

Medicaid and CHIP Access: Coverage and Behavioral Health Data Spotlight

The Centers for Medicare & Medicaid Services' (CMS') Center for Medicaid and Children's Health Insurance Program (CHIP) Services (CMCS) established "Coverage and Access" as one of the three domains of its proactive policy agenda for 2022-2024.¹ This domain spans across an extensive set of policy and operational goals and tactics, in order to advance work in this area.

CMCS seeks to help ensure beneficiaries have equitable access to high-quality and appropriate care across all Medicaid and CHIP payment and delivery systems—including fee-for-service, managed care, and alternative payment models. We view the continuum of health care access across three dimensions: (1) enrollment in coverage; (2) maintaining coverage; and (3) access to services and supports. Under the dimension of *access to services and supports*, CMCS looks at the multiple domains of access that span: (1) potential access, (2) realized access, and (3) beneficiaries' experiences with care.²

Access to health care plays a critical role in health outcomes. By exploring several Medicaid and CHIP datasets, we take the first steps to understanding recent trends and to identify opportunities to improve programs in ways that can facilitate beneficiaries getting access to the health coverage and care needed.

This data brief presents a snapshot of selected metrics pulled from multiple data sources that, when combined, represent three key areas of Medicaid and CHIP access (see 1-3 on this page).

In the middle section of the brief, we highlight access under a behavioral health lens to understand baseline access metrics so that we can create a path towards improvement. CMS has a prioritized focus on behavioral health through its Behavioral Health Strategy which seeks to remove barriers to care and services.³ Improving access to behavioral health services (mental health condition and substance use disorder) is a critical, national issue facing all payors.

- 1. Access to Medicaid and CHIP coverage**, as measured by enrollment and retention;
- 2. Access to services**, with a focus on mental health condition and substance use disorder services; and
- 3. Perceived access**, as measured by beneficiary experiences.

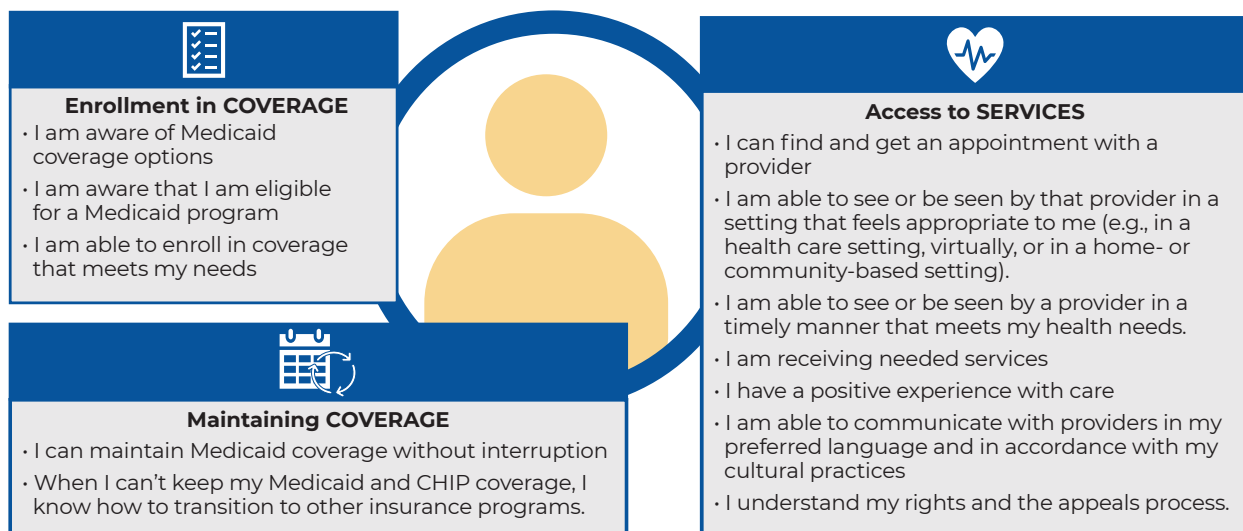
Many factors influence access to care and using these three dimensions of health care access can help to illustrate the types of issues facing Medicaid and CHIP beneficiaries across the country. As we begin to delve into understanding the range of barriers to health care access, we must also look for multivariate solutions and opportunities to collaborate across the federal, state, and local levels.

¹ Brooks-La Sure, Chiquita and Daniel Tsai. "A Strategic Vision for Medicaid And The Children's Health Insurance Program (CHIP)." Health Affairs Blog. November 2021. Available at <https://www.healthaffairs.org/doi/10.1377/forefront.20211115.537685/>.

² Kenney, Genevieve M., Kathy Gifford, Jane Wishner, Vanessa Forsberg, Amanda I. Napoles, and Danielle Pavliv. "Proposed Medicaid Access Measurement and Monitoring Plan." Washington, D.C.: The Urban Institute. August 2016. Available at <https://www.medicaid.gov/sites/default/files/2019-12/monitoring-plan.pdf>.

³ CMS Behavioral Health Strategy. Accessed at: <https://www.cms.gov/cms-behavioral-health-strategy>.

Figure 1. Access to Medicaid & CHIP: A Person-Centered Framework



We use “I” to represent a potential or current Medicaid or CHIP beneficiary, but acknowledge that in many circumstances a caregiver might perform or assist the beneficiary with many of these tasks or functions. The term “provider” refers to those providing health care services of all kinds, including physical health care services, mental health services, substance use services, long-term care services and supports, etc.

Section 1: Access to Medicaid and CHIP Coverage

Medicaid and CHIP Enrollment

- Medicaid and CHIP provide coverage to millions of Americans, many of whom might otherwise have no coverage. Data from the 50 states and the District of Columbia that reported Medicaid and CHIP enrollment data for [July 2022](#) show that 89,960,717 individuals were enrolled in those programs.
 - **82,845,954** individuals were enrolled in Medicaid.
 - **7,114,763** individuals were enrolled in CHIP.
 - **40,901,520** individuals (or 45.5 percent of total Medicaid and CHIP enrollment) were children enrolled in CHIP or the Medicaid program in the 49 states and the District of Columbia that reported child enrollment data for July 2022.

- **21,043,027** individuals ages 19 through 64 at or below 133 percent of the federal poverty level were enrolled in the Medicaid adult expansion group (also referred to as the new Adult VIII Group eligible under the Affordable Care Act [ACA]) in [September 2021](#).

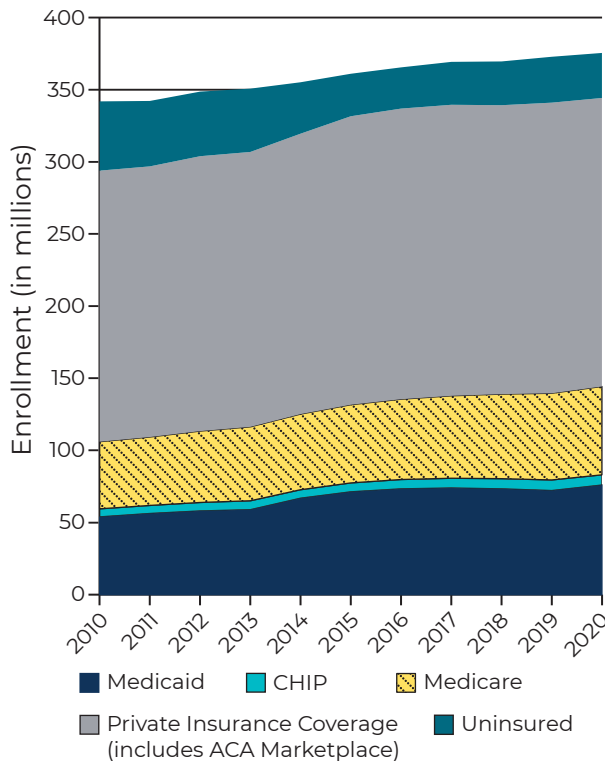
Trends in Insurance Coverage by Payor Type

- Following the enactment of the ACA in 2010 and implementation of Medicaid expansion in 2014, the number of people covered by Medicaid increased and fewer are uninsured. Figure 2 shows how the number of individuals enrolled in Medicaid and CHIP compare to the number of Americans with private insurance coverage, Medicare coverage, and no insurance coverage (uninsured) from 2010 to 2020 (before the onset of the COVID-19 Public Health Emergency).

Changes in Medicaid and CHIP Enrollment

- Examining Medicaid and CHIP program enrollment over time can provide a high-level picture of shifts in the number of people eligible and enrolled in Medicaid and CHIP and/or the ability of programs to provide access to coverage for eligible beneficiaries, particularly when there are larger issues at play such as changes in the economy or public health emergencies.
- Enrollment of eligible beneficiaries in Medicaid and CHIP programs increased nationally in both calendar years 2020 and 2021 (Table 1). The vast majority of states experienced increases in enrollment (Figure 3). This was likely driven by COVID-19 and the continuous enrollment condition in the Families First Coronavirus Response Act (FFCRA).

Figure 2. Trends in National Insurance Coverage by Payor, CY 2010-2020



Source: Data on trends in insurance coverage by Payor come from the [National Health Expenditures Account Data](#).

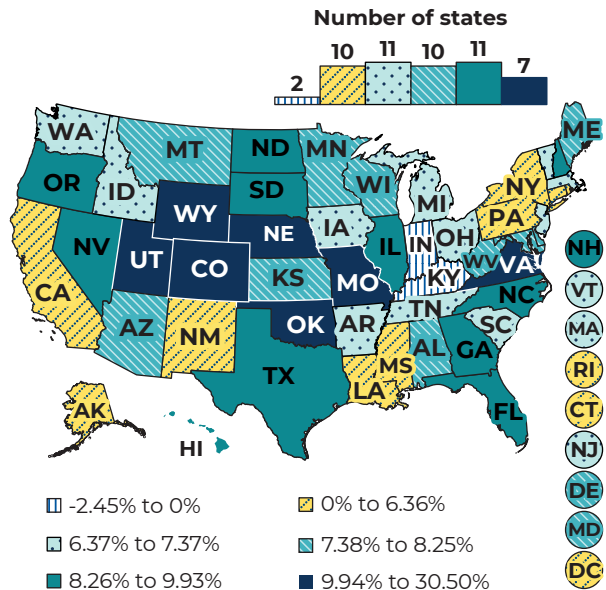
Table 1. Changes in Total National Medicaid and CHIP Enrollment, CY 2019-2021

| Year | Total National Medicaid & CHIP Enrollment in January | Total National Medicaid & CHIP Enrollment in December | Percentage Change from January and December |
|------|--|---|---|
| 2019 | 71,248,547 | 70,648,282 | -1.1% |
| 2020 | 70,748,954 | 79,805,216 | 12.8% |
| 2021 | 80,584,252 | 86,396,073 | 7.2% |

Source: [Medicaid and CHIP Eligibility and Enrollment Performance Indicators](#), as of July 2022. For more information on enrollment data, visit [Medicaid and CHIP Enrollment Data](#).

Notes: The calculation includes preliminary January 2019 data for New Mexico. The percentage change of each state's population enrolled in Medicaid or CHIP was calculated by subtracting the total Medicaid and CHIP enrollment in January from enrollment in December. The difference in enrollment was then divided by total Medicaid and CHIP enrollment in January.

Figure 3. Change in Total Medicaid and CHIP Enrollment by State, January 2021 to December 2021



Source: [Medicaid and CHIP Eligibility and Enrollment Performance Indicators](#) from January 2021 and December 2021, as of July 2022. For more information on enrollment data, visit [Medicaid and CHIP Enrollment Data](#). Refer to Table A.1 in the Appendix for detailed data.

Notes: The percentage change of each state's population enrolled in Medicaid or CHIP was calculated by subtracting the total Medicaid and CHIP enrollment in January 2021 from enrollment in December 2021. The difference in enrollment was then divided by total Medicaid and CHIP enrollment in January 2021.

Retention of Medicaid and CHIP Coverage⁴

Retention in this brief refers to whether eligible Medicaid and CHIP beneficiaries are able to remain enrolled in coverage. Related measures aim to assess the extent to which eligible Medicaid and CHIP beneficiaries experience gaps in coverage. Disruptions in coverage can lead to periods of uninsurance, delayed care, and reduced access to preventive care and other critical care for beneficiaries. Beneficiaries moving on and off of Medicaid and CHIP coverage (sometimes called “churning”) can lead to higher administrative costs, less predictable state expenditures, and higher monthly health care costs due to pent-up demand for health care services.⁵ Beneficiaries who are disenrolled from Medicaid or CHIP coverage may still be eligible to receive coverage, and may be re-enrolled within a short period of time. The impact of states’ challenges with and approaches used to retain eligible beneficiaries can begin to be better understood by examining rates of churn. This section highlights a new CMS analysis that looks at continuous coverage and re-enrollment.

Percentage of Beneficiaries with 12 Months of Continuous Coverage

- These data illustrate how many eligible beneficiaries maintain Medicaid or CHIP coverage for a full 12-month period after they initially enroll. This measure shows the percentage of beneficiaries ever enrolled in 2018 that had 12 months of continuous coverage following their initial enrollment into the program. Results of the analyses are presented by the following eligibility groups: adults and children who qualify for Medicaid on the basis of low income alone (referred

Figure 4. Percentage of beneficiaries with and without continuous coverage, CY 2018

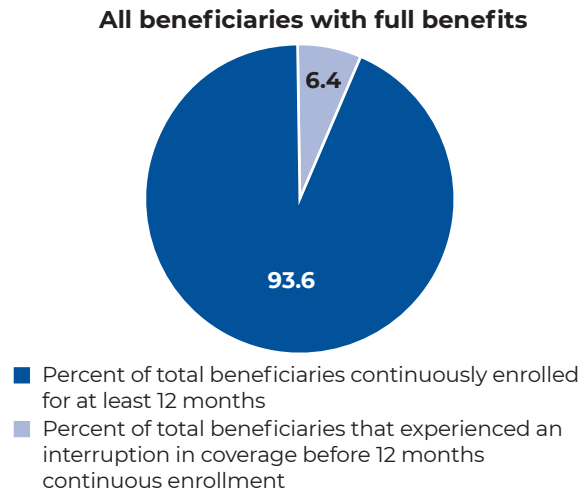
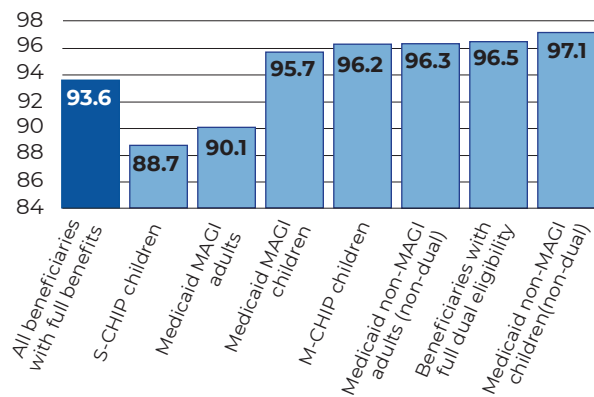


Figure 5. Percentage of Medicaid beneficiaries with at least 12 months continuous coverage, CY 2018



to as Modified Adjusted Gross Income [MAGI] pathways); adults and children who qualify for Medicaid based on income and other factors, primarily disability (referred to as non-MAGI or Aged, Blind, Disabled pathways); CHIP children (M-CHIP and

⁴ A related analysis of continuity of coverage in the dually-eligible population retention has been developed by the CMS Medicare-Medicaid Coordination Office.

⁵ Sugar, S., Peters, C., De Lew, N., Sommers, B.D. “Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic.” Washington, D.C.: Assistant Secretary for Planning and Evaluation, Office of Health Policy. April 2021. Available at <https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf>.

S-CHIP);⁶ and individuals who are dually eligible for both Medicaid and Medicare.

- Overall, the vast majority (93.6 percent) of Medicaid and CHIP beneficiaries enrolled at any time in 2018 experienced uninterrupted coverage for at least 12 months, with some variation by eligibility group (Figures 4-5). Children enrolled in separate CHIP programs (S-CHIP) and Medicaid MAGI adults were somewhat more likely to experience an interruption in coverage compared to other eligibility groups; only 88.7 and 90.1 percent of beneficiaries in these groups, respectively, maintained coverage for a full 12 months after enrollment.

Percentage of Beneficiaries who Disenrolled and Re-Enrolled within 3 Months and 12 Months

- These data illustrate how often beneficiaries who lose coverage, either at annual renewal or at another time, subsequently re-enroll into coverage within a short period of time. These measures show the percentage of beneficiaries who disenrolled from Medicaid or CHIP coverage in 2018 and were re-enrolled in fewer than 3 months or 12 months by eligibility group (Figures 6-8).
- Among all beneficiaries who disenrolled in CY 2018, the data show a notable proportion “churned” back onto the Medicaid and CHIP programs within a year (17.2 percent re-enrolled within 3 months, and 35.9 percent re-enrolled within 12 months).

⁶ M-CHIP (Medicaid expansion CHIP) is a program under which a state receives federal financial participation to expand Medicaid coverage to optional targeted low-income children that meets the requirements of section 2103 of the Social Security Act. S-CHIP (Separate CHIP) is a program under which a state receives federal financial participation to provide child health assistance to uninsured, low-income children that meets the requirements of section 2103 of the Social Security Act.

Figure 6. Percentage of disenrollees who re-enrolled within 12 months, CY 2018

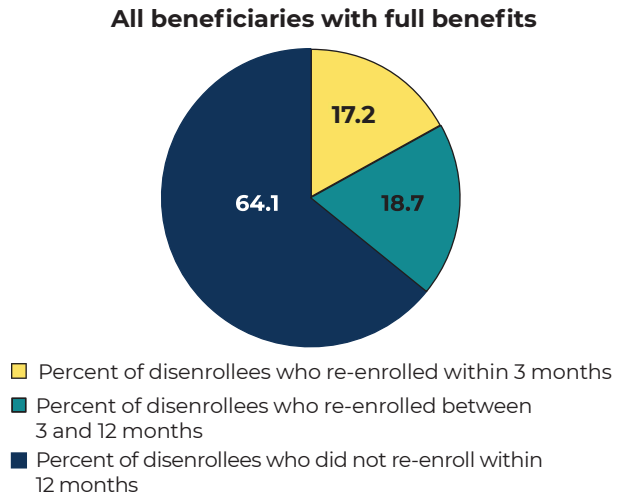


Figure 7. Percentage of Medicaid beneficiaries who disenrolled and re-enrolled within 3 months, CY 2018

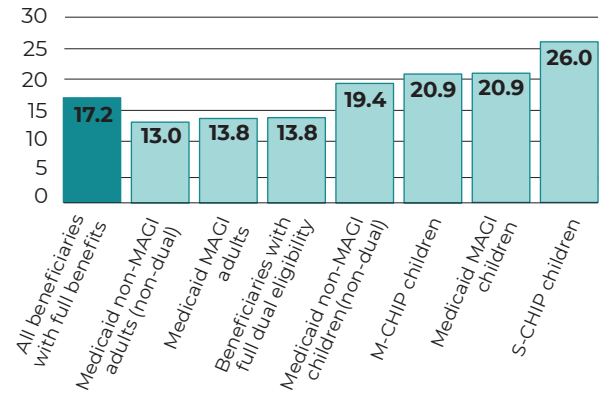
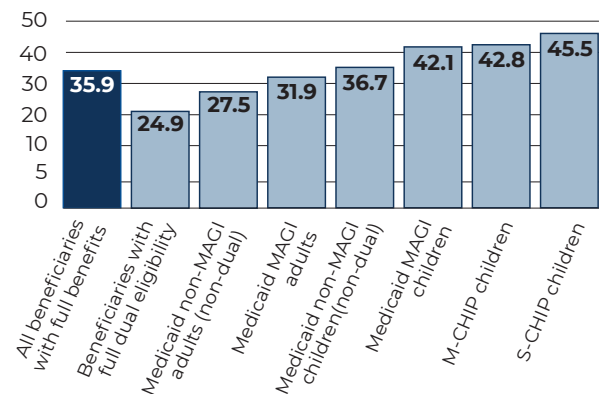


Figure 8. Percentage of Medicaid beneficiaries who disenrolled and re-enrolled within 12 months, CY 2018



Section 2: Access to Services – Data Spotlight on Behavioral Health Services

When assessing access to health care services, it is important to consider multiple domains of access including: (1) potential access, (2) realized access, and (3) beneficiaries' experiences with care. This section of the brief explores access to services through the lens of access to behavioral health. Behavioral health provides a useful view into Medicaid and CHIP access to health care services because individuals with behavioral health conditions may face many challenges accessing care, including stigma, and often times may not seek treatment.⁷

Medicaid pays for more than a quarter of the country's behavioral health services (mental health and substance use disorder services) making it the largest single payer.⁸ CMS collaborates with states to provide numerous pathways to meet the needs of beneficiaries with mental health conditions and substance use disorders, and works continuously to improve accessibility of behavioral health services.

This section highlights beneficiary utilization measures that reflect usage of services for mental health conditions and substance use disorder. Also included here are utilization measures that may reflect outcomes associated with challenges accessing appropriate follow-up and care after emergency department visits and hospitalizations for mental health conditions and substance use disorders. In order to get a clearer understanding of what these data represent, we would also want to understand the size of the population that needs behavioral services, the scope of unmet need, and a clearer picture of the nuances within each state that comprises additional challenges with accessing behavioral health services.

The data in this section are compiled from the [Child and Adult Core Sets](#) or derived from an analysis of the underlying data published in the [Medicaid & CHIP and COVID-19 Public Health Emergency Data Snapshot](#) for services through January 31, 2022, and non-public T-MSIS service utilization tables.

Mental Health

Number of mental health services per 1,000 Medicaid and CHIP beneficiaries

- Figures 9-11 display national utilization rates of mental health services by service type: outpatient and telehealth.
- The rates of mental health services provided to Medicaid and CHIP beneficiaries declined following the beginning of the PHE in March 2020 compared to 2018 and 2019, despite beginning the year at a higher level than the two previous years. Lower levels of service utilization rates persisted through the end of 2021.
- A similar pattern was observed across the rates in outpatient services. Conversely, there was an increase in rates of behavioral health services delivered via telehealth. The rate of mental health service delivery via telehealth (Figure 11) increased greatly during the PHE, peaking in April 2020 but remaining higher than pre-PHE levels through December 2021. Although there was a notable increase in the rate of behavioral health services delivered via telehealth, it was not enough to offset the decline in the rate of outpatient services.

Follow-Up After Emergency Department (ED) Visit for Mental Illness: Age 18 and Older

- Timely follow-up care after an ED visit for mental illness or intentional self-harm may reduce repeat ED visits, prevent hospital

⁷ "Stigma, Prejudice and Discrimination Against People with Mental Illness." American Psychiatric Association. August 2020. Available at: <https://www.psychiatry.org/patients-families/stigma-and-discrimination>.

⁸ Soni, Anita. "Health Care Expenditures for Treatment of Mental Disorders: Estimates for Adults Ages 18 and Older, U.S. Civilian Noninstitutionalized Population, 2019." Statistical Brief #539. Rockville, MD: Agency for Healthcare Research and Quality. February 2022. Available at: https://meps.ahrq.gov/data_files/publications/st539/stat539.pdf.

Figure 9. Number of mental health services per 1,000 Medicaid and CHIP beneficiaries (all ages), CY 2018-2021⁹

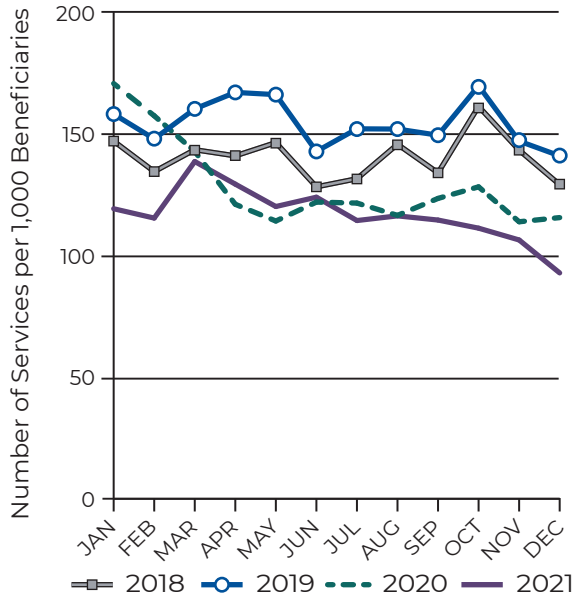


Figure 11. Number of mental health services delivered via telehealth per 1,000 Medicaid and CHIP beneficiaries (all ages), CY 2018-2021

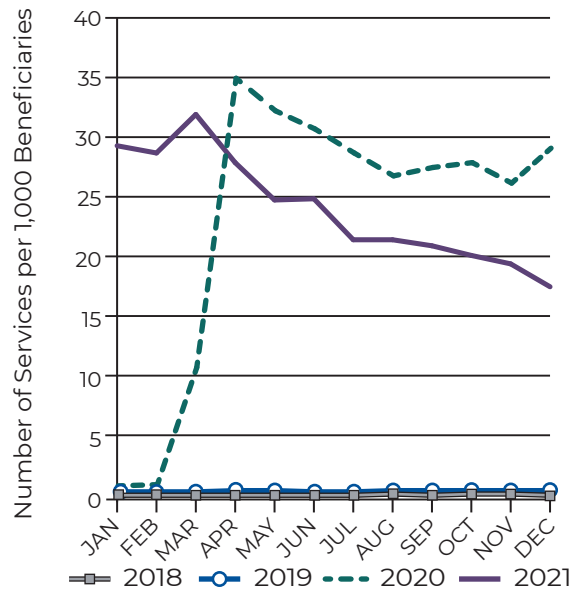
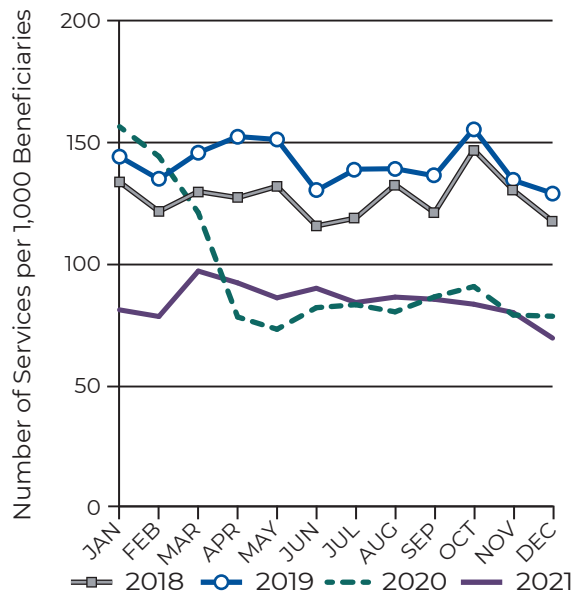


Figure 10. Number of mental health outpatient services per 1,000 Medicaid and CHIP beneficiaries (all ages), CY 2018-2021



Source for Figures 9-11: Mathematica’s analysis of TAF, v 7.0 data from January 1, 2018 through December 31, 2021. The results are based on T-MSIS submissions through March 2022.

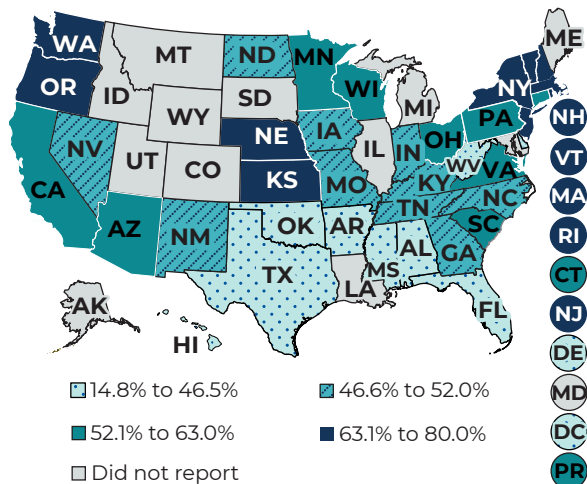
Notes: Services reflected in these figures include only those paid by Medicaid and CHIP programs. CMS collects Medicaid and CHIP data for programmatic purposes, but not for public health surveillance. States’ T-MSIS submissions have considerable variation in terms of completeness and quality. CMS processes states’ submissions and transforms them into the TAF, which form the basis of this analysis. Given this process, 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. It is possible that there is a longer claims lag due to the pandemic. 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. On average, states need 9 months to submit 95% of all claims. Recent dates of service have minimal time for claims runout and results are likely to change for more recent months of data after future updates. Therefore, users should interpret recent months with caution. For additional information regarding state variability in data quality, refer to the [TAF DQ Atlas](#). For additional information regarding the methodology used, refer to the [Medicaid and CHIP and the COVID-19 Public Health Emergency: Preliminary Medicaid and CHIP Data Snapshot for Services through January 31, 2022](#).

⁹ The number of mental health services per 1,000 Medicaid and CHIP beneficiaries includes services delivered in-person (including at an emergency department, intensive outpatient care/partial hospitalizations, and outpatient care) and via telehealth.

admissions, and improve health outcomes. The period immediately after the ED visit is important for engaging individuals in treatment and establishing continuity of care. For more information on the Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD) measure, visit [Adult Health Care Quality Measures](#).

- Among states reporting data, a median of 39.6 percent of adults age 18 and older who visited the ED with a principal diagnosis of mental illness or intentional self-harm had a follow-up visit within 7 days. This varied considerably across states that collected and reported this measure to CMS, from 4.1 percent to 72.8 percent.¹⁰ This rate increased to a median of 52.1 percent for follow-up visits within 30 days (Figure 12), ranging from 14.8 percent to 80.0 percent across states.

Figure 12. Percentage of ED visits for adults age 18 and older who has a principal diagnosis of mental illness or intentional self-harm with a follow-up visit within 30 days of the ED visit, CY 2019



Source: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

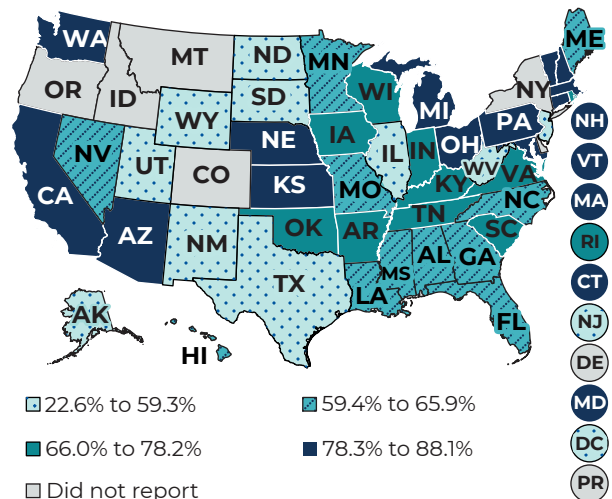
Notes: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle. Refer to Table A.2 in the Appendix for detailed data.

^{10,11} Data not shown, please visit the [Behavioral Health Core Set Chart Pack, FFY 2020](#) for additional details on this measure.

Follow-up After Hospitalization for Mental Illness: Ages 6 to 17

- Follow-up care after hospitalization for mental illness or intentional self-harm helps improve health outcomes and prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health provider within 30 days after discharge. Ideally, patients should see a mental health provider within 7 days after discharge. For more information on the Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH) measure, visit [Child Health Care Quality Measures](#).
- Among states reporting data, a median of 45.6 percent of children ages 6 to 17 who were hospitalized for treatment of mental illness or intentional self-harm had a follow-up visit within 7 days of discharge. This varied widely across states, from 9.1 percent to 68.3 percent.¹¹ This increased to a median of 66.0 percent for follow-up visits within 30 days, ranging from 22.6 percent to 88.1 percent across states (Figure 13).

Figure 13. Percentage of discharges for children ages 6 to 17 hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 30 days after discharge, CY 2019



Source: Mathematica analysis of MACPro reports for the Child Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Notes: Data reflecting services in CY 2019 were reported as part of the Child Core Set FFY 2020 reporting cycle. Refer to Table A.3 in the Appendix for detailed data.

Follow-up After Hospitalization for Mental Illness: Age 18 and Older

- Follow-up care after hospitalization for mental illness or intentional self-harm can prevent readmissions. Recommended post-discharge treatment includes a visit with a mental health provider within 30 days after discharge. For more information on the Follow-Up After Hospitalization for Mental Illness: Age 18 and Older (FUH-AD) measure, visit [Adult Health Care Quality Measures](#).
- Among states reporting data, a median of 33.1 percent of adults age 18 and older who were hospitalized for treatment of mental illness or intentional self-harm had a follow-up visit within 7 days of discharge. This varied widely across states, from 6.0 percent to 63.1 percent.¹² This increased to a median of 54.7 percent for follow-up visits within 30 days, ranging from 10.1 percent to 81.2 percent across states (Figure 14).

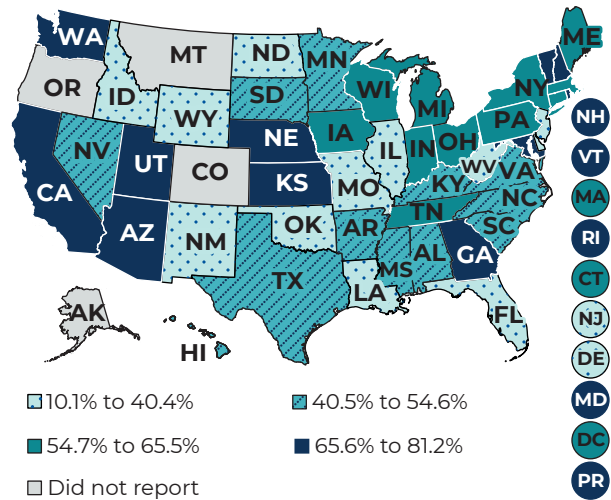
Substance Use Disorder

Number of substance use disorder services per 1,000 Medicaid and CHIP beneficiaries

- Figures 15-16 display overall and outpatient national utilization rates of substance use disorder (SUD) services.
- The rate of substance use disorder services provided to Medicaid and CHIP beneficiaries declined during the PHE compared to pre-PHE levels in 2019. This decline was especially pronounced for the rates of SUD outpatient services.

¹² Data not shown, please visit the [Behavioral Health Core Set Chart Pack, FFY 2020](#) for additional details on this measure.

Figure 14. Percentage of discharges for adults age 18 and older hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 30 days after discharge, CY 2019



Source: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Notes: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle. Refer to Table A.4 in the Appendix for detailed data.

Figure 15. Number of substance use disorder services per 1,000 Medicaid and CHIP beneficiaries (ages 18-64), CY 2018-2021

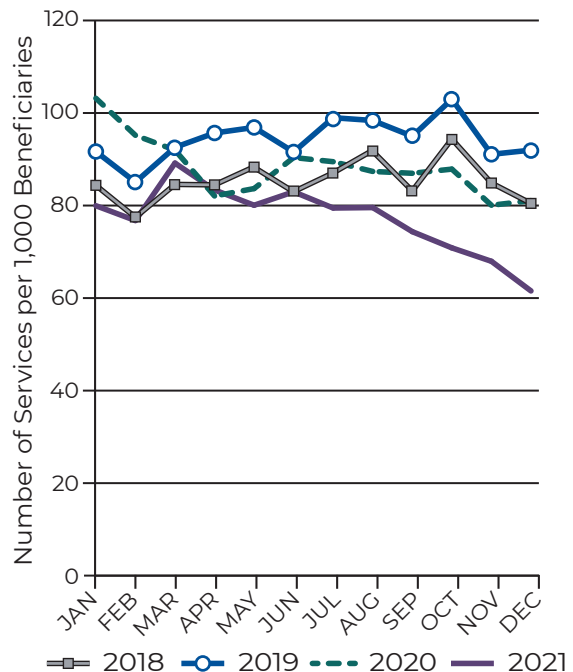
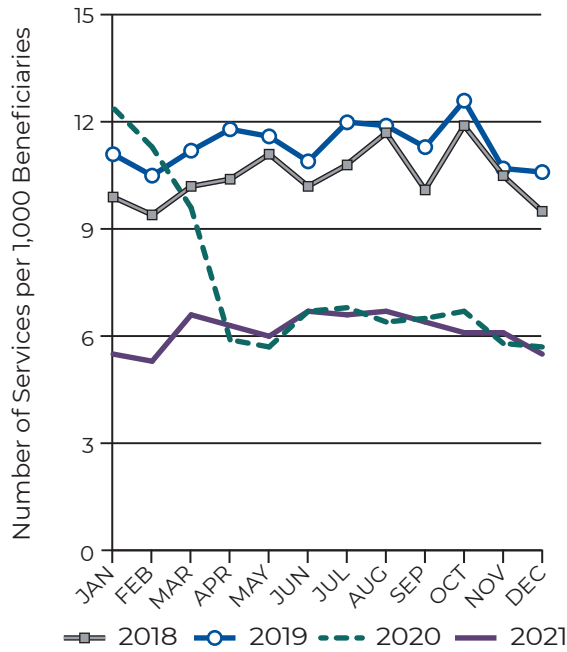


Figure 16. Number of substance use disorder outpatient services per 1,000 Medicaid and CHIP beneficiaries (ages 18-64), CY 2018-2021



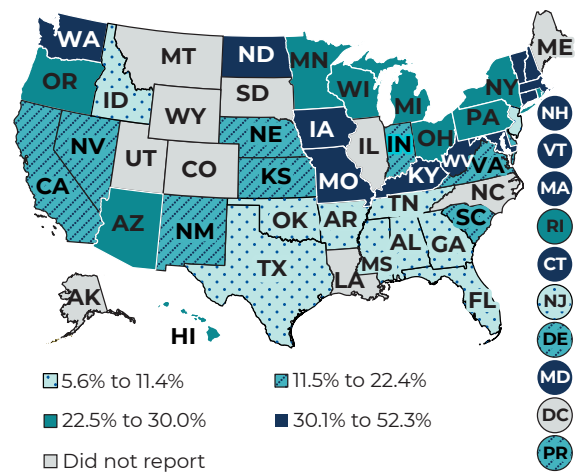
Source for Figures 15-16: Mathematica’s analysis of TAF, v 7.0 data from January 1, 2018 through December 31, 2021. The results are based on T-MSIS submissions through March 2022.

Notes: Services reflected in these figures include only those paid by Medicaid and CHIP programs. CMS collects Medicaid and CHIP data for programmatic purposes, but not for public health surveillance. States’ T-MSIS submissions have considerable variation in terms of completeness and quality. CMS processes states’ submissions and transforms them into the TAF, which form the basis of this analysis. Given this process, 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. It is possible that there is a longer claims lag due to the pandemic. 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. On average, states need 9 months to submit 95% of all claims. Recent dates of service have minimal time for claims runout and results are likely to change for more recent months of data after future updates. Therefore, users should interpret recent months with caution. For additional information regarding state variability in data quality, refer to the [TAF DQ Atlas](#). For additional information regarding the methodology used, refer to the [Medicaid and CHIP and the COVID-19 Public Health Emergency: Preliminary Medicaid and CHIP Data Snapshot for Services through January 31, 2022](#).

Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older

- Timely follow-up care after an ED visit for alcohol or other drug (AOD) abuse or dependence may reduce repeat ED visits, prevent hospital admissions, and improve health outcomes. The period immediately after the ED visit is important for engaging individuals in substance use treatment and establishing continuity of care. This measure shows the percentage of beneficiaries who had a follow-up visit with any practitioner within 7 and 30 days of an ED visit for AOD abuse or dependence. For more information on the Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence: Age 18 and Older (FUA-AD) measure, visit [Adult Health Care Quality Measures](#).

Figure 17. Percentage of ED visits for adults age 18 and older who had a principal diagnosis of AOD abuse or dependence with a follow-up visit within 30 days of the ED visit, CY 2019



Source: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Notes: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle. Refer to Table A.5 in the Appendix for detailed data.

- Among states reporting data, a median of 15.2 percent of adults age 18 and older who visited the ED with a principal diagnosis of AOD abuse or dependence had a follow-up visit with 7 days. This varied across states from 3.2 percent to 45.5 percent.¹³ This increased to a median of 22.5 percent for follow-up visits within 30 days, ranging from 5.6 percent to 52.3 percent across states (Figure 17).

Section 3: Beneficiary Experience

Central to all three domains of CMS’s access strategy (access to coverage, access to services and supports, and maintaining coverage) is how beneficiaries experience care and their perception of the availability of services and supports. This is known as perceived access.¹⁴ Measures in this area aim to assess the extent to which beneficiaries and caregivers find that they can access services and information in a way that is timely and person-centered.

This section includes data from the Consumer Assessment of Healthcare Providers and Systems (CAHPS) experience of care survey tool that is voluntarily submitted by health plans and publicly available through the [Agency for Healthcare Research and Quality \(AHRQ\) CAHPS database](#). While these data are limited to Medicaid beneficiaries enrolled in comprehensive managed care systems, this represents 72.4 percent of all Medicaid beneficiaries in 2020. These data look at experience of care more broadly, so the results shown are not specific to behavioral services.

AHRQ CAHPS Survey Data

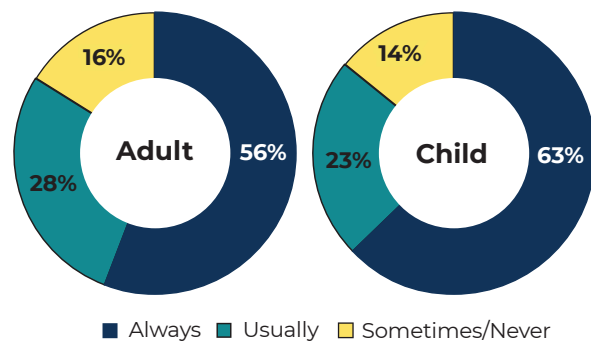
By looking at three indicators from the AHRQ CAHPS survey, reported nationally for children and adult Medicaid population enrolled in managed care, we can begin to understand beneficiary perceptions of access

to care. While the data show that more than 80 percent of beneficiaries reported in 2021 being able to access necessary care and information in a timely and customer-oriented way most or all of the time, it also shows that 20 percent of beneficiaries reported sometimes or never being able to access necessary care and information in a timely and customer-oriented way.

Getting Needed Care (Figure 18)

- The “Getting Needed Care Composite” combines responses to the two individual questions from the CAHPS Health Plan Survey:
 1. In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?
 2. In the last 6 months, how often was it easy to get the care, tests, or treatment you needed?
 - 84 percent of beneficiaries reported always or usually getting needed care for adults
 - 86 percent of beneficiaries reported always or usually getting needed care for children

Figure 18. Getting Needed Care, July 2020-July 2021



¹³ Data not shown, please visit the [Behavioral Health Core Set Chart Pack, FFY 2020](#) for additional details on this measure.

¹⁴ Kenney, Genevieve M., Kathy Gifford, Jane Wishner, Vanessa Forsberg, Amanda I. Napoles, and Danielle Pavliv. “Proposed Medicaid Access Measurement and Monitoring Plan.” Washington, D.C.: The Urban Institute. August 2016. Available at <https://www.medicaid.gov/sites/default/files/2019-12/monitoring-plan.pdf>.

Getting Care Quickly (Figure 19)

- The “Getting Care Quickly Composite” combines responses to the two individual questions from the CAHPS Health Plan Survey:
 1. *In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?*
 2. *In the last 6 months, how often did you get an appointment for a check-up or routine care at a doctor’s office or clinic as soon as you needed?*
 - 83 percent of beneficiaries reported always or usually getting timely care for adults
 - 88 percent of beneficiaries reported always or usually getting timely care for children

Health Plan Information and Customer Service (Figure 20)

- The “Health Plan Information and Customer Service Composite” combines responses to the two individual questions from the CAHPS Health Plan Survey:
 1. *In the last 6 months, how often did your health plan’s customer service give you the information or help you needed?*
 2. *In the last 6 months, how often did your health plan’s customer service staff treat you with courtesy and respect?*
 - 90 percent of beneficiaries reported that, for adults, health plan customer service always or usually gave them the information or help they needed and treated them with courtesy and respect
 - 88 percent of beneficiaries reported that, for children, health plan customer service always or usually gave them the information or help they needed and treated them with courtesy and respect

Figure 19. Getting Care Quickly, July 2020-July 2021

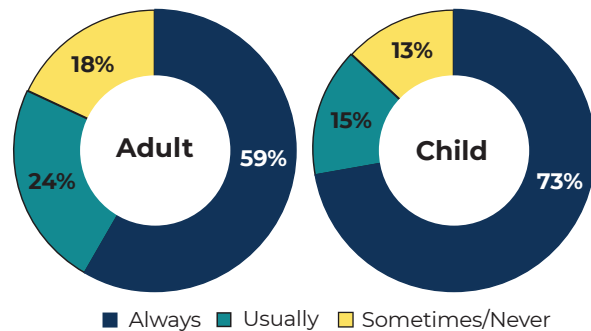
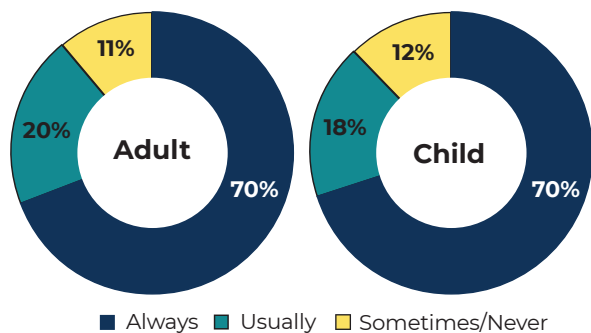


Figure 20. Health Plan Information and Customer Service, July 2020-July 2021



Source: CAHPS Health Plan Survey Database 2021 Chartbook, available at: <https://cahpsdatabase.ahrq.gov/files/2021CAHPSHealthPlanChartbook.pdf>

Notes: Child Medicaid excludes CHIP. The AHRQ CAHPS Database includes data submitted directly by state Medicaid agencies or individual health plans. The data are submitted voluntarily to the CAHPS Database and are not from a statistically representative sample of all plans. Due to the variability in response rates from different states, the data presented in this exhibit are not nationally representative.

Conclusion

Opportunities to improve access to coverage and health care exist in every sector of the health care industry across the country. The data shared in this brief begin to illuminate opportunities to protect, strengthen, and expand Medicaid and CHIP access in a number of areas, particularly behavioral health services. CMS is pursuing a broadened view of access to care that looks at *access to services, maintenance of health care coverage, and experiences with health care* with the goal of taking steps to positively impact the outcome of Medicaid and CHIP beneficiaries’ health.

Appendix. Supplemental Data for the Medicaid and CHIP Access: Coverage and Behavioral Health Data Spotlight

Table A.1. Change in Total Medicaid and CHIP Enrollment by State, January 2021 to December 2021 (Figure 3)

| State | Total Medicaid and CHIP Enrollment January 2021 | Total Medicaid and CHIP Enrollment December 2021 | Change in Total Medicaid and CHIP Enrollment, January 2021 to December 2021 |
|----------------------|---|--|---|
| Alabama | 1,009,033 | 1,091,996 | 8.22 |
| Alaska | 241,410 | 255,746 | 5.94 |
| Arizona | 1,981,809 | 2,139,682 | 7.97 |
| Arkansas | 898,965 | 965,168 | 7.36 |
| California | 12,586,999 | 13,292,295 | 5.60 |
| Colorado | 1,511,250 | 1,682,140 | 11.31 |
| Connecticut | 937,667 | 968,210 | 3.26 |
| Delaware | 257,177 | 278,171 | 8.16 |
| District of Columbia | 264,086 | 275,771 | 4.42 |
| Florida | 4,144,712 | 4,507,461 | 8.75 |
| Georgia | 2,109,497 | 2,305,389 | 9.29 |
| Hawaii | 390,771 | 425,000 | 8.76 |
| Idaho | 383,589 | 409,836 | 6.84 |
| Illinois | 3,257,826 | 3,550,154 | 8.97 |
| Indiana | 1,797,620 | 1,793,407 | -0.23 |
| Iowa | 756,195 | 805,021 | 6.46 |
| Kansas | 431,651 | 466,682 | 8.12 |
| Kentucky | 1,563,251 | 1,524,888 | -2.45 |
| Louisiana | 1,727,026 | 1,812,612 | 4.96 |
| Maine | 313,409 | 338,983 | 8.16 |
| Maryland | 1,473,436 | 1,582,312 | 7.39 |
| Massachusetts | 1,747,127 | 1,859,007 | 6.40 |
| Michigan | 2,673,268 | 2,868,500 | 7.30 |
| Minnesota | 1,185,566 | 1,278,802 | 7.86 |
| Mississippi | 685,690 | 726,597 | 5.97 |
| Missouri | 1,032,349 | 1,186,274 | 14.91 |
| Montana | 281,734 | 303,304 | 7.66 |
| Nebraska | 309,171 | 355,314 | 14.92 |

| State | Total Medicaid and CHIP Enrollment January 2021 | Total Medicaid and CHIP Enrollment December 2021 | Change in Total Medicaid and CHIP Enrollment, January 2021 to December 2021 |
|----------------|---|--|---|
| Nevada | 761,359 | 835,255 | 9.71 |
| New Hampshire | 215,263 | 236,195 | 9.72 |
| New Jersey | 1,928,852 | 2,068,050 | 7.22 |
| New Mexico | 823,477 | 866,606 | 5.24 |
| New York | 6,736,808 | 7,078,662 | 5.07 |
| North Carolina | 2,030,937 | 2,204,052 | 8.52 |
| North Dakota | 107,490 | 118,168 | 9.93 |
| Ohio | 2,976,549 | 3,172,286 | 6.58 |
| Oklahoma | 866,416 | 1,130,652 | 30.50 |
| Oregon | 1,160,651 | 1,268,094 | 9.26 |
| Pennsylvania | 3,285,318 | 3,488,237 | 6.18 |
| Rhode Island | 328,028 | 344,318 | 4.97 |
| South Carolina | 1,138,380 | 1,218,518 | 7.04 |
| South Dakota | 123,964 | 134,963 | 8.87 |
| Tennessee | 1,587,057 | 1,688,217 | 6.37 |
| Texas | 4,841,366 | 5,241,375 | 8.26 |
| Utah | 396,447 | 442,121 | 11.52 |
| Vermont | 173,615 | 184,874 | 6.49 |
| Virginia | 1,655,186 | 1,844,299 | 11.43 |
| Washington | 1,921,268 | 2,055,411 | 6.98 |
| West Virginia | 564,792 | 606,658 | 7.41 |
| Wisconsin | 1,231,882 | 1,332,720 | 8.19 |
| Wyoming | 65,364 | 72,773 | 11.33 |

Source: [Medicaid and CHIP Eligibility and Enrollment Performance Indicators](#) from January 2021 and December 2021, as of July 2022. For more information on enrollment data, visit [Medicaid and CHIP Enrollment Data](#).

Notes: The percentage change of each state's population enrolled in Medicaid or CHIP was calculated by subtracting the total Medicaid and CHIP enrollment in January 2021 from enrollment in December 2021. The difference in enrollment was then divided by total Medicaid and CHIP enrollment in January 2021.

Table A.2. Percentage of ED visits for adults age 18 and older who has a principal diagnosis of mental illness or intentional self-harm with a follow-up visit within 30 days of the ED visit, CY 2019 (Figure 12)

| State or Territory | Percentage |
|----------------------|----------------|
| Alabama | 41.5 |
| Alaska | Did Not Report |
| Arizona | 59.3 |
| Arkansas | 39.2 |
| California | 62.6 |
| Colorado | Did Not Report |
| Connecticut | 55.6 |
| Delaware | 40.4 |
| District of Columbia | 32.3 |
| Florida | 37.5 |
| Georgia | 51.4 |
| Hawaii | 42.8 |
| Idaho | Did Not Report |
| Illinois | Did Not Report |
| Indiana | 51.0 |
| Iowa | 49.9 |
| Kansas | 71.4 |
| Kentucky | 48.6 |
| Louisiana | Did Not Report |
| Maine | Did Not Report |
| Maryland | Did Not Report |
| Massachusetts | 80.0 |
| Michigan | Did Not Report |
| Minnesota | 60.3 |
| Mississippi | 39.4 |
| Missouri | 51.5 |

| State or Territory | Percentage |
|--------------------|----------------|
| Montana | Did Not Report |
| Nebraska | 63.6 |
| Nevada | 48.9 |
| New Hampshire | 78.7 |
| New Jersey | 63.7 |
| New Mexico | 51.2 |
| New York | 72.0 |
| North Carolina | 51.6 |
| North Dakota | 49.4 |
| Ohio | 55.1 |
| Oklahoma | 44.5 |
| Oregon | 71.5 |
| Pennsylvania | 52.6 |
| Puerto Rico | 60.7 |
| Rhode Island | 74.8 |
| South Carolina | 61.3 |
| South Dakota | Did Not Report |
| Tennessee | 50.1 |
| Texas | 43.9 |
| Utah | Did Not Report |
| Vermont | 75.6 |
| Virginia | 54.7 |
| Washington | 64.8 |
| West Virginia | 14.8 |
| Wisconsin | 55.0 |
| Wyoming | Did Not Report |

Source: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle.

Notes: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Table A.3. Percentage of discharges for children ages 6 to 17 hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 30 days after discharge, CY 2019 (Figure 13)

| State or Territory | Percentage |
|----------------------|----------------|
| Alabama | 61.3 |
| Alaska | 43.0 |
| Arizona | 85.1 |
| Arkansas | 69.6 |
| California | 82.1 |
| Colorado | Did Not Report |
| Connecticut | 82.7 |
| Delaware | Did Not Report |
| District of Columbia | 49.2 |
| Florida | 61.8 |
| Georgia | 65.9 |
| Hawaii | 59.4 |
| Idaho | Did Not Report |
| Illinois | 54.3 |
| Indiana | 75.1 |
| Iowa | 66.0 |
| Kansas | 78.6 |
| Kentucky | 72.8 |
| Louisiana | 61.2 |
| Maine | 60.1 |
| Maryland | 82.6 |
| Massachusetts | 78.3 |
| Michigan | 78.9 |
| Minnesota | 62.9 |
| Mississippi | 64.1 |
| Missouri | 60.9 |

| State or Territory | Percentage |
|--------------------|----------------|
| Montana | Did Not Report |
| Nebraska | 85.4 |
| Nevada | 64.4 |
| New Hampshire | 79.7 |
| New Jersey | 22.6 |
| New Mexico | 53.0 |
| New York | Did Not Report |
| North Carolina | 63.9 |
| North Dakota | 54.4 |
| Ohio | 85.6 |
| Oklahoma | 68.1 |
| Oregon | Did Not Report |
| Pennsylvania | 78.3 |
| Puerto Rico | Did Not Report |
| Rhode Island | 76.6 |
| South Carolina | 73.0 |
| South Dakota | 37.3 |
| Tennessee | 73.1 |
| Texas | 58.5 |
| Utah | 54.7 |
| Vermont | 88.1 |
| Virginia | 76.7 |
| Washington | 81.2 |
| West Virginia | 42.0 |
| Wisconsin | 73.5 |
| Wyoming | 30.3 |

Source: Data reflecting services in CY 2019 were reported as part of the Child Core Set FFY 2020 reporting cycle.

Notes: Mathematica analysis of MACPro reports for the Child Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Table A.4. Percentage of discharges for adults age 18 and older hospitalized for treatment of mental illness or intentional self-harm with a follow-up visit with a mental health practitioner within 30 days after discharge, CY 2019 (Figure 14)

| State or Territory | Percentage |
|----------------------|----------------|
| Alabama | 49.5 |
| Alaska | Did Not Report |
| Arizona | 70.1 |
| Arkansas | 42.0 |
| California | 69.2 |
| Colorado | Did Not Report |
| Connecticut | 65.4 |
| Delaware | 35.1 |
| District of Columbia | 59.1 |
| Florida | 38.9 |
| Georgia | 65.9 |
| Hawaii | 50.8 |
| Idaho | 10.1 |
| Illinois | 26.5 |
| Indiana | 56.1 |
| Iowa | 55.8 |
| Kansas | 67.4 |
| Kentucky | 48.5 |
| Louisiana | 34.1 |
| Maine | 59.2 |
| Maryland | 69.4 |
| Massachusetts | 65.5 |
| Michigan | 61.6 |
| Minnesota | 53.6 |
| Mississippi | 52.7 |
| Missouri | 26.1 |

| State or Territory | Percentage |
|--------------------|----------------|
| Montana | Did Not Report |
| Nebraska | 76.3 |
| Nevada | 49.2 |
| New Hampshire | 72.8 |
| New Jersey | 40.0 |
| New Mexico | 36.6 |
| New York | 58.8 |
| North Carolina | 42.6 |
| North Dakota | 36.0 |
| Ohio | 64.2 |
| Oklahoma | 40.0 |
| Oregon | Did Not Report |
| Pennsylvania | 55.8 |
| Puerto Rico | 81.2 |
| Rhode Island | 71.7 |
| South Carolina | 53.8 |
| South Dakota | 53.9 |
| Tennessee | 55.4 |
| Texas | 40.9 |
| Utah | 68.7 |
| Vermont | 71.7 |
| Virginia | 50.6 |
| Washington | 65.6 |
| West Virginia | 23.1 |
| Wisconsin | 62.2 |
| Wyoming | 11.0 |

Source: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle.

Notes: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).

Table A.5. Percentage of ED visits for adults age 18 and older who had a principal diagnosis of AOD abuse or dependence with a follow-up visit within 30 days of the ED visit, CY 2019 (Figure 17)

| State or Territory | Percentage |
|----------------------|----------------|
| Alabama | 10.6 |
| Alaska | Did Not Report |
| Arizona | 28.3 |
| Arkansas | 7.3 |
| California | 14.2 |
| Colorado | Did Not Report |
| Connecticut | 32.9 |
| Delaware | 17.7 |
| District of Columbia | Did Not Report |
| Florida | 9.9 |
| Georgia | 9.9 |
| Hawaii | 22.5 |
| Idaho | 10.1 |
| Illinois | Did Not Report |
| Indiana | 20.9 |
| Iowa | 52.3 |
| Kansas | 22.2 |
| Kentucky | 31.6 |
| Louisiana | Did Not Report |
| Maine | Did Not Report |
| Maryland | 33.3 |
| Massachusetts | 34.7 |
| Michigan | 22.7 |
| Minnesota | 27.4 |
| Mississippi | 5.6 |
| Missouri | 33.0 |

| State or Territory | Percentage |
|--------------------|----------------|
| Montana | Did Not Report |
| Nebraska | 11.5 |
| Nevada | 18.0 |
| New Hampshire | 41.2 |
| New Jersey | 11.1 |
| New Mexico | 19.1 |
| New York | 28.8 |
| North Carolina | Did Not Report |
| North Dakota | 31.4 |
| Ohio | 29.9 |
| Oklahoma | 10.0 |
| Oregon | 27.8 |
| Pennsylvania | 27.3 |
| Puerto Rico | 21.5 |
| Rhode Island | 23.8 |
| South Carolina | 15.9 |
| South Dakota | Did Not Report |
| Tennessee | 8.2 |
| Texas | 6.8 |
| Utah | Did Not Report |
| Vermont | 36.6 |
| Virginia | 19.1 |
| Washington | 30.1 |
| West Virginia | 37.5 |
| Wisconsin | 26.5 |
| Wyoming | Did Not Report |

Source: Data reflecting services in CY 2019 were reported as part of the Adult Core Set FFY 2020 reporting cycle.

Notes: Mathematica analysis of MACPro reports for the Adult Core Set FFY 2020 reporting cycle as of June 18, 2021; see [2020 Child and Adult Health Care Quality Measures](#).