results are only presented through July 31, 2020. We compare SUD service use in 2020 to 2019 only. Coverage of SUD treatment services has increased dramatically over the past three years with the implementation of several 1115 demonstrations. As a result, we do not compare treatment rates in 2020 to treatment rates in 2018 and 2017, when coverage of services was generally lower.

# Preliminary data show SUD service use among adults age 19 to 64 declined in nearly all states from February to July, but the rate of decline varied across states



NE, NH, NC, OK, and WY had a relatively flat trend in SUD services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

Nebraska New Hampshire North Carolina Oklahoma Wyoming



AK, CA, IL, MA, and PA had the largest percent decrease in SUD services among adults ages 19 to 64 from February 2020 to July 2020 (data incomplete)

Alaska California Illinois Massachusetts Pennsylvania

Grouped Display

**Notes:** These data are preliminary. Data are sourced from the T-MSIS Analytic Files v4 in AREMAC, using final action claims. They are based on September T-MSIS submissions with services through the end of August. 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 August are incomplete, results are only presented through July 31, 2020. There is significant variation in how quickly states submit claims to CMS. It is possible that this variation in claims lag is responsible for the differences in utilization across states. Please refer to Slides 3 to 5 for additional information.