



Medicaid and CHIP and the COVID-19 Public Health Emergency



***Preliminary Medicaid and
CHIP Data Snapshot***

Services through February 28, 2021

Medicaid and CHIP Content Overview

Medicaid and CHIP Population: Based on an analysis of T-MSIS submissions during the COVID-19 Public Health Emergency (PHE), from March 2020 – February 2021, over 103 million Americans, including children, pregnant women, parents, seniors, and individuals with disabilities, were enrolled across each state’s Medicaid or the Children’s Health Insurance Program (CHIP) for at least one day during the PHE period. About 42% of beneficiaries were children, which translates to about 44 million beneficiaries, and 9% of beneficiaries were over the age of 65. Approximately 55% of beneficiaries were female. 14% of the population were dually-eligible for Medicare and Medicaid. 34% of the population were white, 23% of the population were of unknown race, 20% were Hispanic, 17% were black, 4% were Asian, and 2% were American Indian and Alaska Native, Hawaiian/Pacific Islander, or multiracial.

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

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

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

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

Data Quality Concerns: The results are based on T-MSIS submissions through April 2021, which include services through the end of March 2021. Because data for March are mostly incomplete, results are only presented through February 28, 2021. For additional information regarding state variability in data quality, please refer to the [TAF DQ Atlas](#).

What You Should Know When Using the Data

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

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

*Less than 50 percent of claims submitted.

^Greater than 90 percent of claims submitted.

State Variation in Inpatient Hospital Claims Lag

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

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

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

*Less than 50 percent of claims submitted.

[^]Greater than 90 percent of claims submitted.

State Variation in Other Services Claims Lag

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

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

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

*Less than 50 percent of claims submitted.

[^]Greater than 90 percent of claims submitted.

Table of Contents

- 1. COVID-19 Treatment, Acute Care Use, and Testing** [Slides 7 – 14](#)
- 2. Service Use Among Medicaid and CHIP Beneficiaries Under Age 19 during the COVID-19 Public Health Emergency** [Slides 15 – 23](#)
- 3. Services Delivered via Telehealth to Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency** [Slides 24 – 28](#)
- 4. Services for Mental Health and Substance Use Disorders Among Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency** [Slides 29 – 35](#)
- 5. Reproductive Health Services for Female Medicaid and CHIP Beneficiaries during the COVID-19 Public Health Emergency** [Slides 36 – 44](#)
- 6. Appendix: State-level Average Monthly Rate Tables** [Slides 45 – 49](#)



COVID-19 Treatment, Acute Care Use, and Testing

What You Should Know When Using the Data

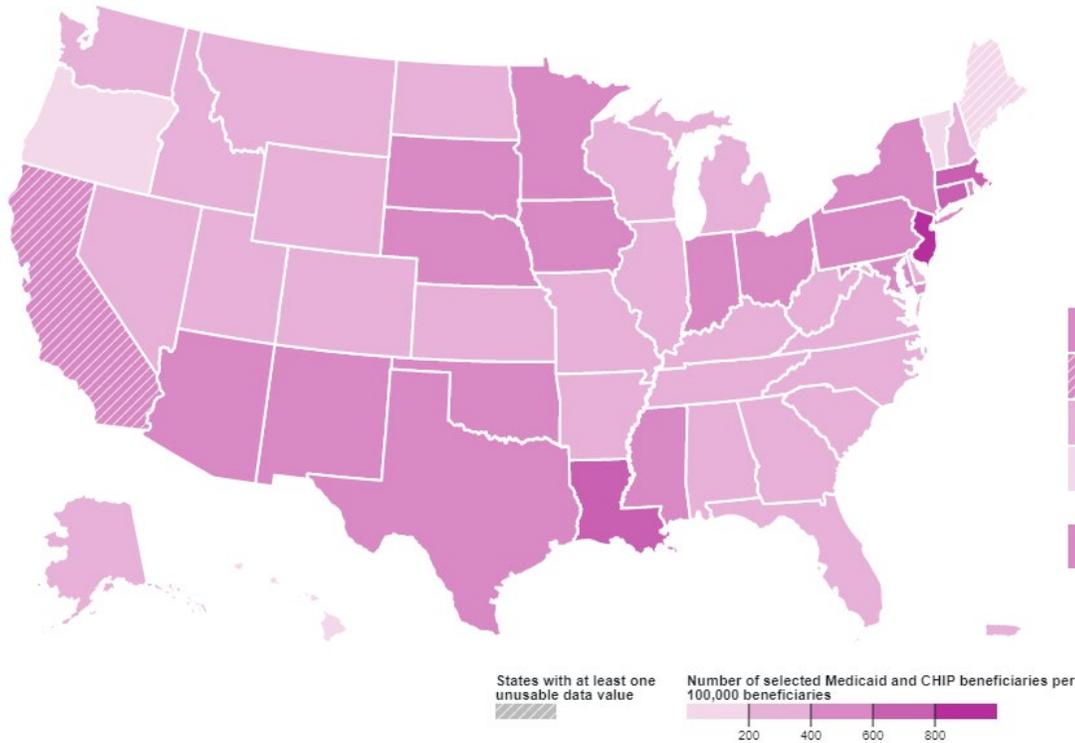
- These estimates reflect COVID-19 treatment, services, and outcomes that are covered by Medicaid and CHIP.
- Services covered by other insurance programs, such as Medicare, are not included in these results.
- In 2019, there were 12.3 million dually eligible beneficiaries enrolled in both Medicare and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

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

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

Medicaid and CHIP beneficiaries treated for COVID-19

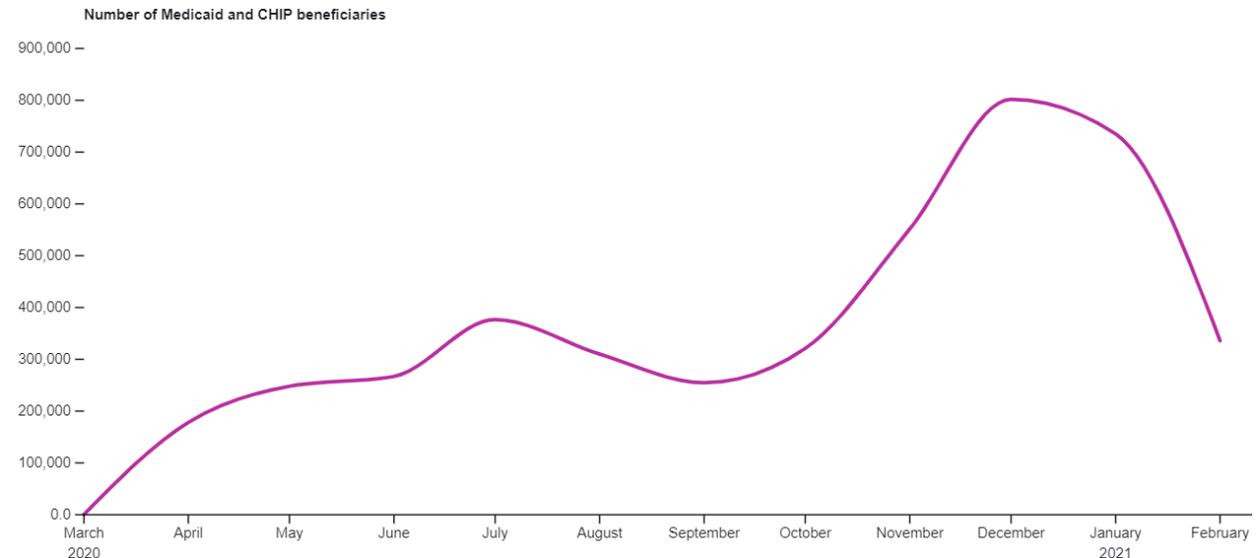
Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE



Beneficiaries treated for COVID-19 during the PHE:
3,164,298

COVID-19 treatment rate during the PHE:
3,054 per 100,000 beneficiaries

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

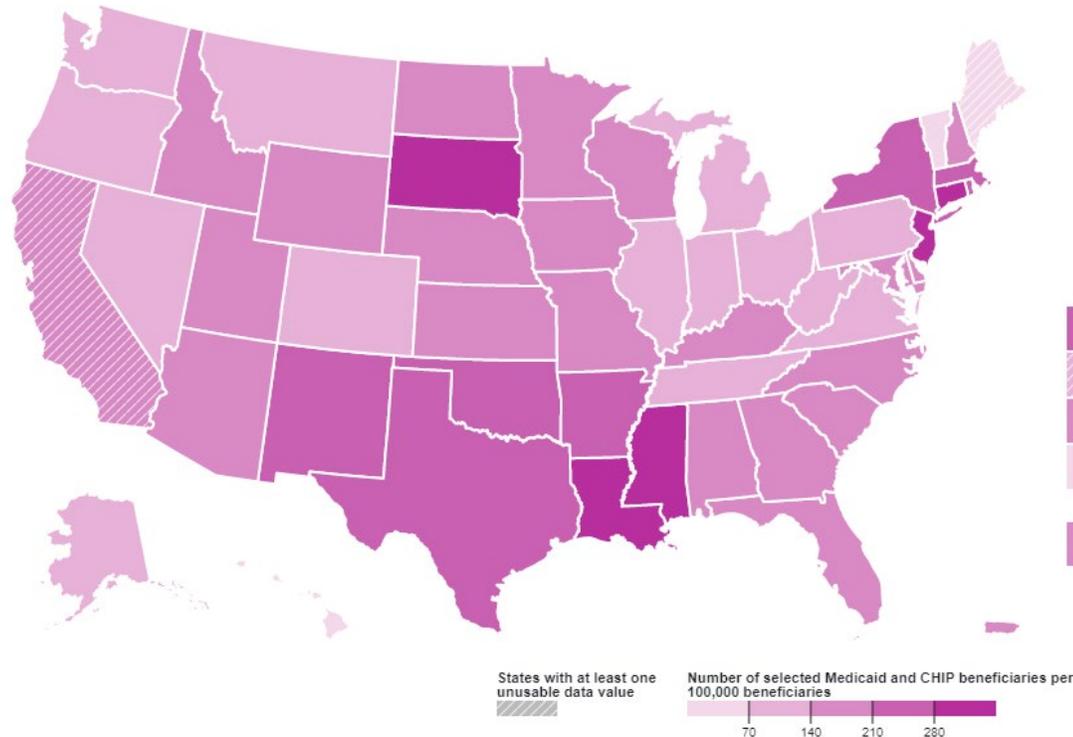


Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021.

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

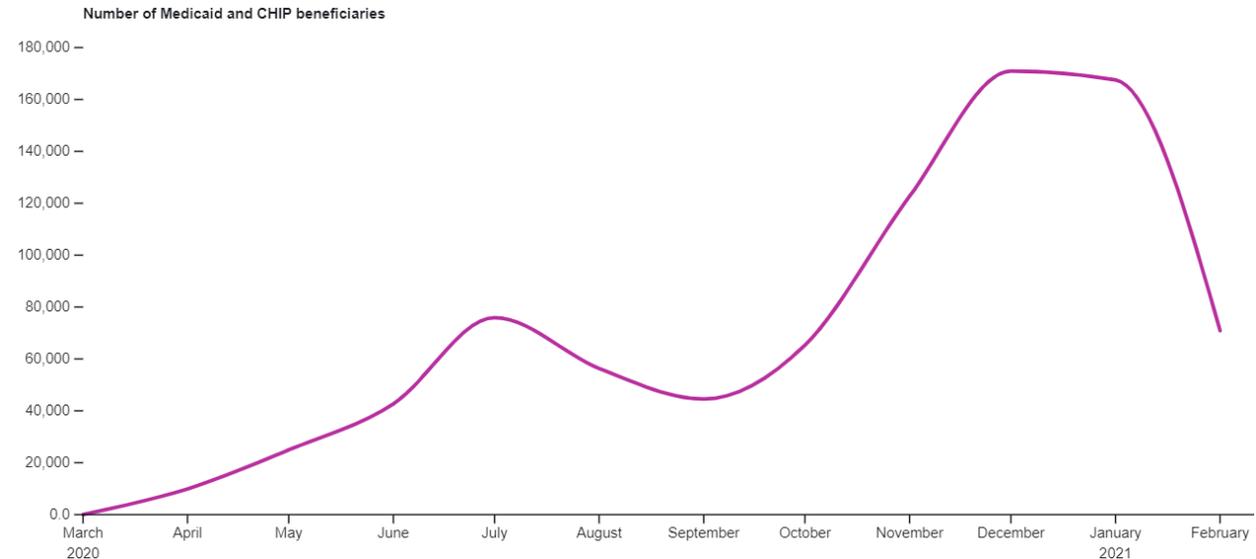
Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE



Beneficiaries under age 19 treated for COVID-19 during the PHE:
784,804

Average monthly COVID-19 treatment rate during the PHE:
1,800 per 100,000 beneficiaries < age 19

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

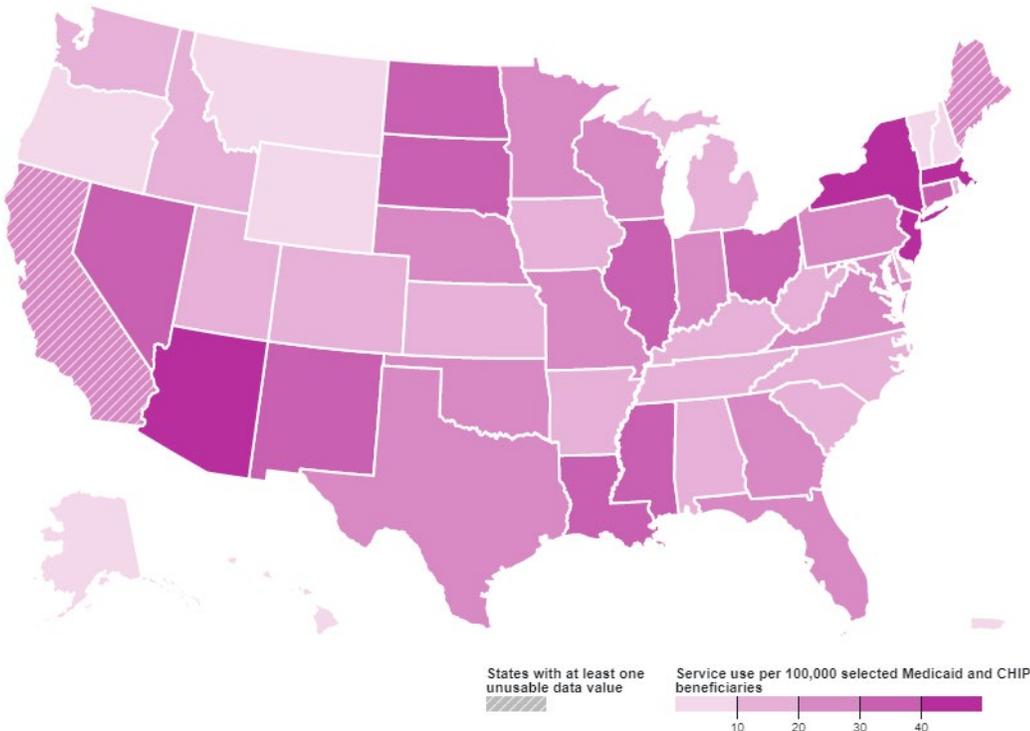


Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among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

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COVID-19 acute care use among Medicaid and CHIP beneficiaries

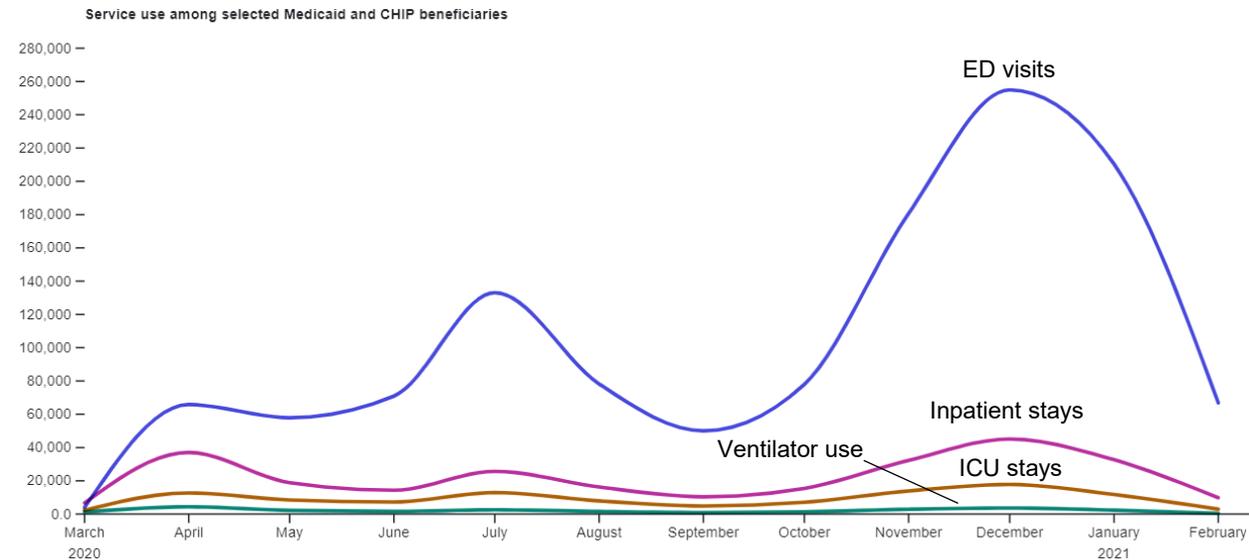
Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE



Number of COVID-19 hospitalizations during the PHE:
264,468

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

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

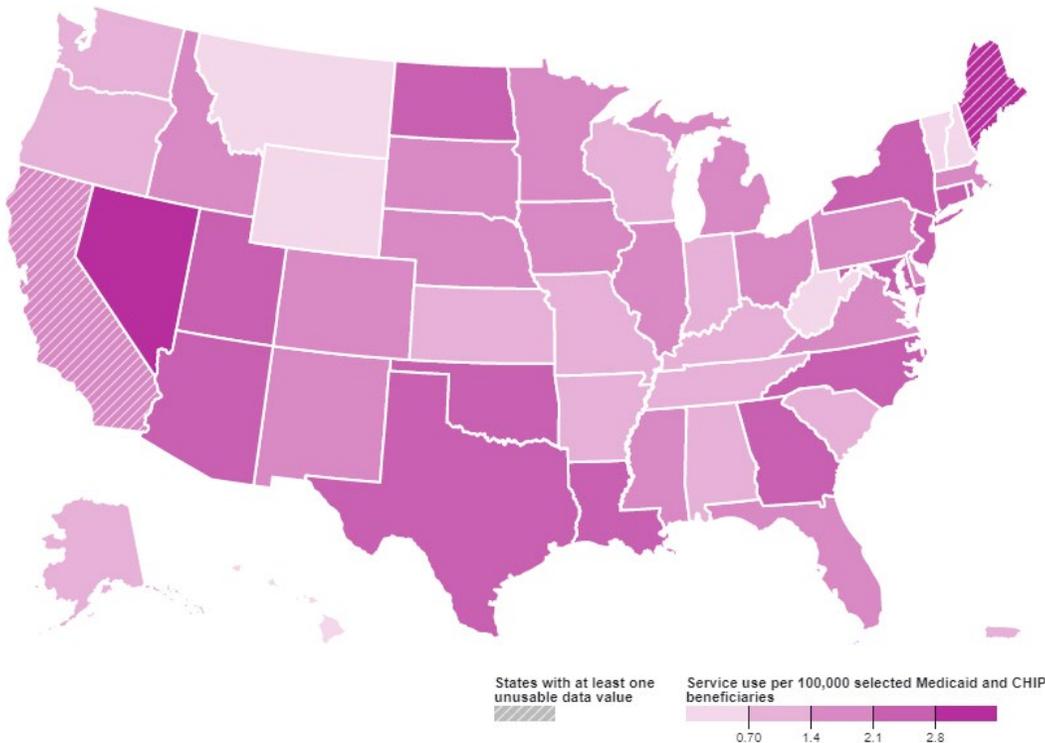


Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among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

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

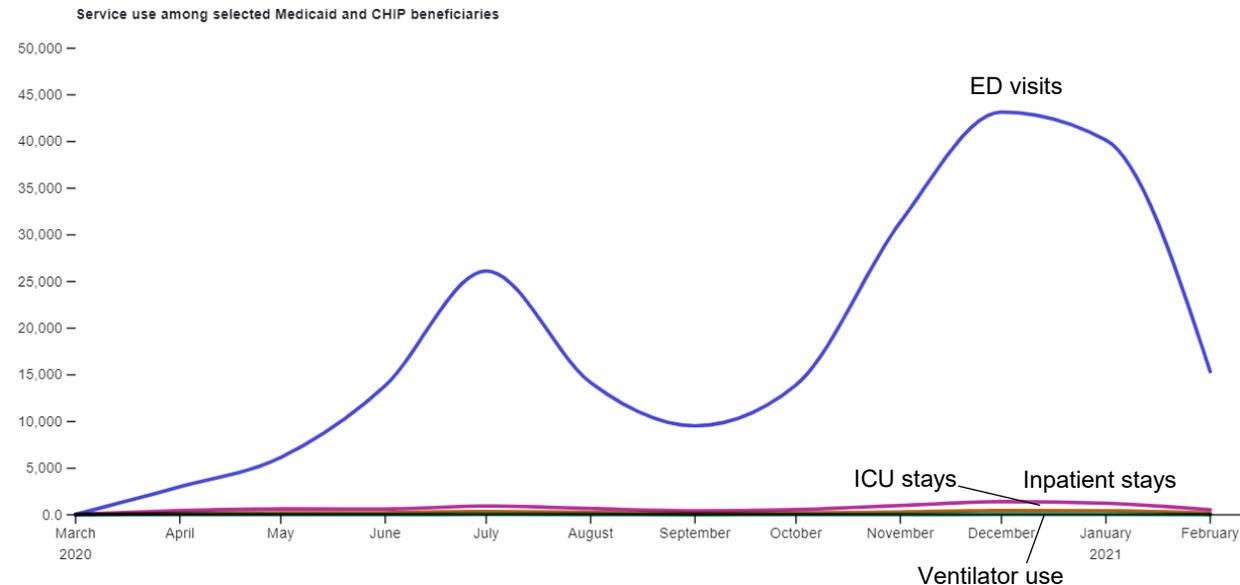
Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE



Number of COVID-19 hospitalizations for beneficiaries under age 19 during the PHE:
8,518

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

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



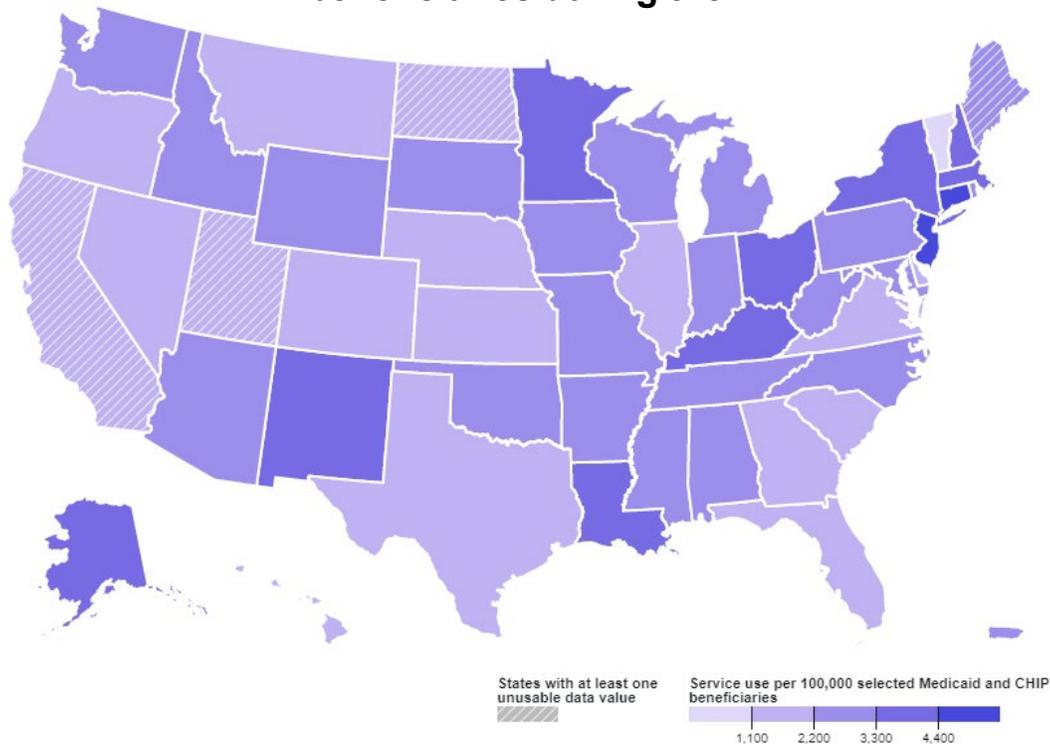
Note: Data for recent months are likely to be adjusted upward due to claims lag. These results are for Medicaid and CHIP only. Therefore, they do not represent the full set of services received by dually eligible beneficiaries. For more information about COVID-related cases and hospitalizations among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

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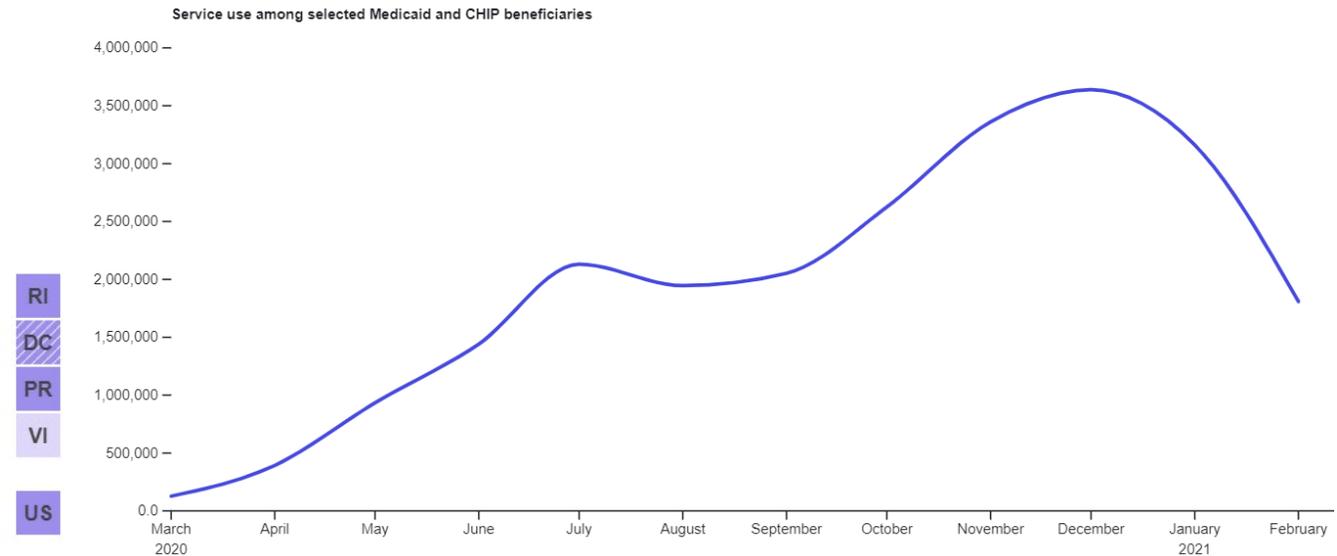
Preliminary data show that Medicaid and CHIP paid for more than 23.6 million COVID-19 tests during the PHE

Average monthly COVID-19 tests paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE (March 2020 – February 2021): 2,592.0

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



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



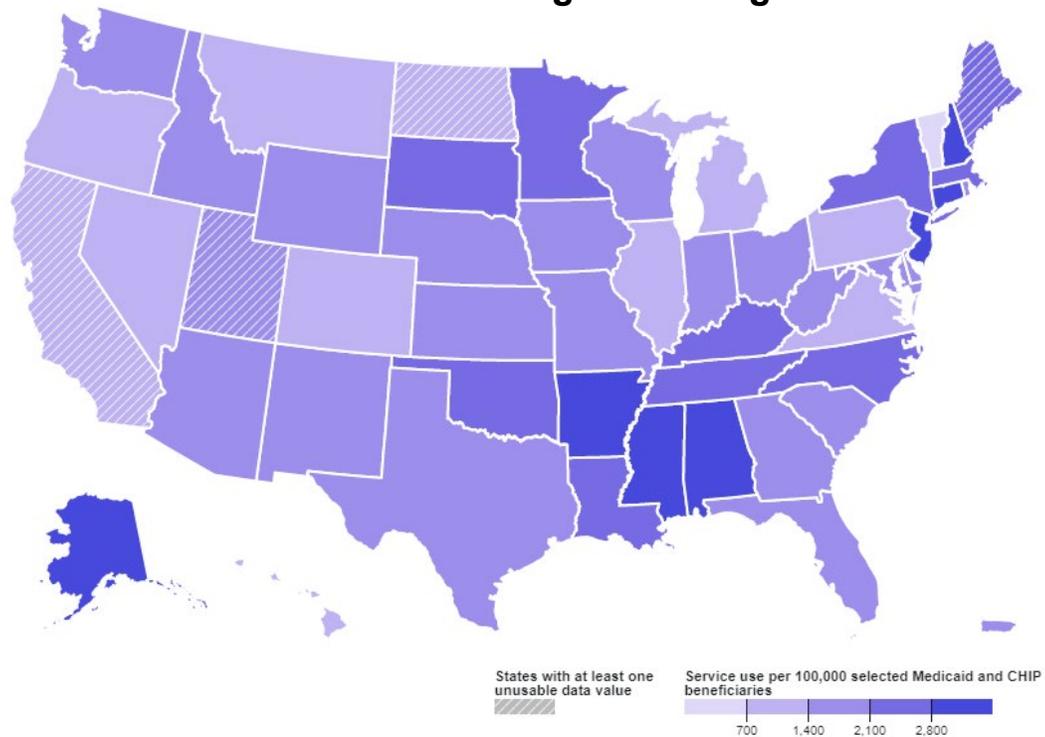
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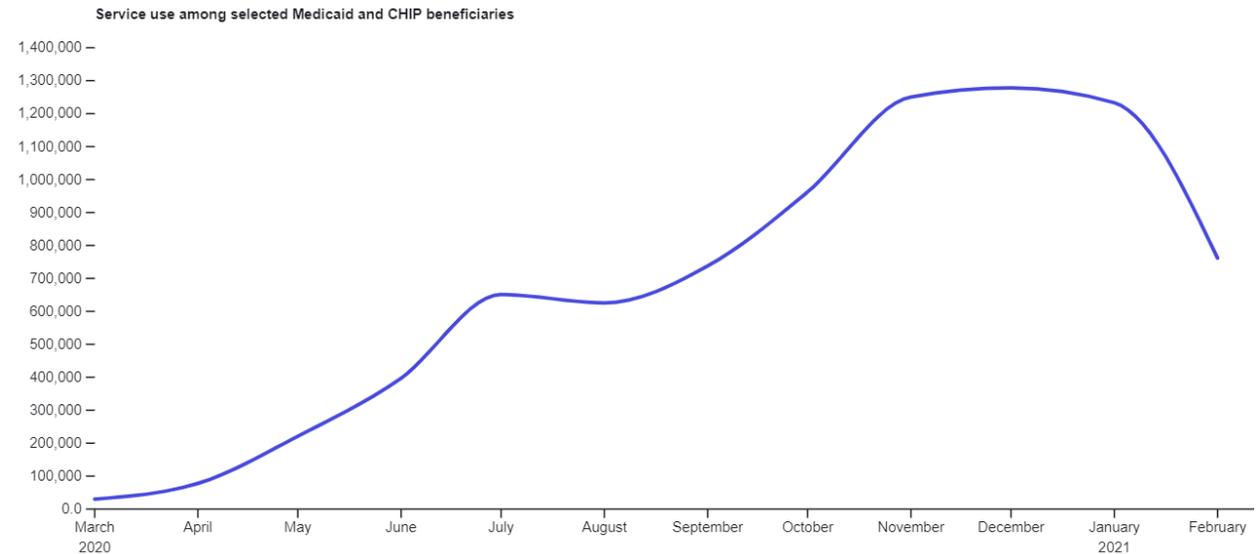
Preliminary data show that Medicaid and CHIP paid for more than 8.2 million COVID-19 tests for beneficiaries under age 19 during the PHE

Average monthly COVID-19 tests paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE (March 2020 – February 2021): 1,759.8

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



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



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

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

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

- Medicaid and CHIP covered nearly 44 million children during the COVID-19 Public Health Emergency (PHE) between March 2020 and February 2021
- The programs cover three quarters of children living in poverty¹
- Approximately four in ten children covered under the programs have a special health care need²

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

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

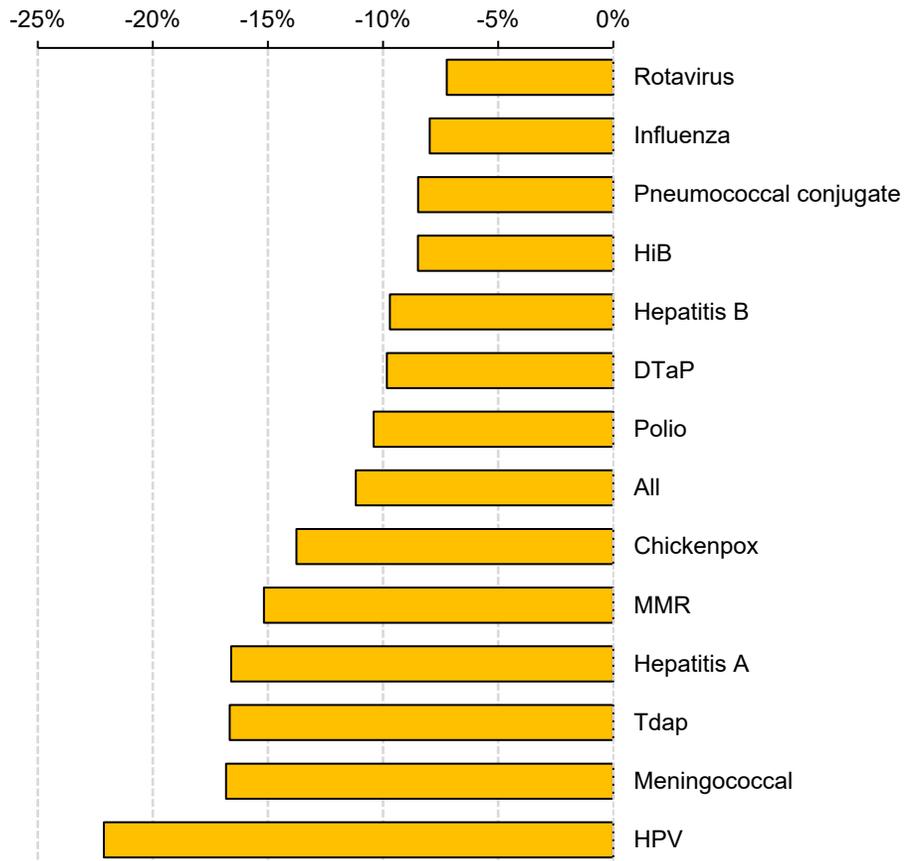
Service use among children under age 19 during the COVID-19 PHE: Key highlights

Preliminary data suggest that, during the PHE:

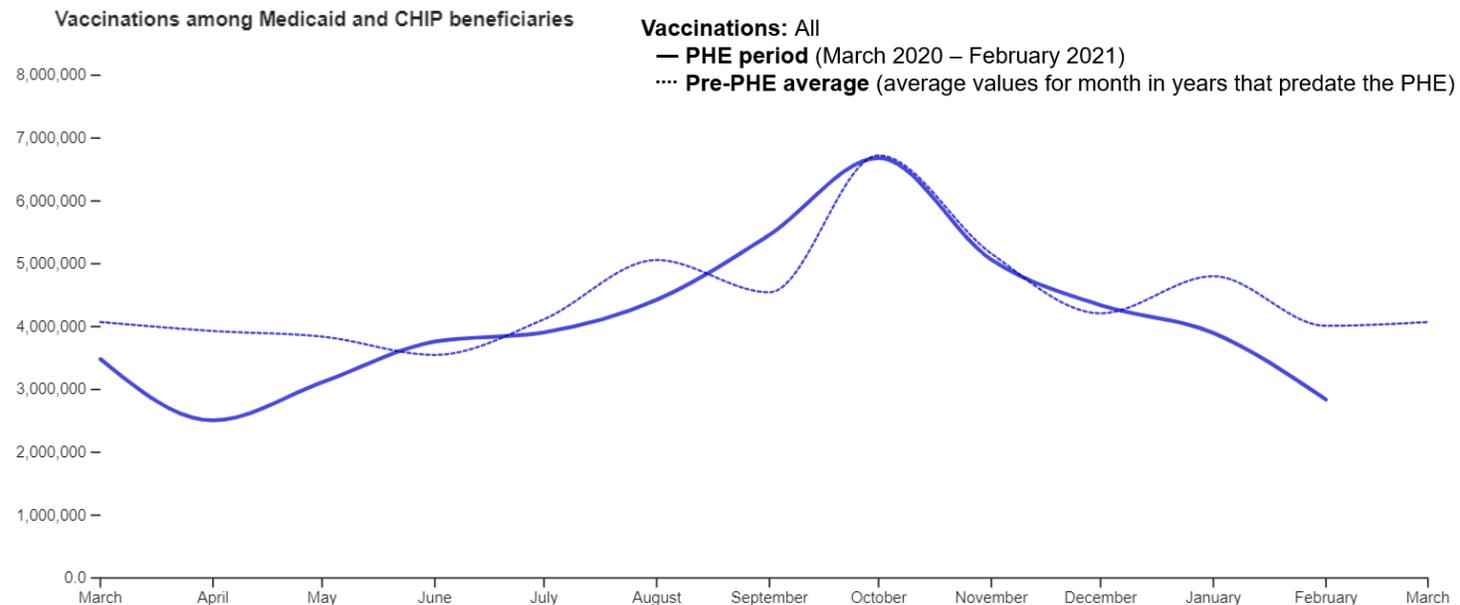
- Primary, preventive, and mental health service use declined among children under age 19 in April 2020.
- Although rates have rebounded for primary and preventive care, millions of services still need to be delivered to make up for those missed between March 2020 and February 2021. Of all services examined in this analysis, the smallest improvement has been for mental health services.
- Service delivery via telehealth for children increased dramatically starting in April 2020 compared to prior years.
- The COVID-19 treatment rate for children was low; ~1.8% of beneficiaries received treatment for COVID-19 under Medicaid or CHIP and fewer than 8,600 were hospitalized.

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

Percent change in the number of vaccinations delivered to children under age 19 during the PHE compared to the same period the year prior



Number of vaccinations delivered to Medicaid and CHIP beneficiaries under age 19, by month

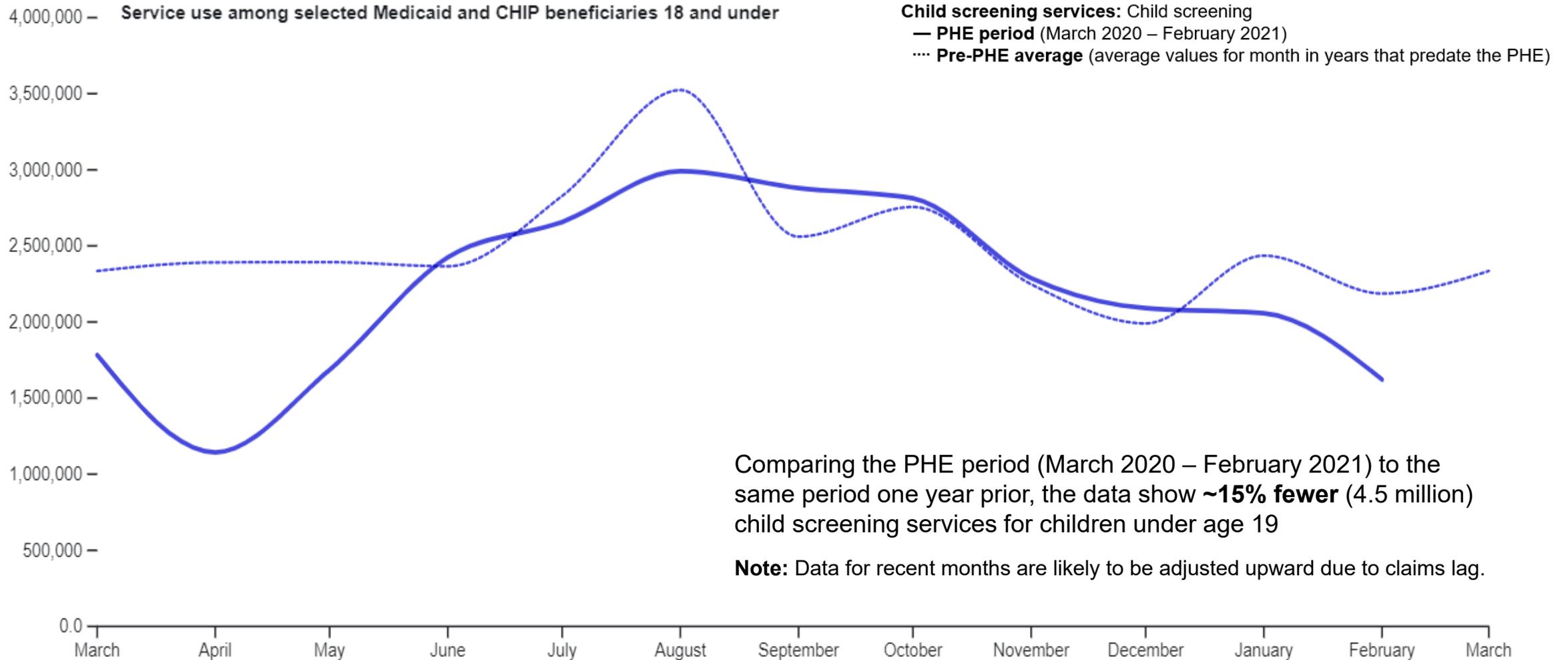


Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~11% fewer** (6.2 million) vaccinations for children under age 19

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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show child screening services declined in April and increased through August, but they did not demonstrate the expected increase in services prior to the new school year



Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~15% fewer** (4.5 million) child screening services for children under age 19

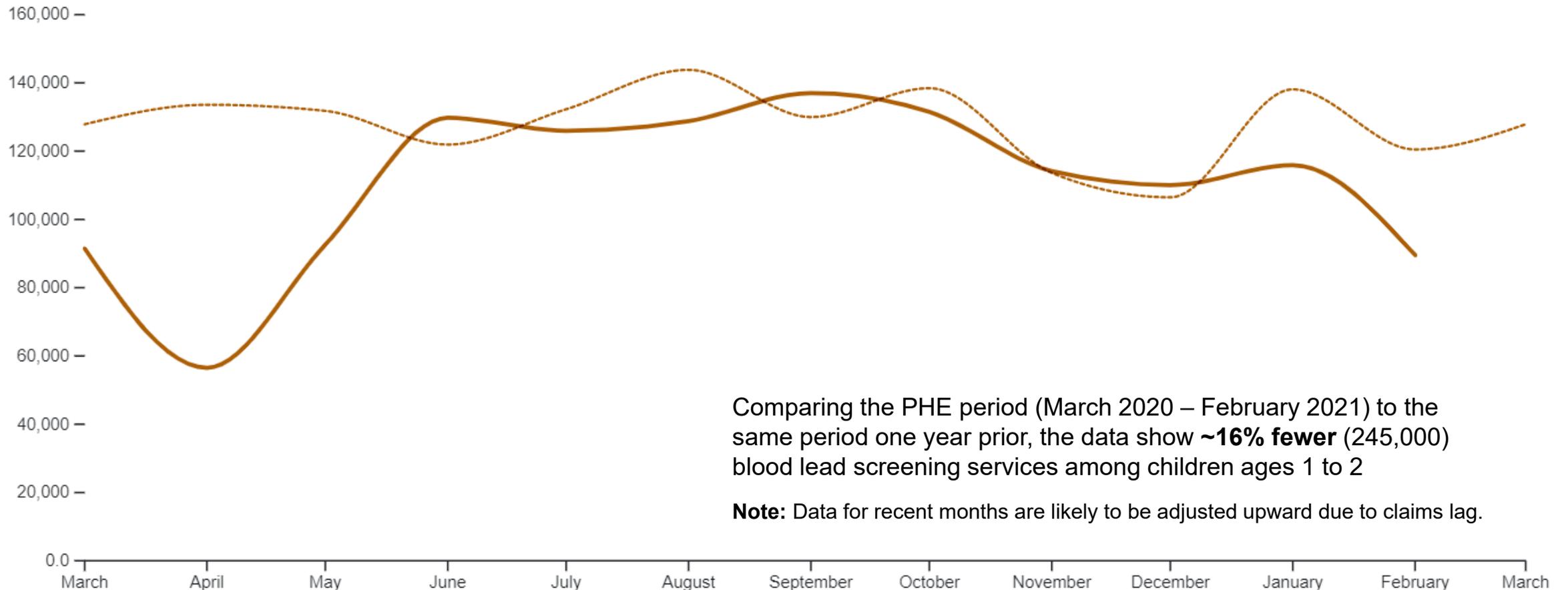
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Preliminary data show blood lead screening services for children ages 1 to 2 declined in April and increased through September

Service use among selected Medicaid and CHIP beneficiaries 18 and under

Child screening services: Blood lead screening
 — PHE period (March 2020 – February 2021)
 Pre-PHE average (average values for month in years that predate the PHE)

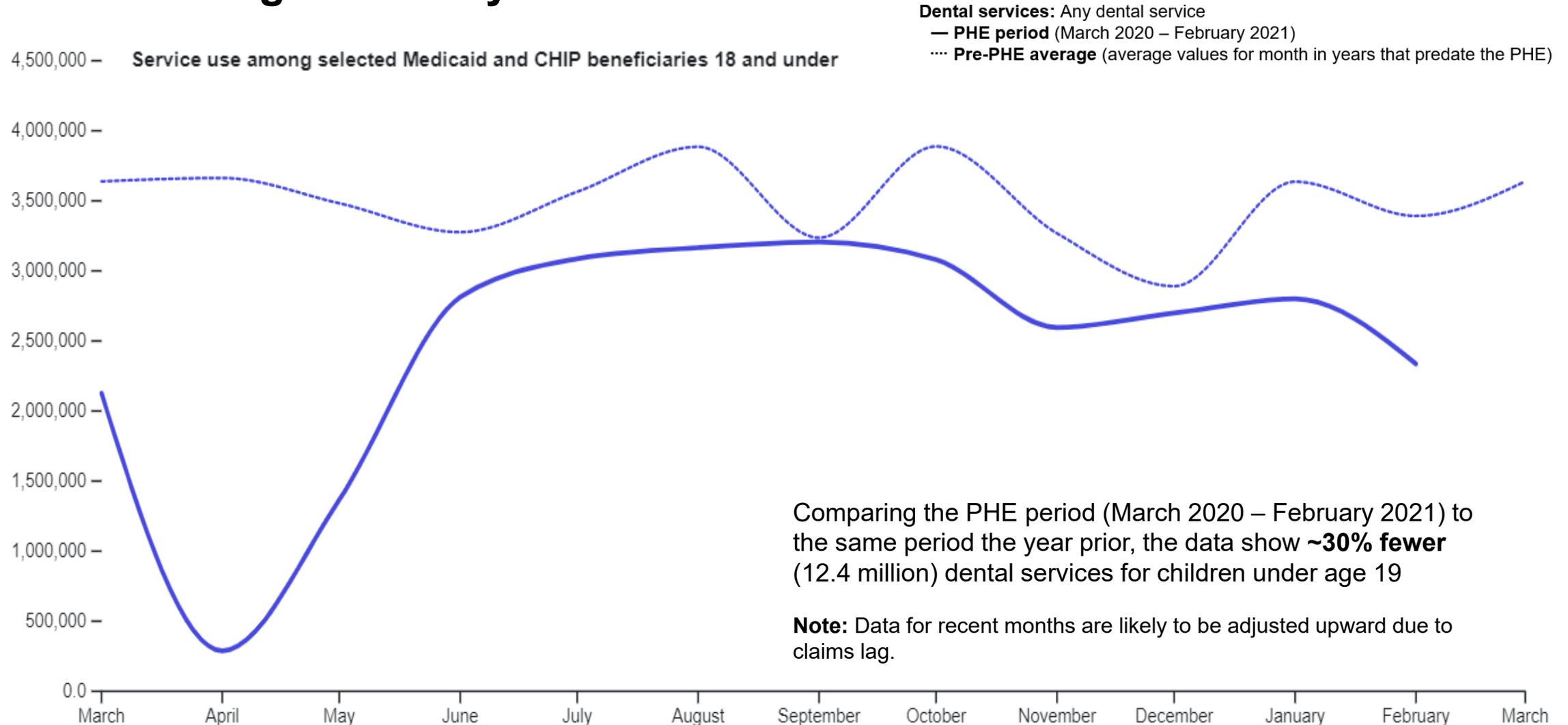


Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~16% fewer** (245,000) blood lead screening services among children ages 1 to 2

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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show the number of dental services for children declined drastically in April and increased starting in May, but remain below pre-PHE rates through February 2021

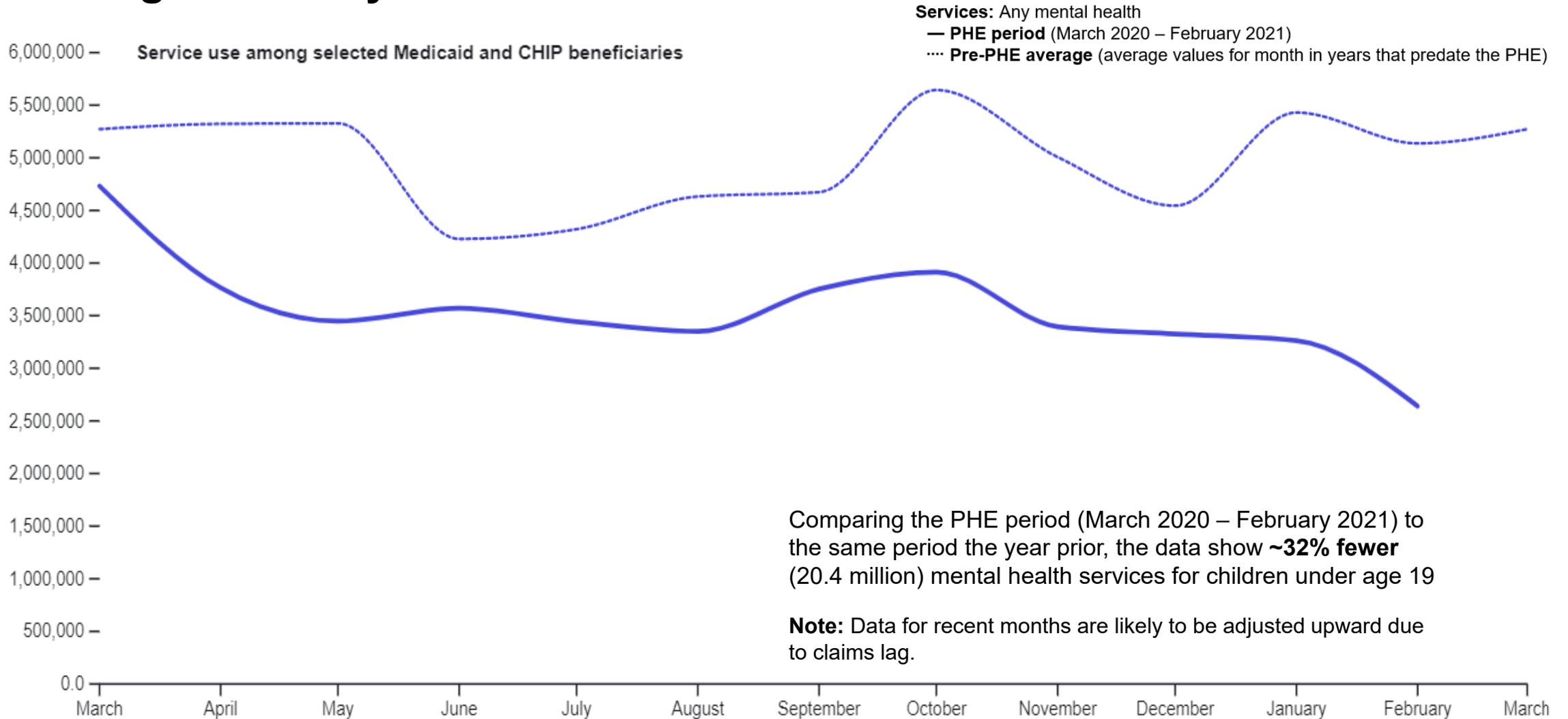


Comparing the PHE period (March 2020 – February 2021) to the same period the year prior, the data show **~30% fewer** (12.4 million) dental services for children under age 19

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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show mental health services for children under age 19 declined starting in March and continue to be lower than prior years' levels through February 2021



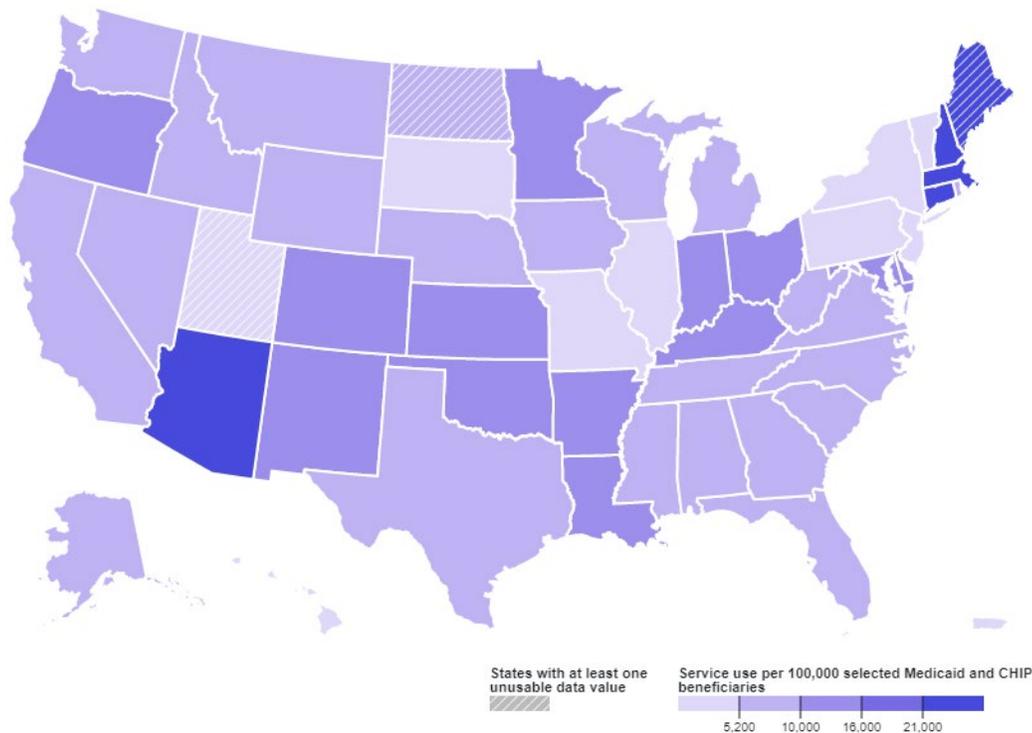
Comparing the PHE period (March 2020 – February 2021) to the same period the year prior, the data show **~32% fewer** (20.4 million) mental health services for children under age 19

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

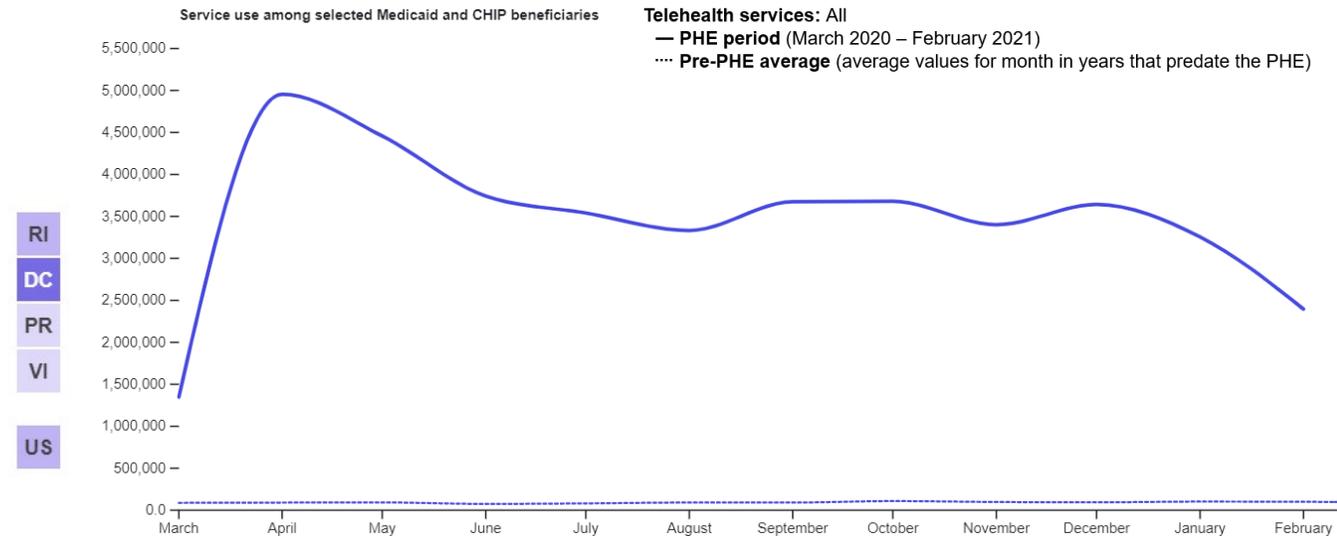
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show rates of services delivered through telehealth among beneficiaries under age 19 peaked in April 2020 and were generally highest in the northeast

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



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



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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.



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

Services delivered via telehealth in Medicaid and CHIP

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

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

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

Preliminary data suggest that, during the PHE:

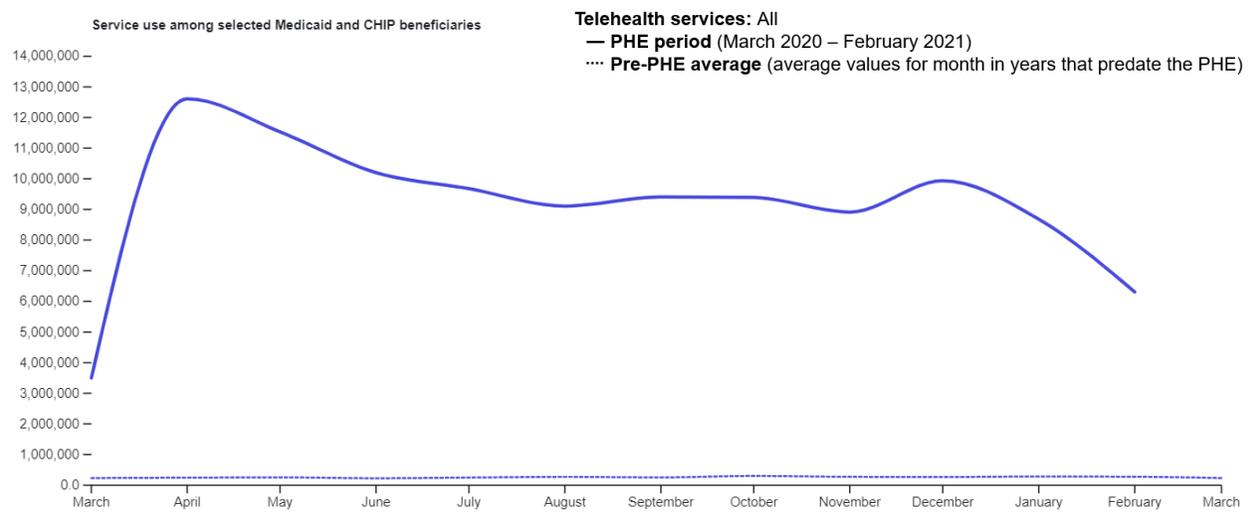
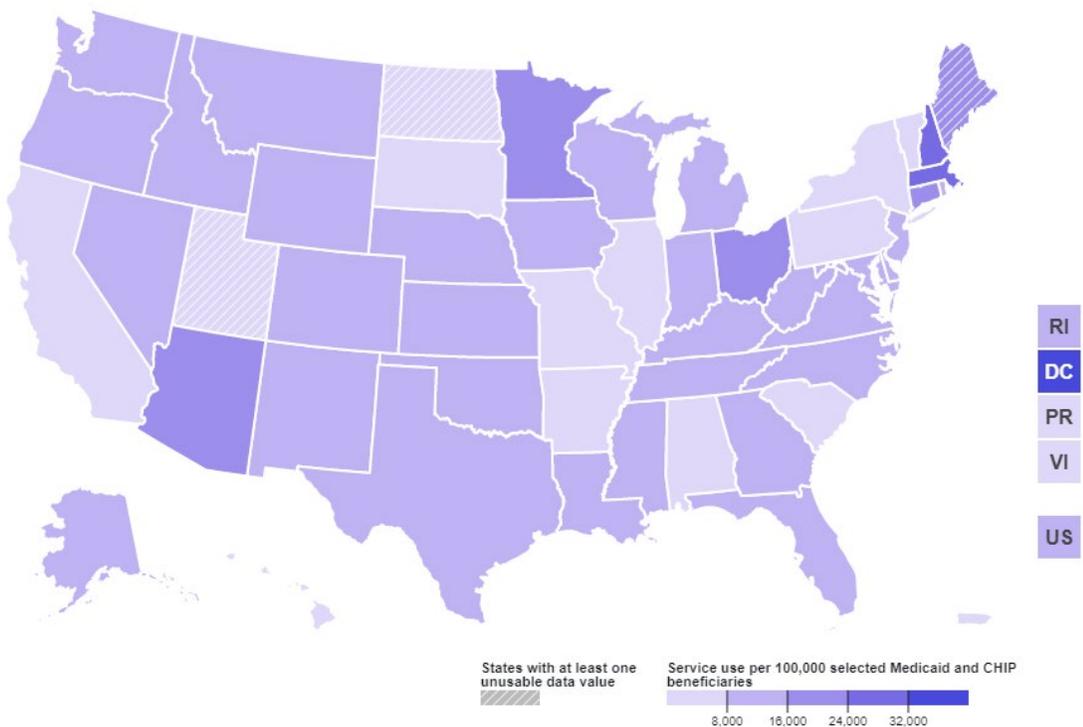
- In the US, among all age groups, services delivered through telehealth spiked in April 2020 and declined steadily from May 2020 through February 2021
- The rate of telehealth use per 100,000 beneficiaries was highest among adults ages 19 to 64, while children under age 19 and adults age 65 and older had lower, comparable rates
- Use of telehealth services varied considerably across states and across age groups within states

Preliminary data show rates of services delivered through telehealth peaked in April 2020, fell through November, and were highest in a few states

Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show 105,401,568 more services delivered through telehealth, an increase of 2,732%

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

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

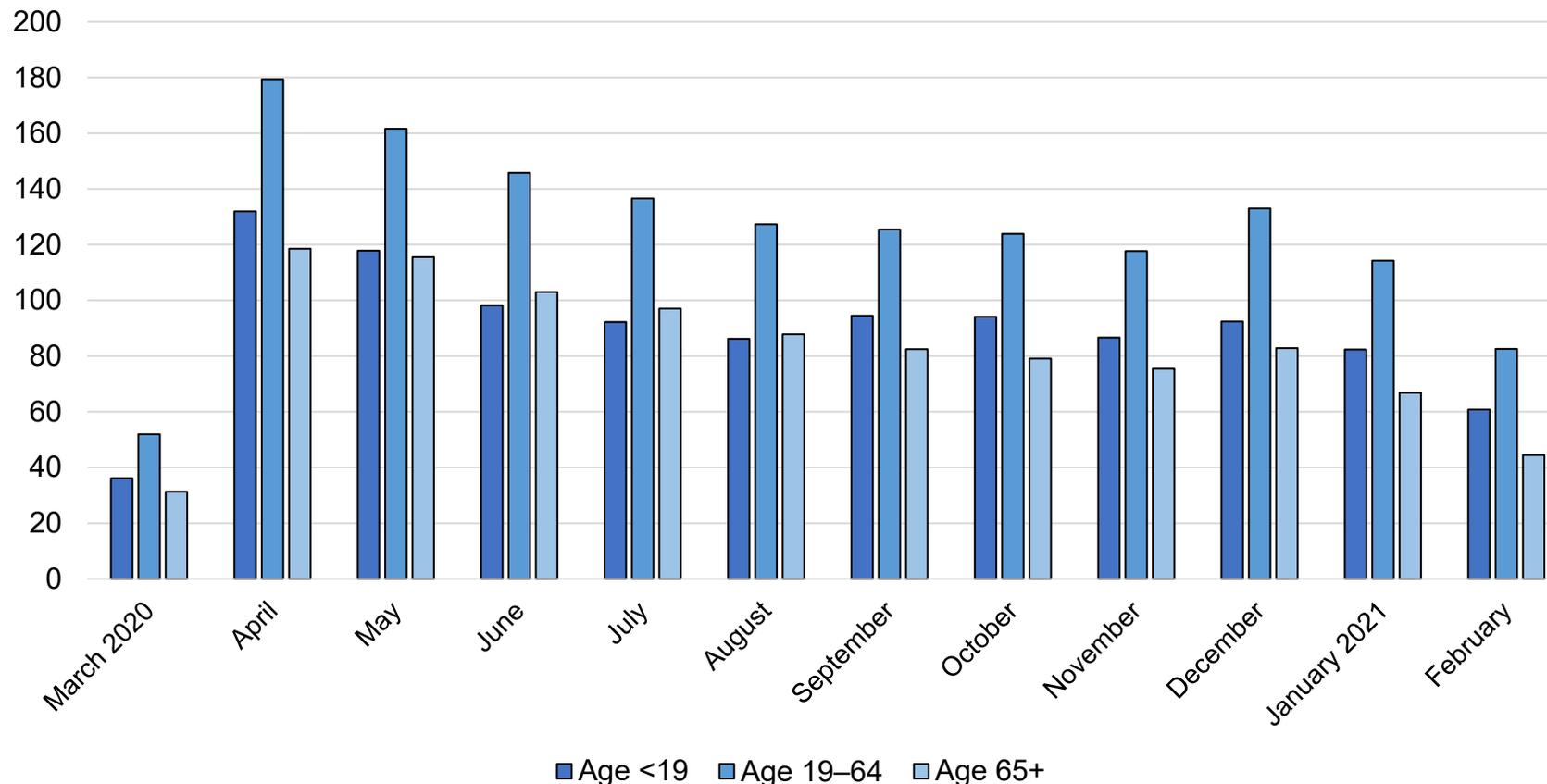


Note: Data for recent months are likely to be adjusted upward due to claims lag.

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021.

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

Services delivered via telehealth per 1,000 beneficiaries during the PHE (March 2020 – February 2021)



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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021.



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

Mental health and substance use care in Medicaid and CHIP

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

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

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

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

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

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

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

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

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

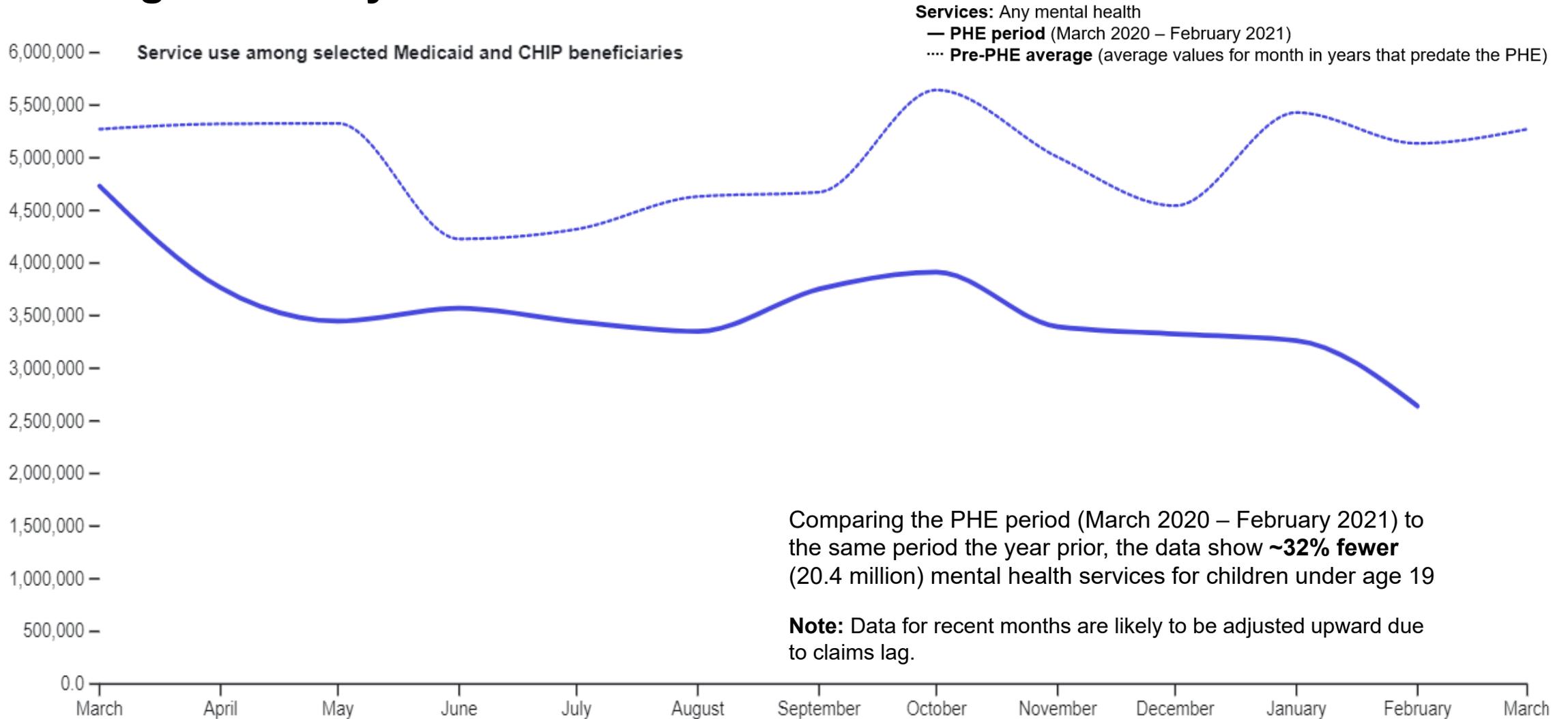
3. Centers for Disease Control and Prevention (CDC). “Press Release: Overdose Deaths Accelerating During COVID-19.” December 17, 2020. Available at: [Overdose Deaths Accelerating During COVID-19 | CDC Online Newsroom | CDC](https://www.cdc.gov/media/releases/2020/s1217-overdose-deaths.html).

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

Preliminary data suggest that, during the PHE:

- Mental health services for adults ages 19 to 64 and children under age 19 declined throughout the PHE and are consistently lower than prior years' levels.
- Substance use disorder services for adults ages 19 to 64 have declined during the PHE and generally remained below prior years' levels.
- 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 mental health services for children under age 19 declined starting in March and continue to be lower than prior years' levels through February 2021

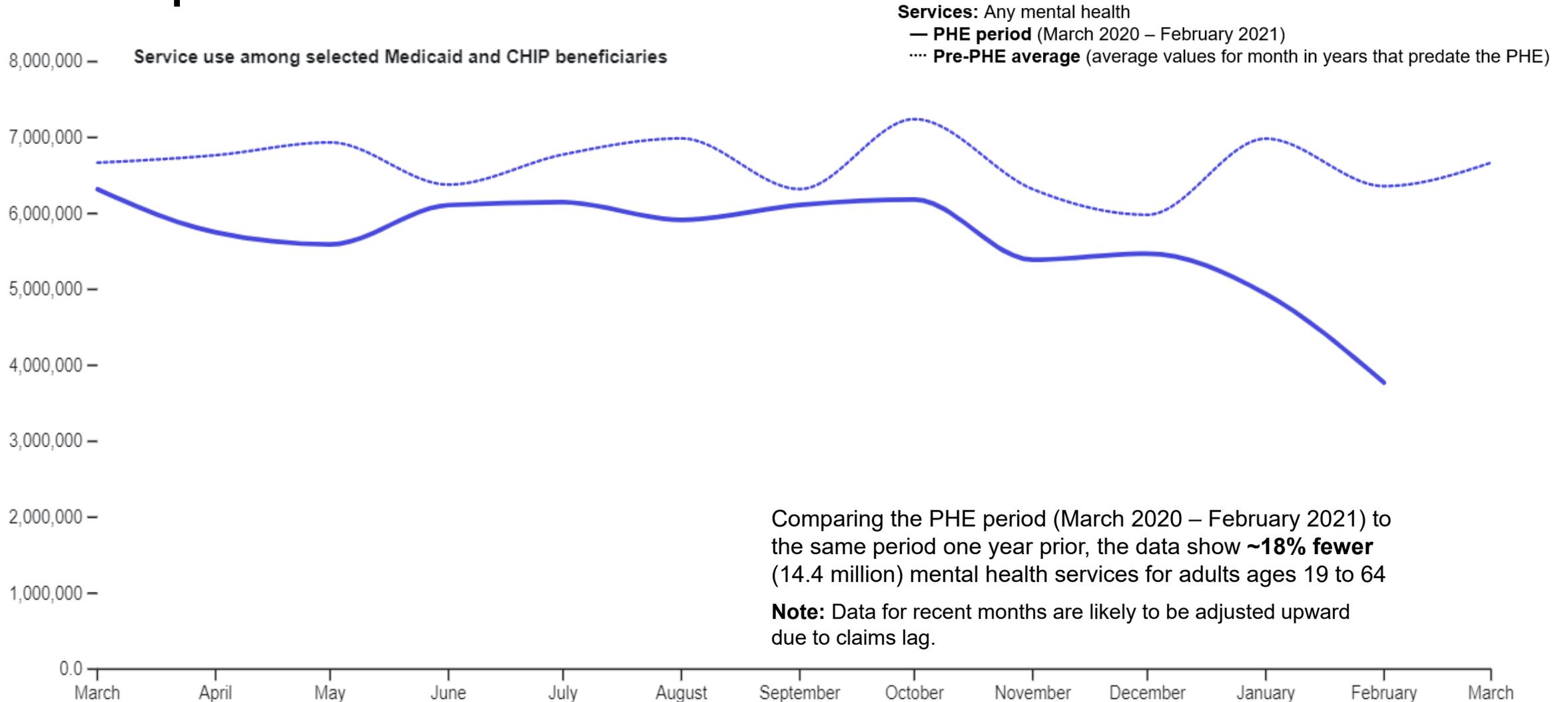


Comparing the PHE period (March 2020 – February 2021) to the same period the year prior, the data show **~32% fewer** (20.4 million) mental health services for children under age 19

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

Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show mental health services for adults ages 19 to 64 began to recover slightly from June through October 2020, but remain below pre-PHE levels

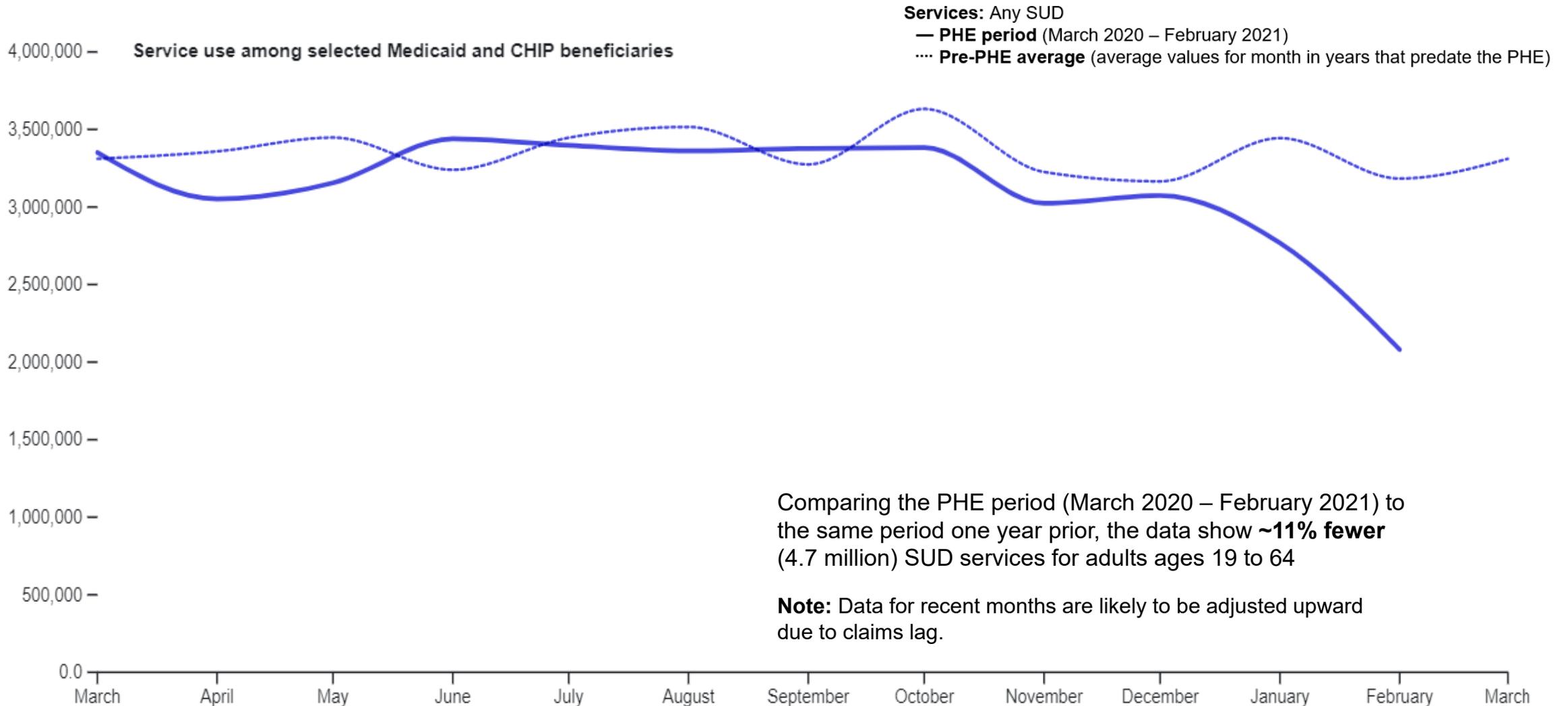


Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~18% fewer** (14.4 million) mental health services for adults ages 19 to 64

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 v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show SUD services for adults ages 19 to 64 declined in April and recovered from June through October 2020, but are still below pre-PHE levels



Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~11% fewer** (4.7 million) SUD services for adults ages 19 to 64

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 v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020. As of January 1, 2020, Medicare Part B pays Opioid Treatment Programs (OTPs) through bundled payments for opioid use disorder. This change in coverage may impact results for dually eligible beneficiaries.



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

Reproductive health care services in Medicaid and CHIP

- Medicaid is the largest payer for maternity care in the United States, covering more than 4 in 10 births. Nearly two of every three adult women enrolled in Medicaid are of reproductive age (ages 19 to 44).¹ Medicaid and CHIP also cover a variety of reproductive health care services, including prenatal services, deliveries, and postpartum services, as well as family planning services and contraceptive methods, such as long-acting reversible contraception (LARC).
- Maternity care services, including prenatal care, delivery, and postpartum care, can be billed either separately for each service or as a “bundle” of services with a bundled payment procedure code.
- Prenatal and postpartum care are essential to improve maternal and perinatal health outcomes and address pregnancy-related health disparities.² As a response to the COVID-19 PHE, Congress passed the Families First Coronavirus Response Act, which includes enhanced federal funding for state Medicaid agencies to provide continuous coverage for postpartum women through the PHE.³

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

2. More information is available at: [Medicaid and CHIP Beneficiary Profile: Maternal and Infant Health December 2020](#).

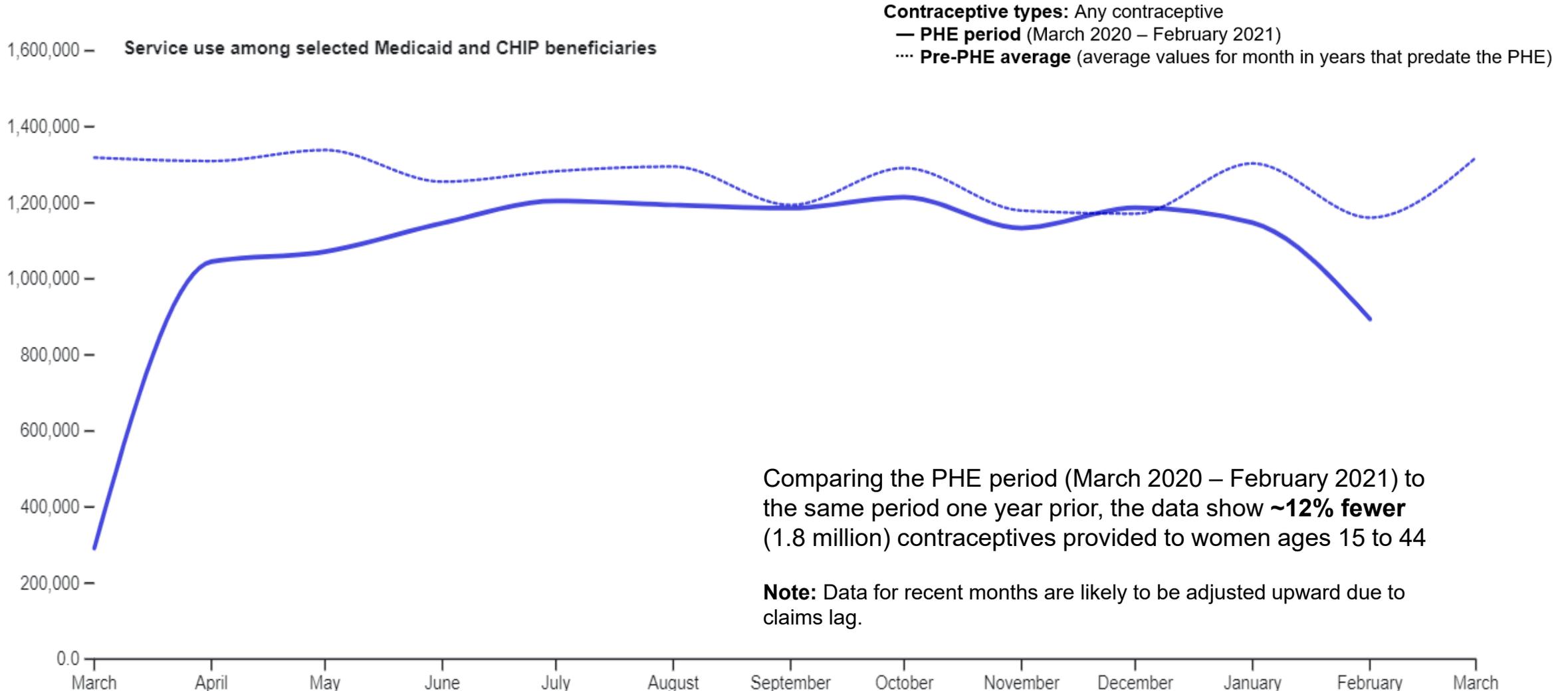
3. H.R.1319 - American Rescue Plan Act of 2021. More information is available at: <https://www.congress.gov/bill/117th-congress/house-bill/1319/text#toc-HD0A062309C1143928EF82EC5845217C3/>.

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

Preliminary data suggest that, during the PHE:

- Provision of any contraceptives and long-acting reversible contraception dropped in April 2020 and rebounded through January 2021, though there is still a gap in services compared to pre-PHE levels.
- The numbers of live births, miscarriages, and stillbirths during the PHE are lower than prior years' levels. The decline in pregnancy outcomes in earlier months of the PHE is not attributable to COVID-19 since these pregnancies were initiated prior to March 2020 (the start of the PHE).
- Perinatal care services including prenatal and postpartum visits and bundled payments declined despite increased enrollment in Medicaid and CHIP among pregnant women and extended Medicaid coverage for postpartum services during the PHE.

Preliminary data show provision of any contraceptives for women declined starting in January 2020 and continued to be lower than pre-PHE levels through February 2021

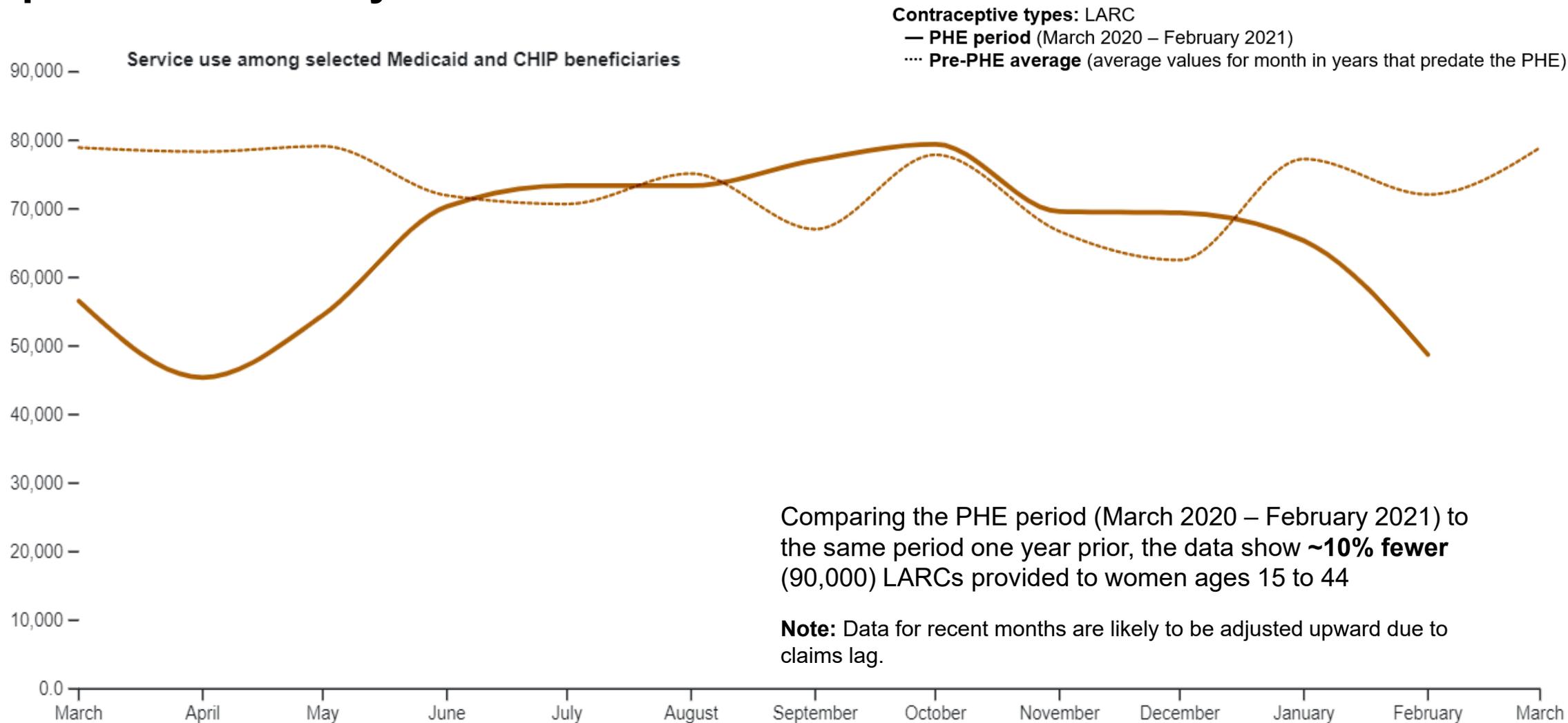


Comparing the PHE period (March 2020 – February 2021) to the same period one year prior, the data show **~12% fewer** (1.8 million) contraceptives provided to women ages 15 to 44

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

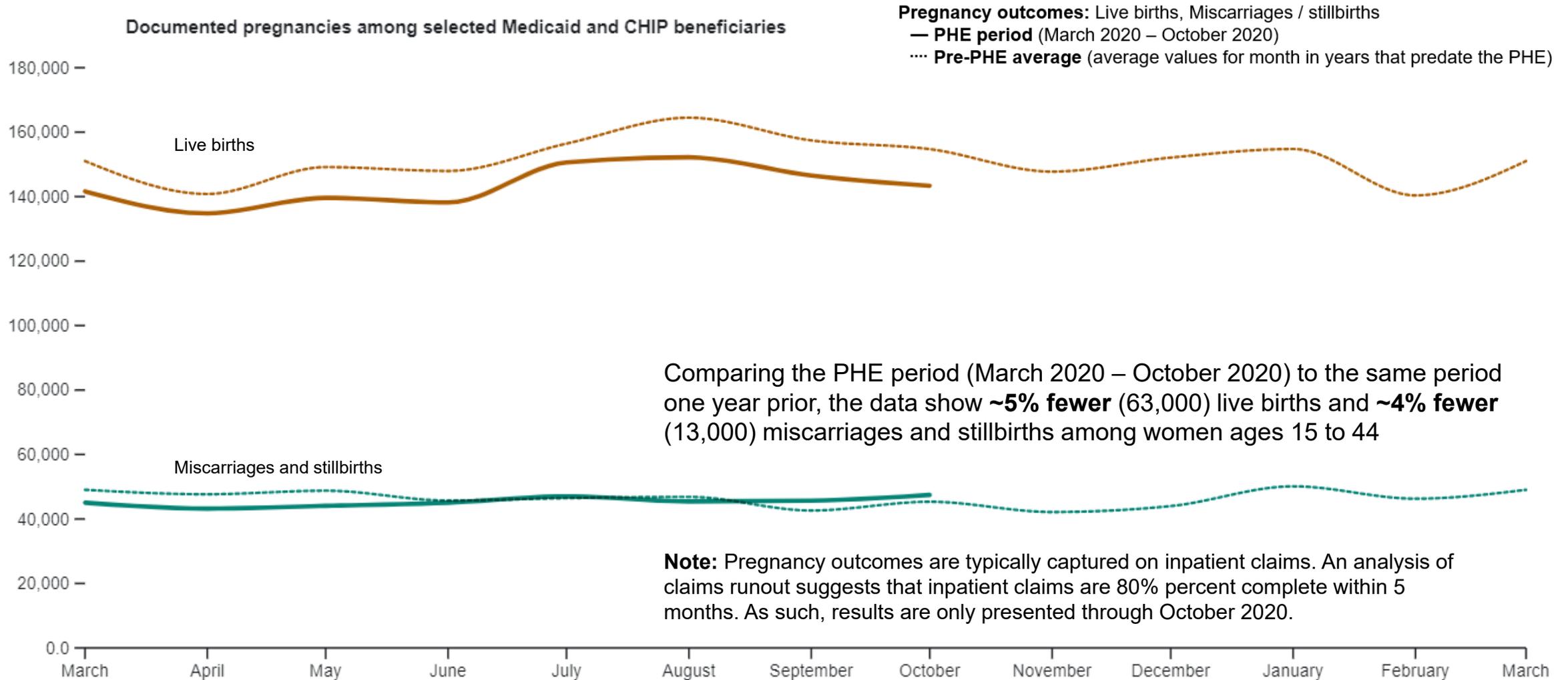
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because data for March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show provision of long-acting reversible contraceptives (LARC) for women declined starting in January 2020 and rebounded to pre-PHE levels by June



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020.

Preliminary data show declines across both live births and non-live births (miscarriages and stillbirths) during the PHE period compared to pre-PHE levels



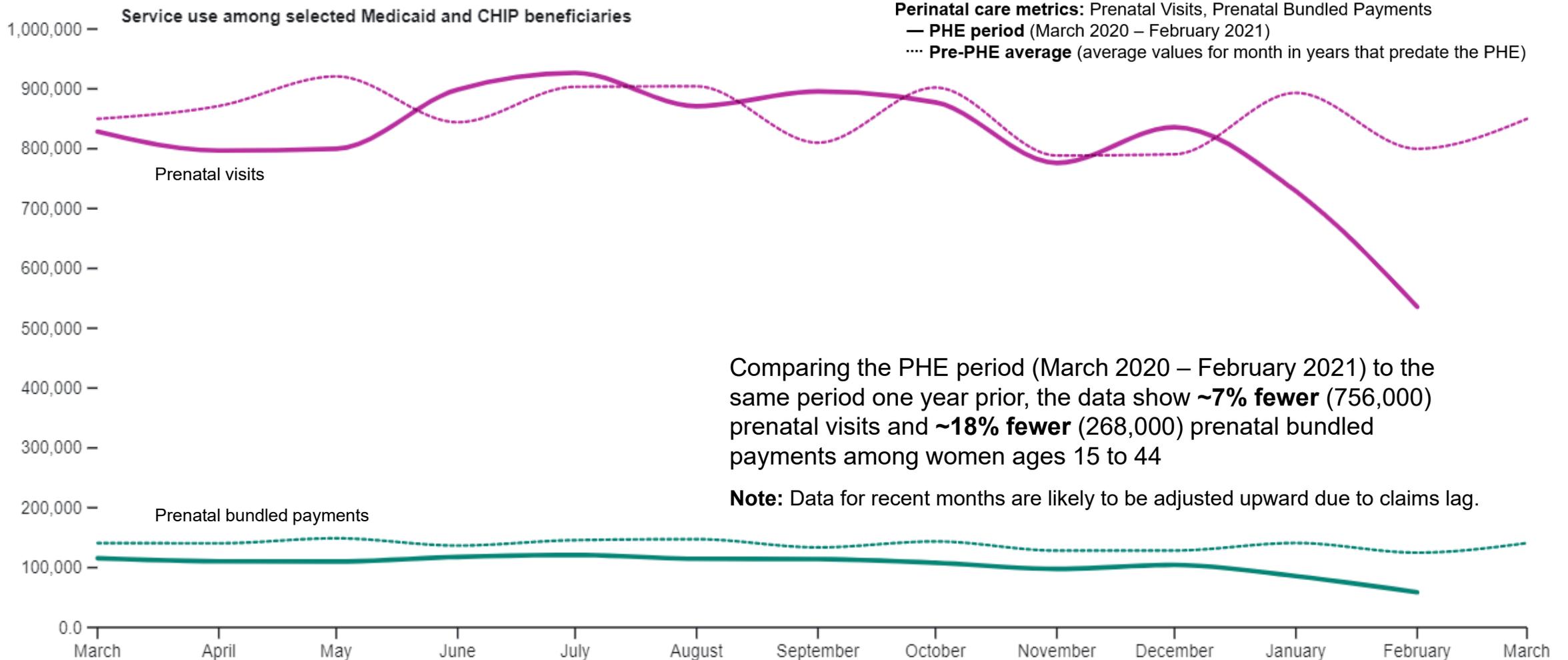
Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. Recent dates of service have very little time for claims runout and we expect large changes in the results after each monthly update. Because inpatient data are incomplete for at least 5 months, results are only presented through October 31, 2020. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from March 2018 through October 2019.

Counting prenatal and postpartum services

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

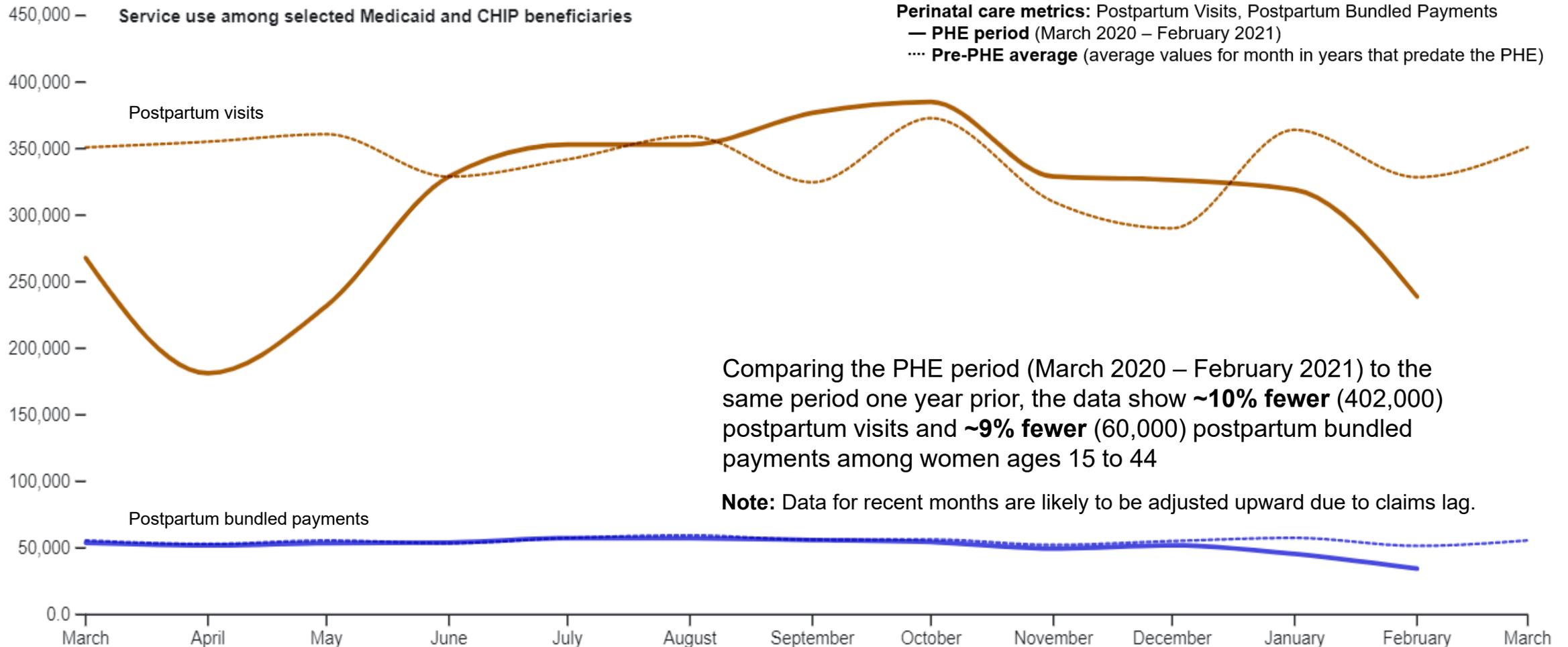
1. More information about the use of bundled payment codes to bill for maternity services in TAF is available at: [Use of Bundled Payment Codes to Bill for Maternity Services in 2016 \(medicaid.gov\)](https://www.medicaid.gov/use-of-bundled-payment-codes-to-bill-for-maternity-services-in-2016)

Preliminary data show prenatal visits declined in April 2020 and rebounded to pre-PHE levels in June, whereas the volume of prenatal bundled payments during the PHE remain below pre-PHE levels



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020. This measure is likely an undercount of prenatal services among women ages 15 to 44 in states where perinatal services are billed together as bundled payments.

Preliminary data show postpartum visits declined in April 2020 and rebounded to pre-PHE levels in June, whereas the volume of postpartum bundled payments during the PHE remain slightly below pre-PHE levels



Notes: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021. The pre-PHE average is the average of all values for that month in the years that predate the PHE, including data from January 2018 through February 2020. This measure is likely an undercount of postpartum services among women ages 15 to 44 in states where perinatal services are billed together as bundled payments.



Appendix: State-level Average Monthly Rate Tables

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

State	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE
United States	414.65	181.60	25.31	1.83
Alaska	221.16	117.83	9.47	1.32
Alabama	269.63	205.20	15.19	0.96
Arkansas	374.75	244.80	18.79	1.37
Arizona	508.47	206.72	41.30	2.40
California	408.27*	182.23*	20.49*	1.40*
Colorado	301.79	99.08	19.41	1.62
Connecticut	636.18	282.25	36.17	2.30
District of Columbia	425.12*	124.50*	38.94	3.35
Delaware	391.04	182.91	16.38	1.72
Florida	326.95	160.54	25.05	2.04
Georgia	374.46	155.57	21.88	2.31
Hawaii	93.92	46.02	8.63	0.66
Iowa	417.81	175.65	18.10	1.41
Idaho	387.52	170.46	19.28	1.72
Illinois	391.50	122.88	32.61	1.92
Indiana	421.75	129.46	25.01	1.11
Kansas	353.17	142.46	15.70	1.29
Kentucky	388.75	146.81	19.01	0.94
Louisiana	600.76	286.67	35.37	2.11
Massachusetts	760.97	235.47	44.69	1.95
Maryland	462.82	174.10	26.05	2.38
Maine	156.50*	51.81*	22.99*	4.82*
Michigan	324.52	109.80	14.94	1.47
Minnesota	522.13	174.69	26.24	1.60
Missouri	386.85	145.74	25.44	1.37
Mississippi	573.93	289.71	37.82	1.74
Montana	278.68	119.37	0.15	0.07
North Carolina	318.93	173.46	18.59	2.30
North Dakota	345.73	146.31	31.66	2.69
Nebraska	404.13	176.20	25.42	1.66
New Hampshire	299.65	187.99	0.44	0.00
New Jersey	901.68	312.06	49.03	2.56
New Mexico	466.16	219.33	32.43	1.76
Nevada	386.98	133.10	35.27	3.04
New York	544.44	242.87	40.95	2.54

Appendix

State	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 treatment per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 hospitalizations per 100,000 beneficiaries under age 19 during the PHE
Ohio	400.36	108.54	30.47	1.59
Oklahoma	441.75	252.69	22.33	2.52
Oregon	171.80	96.01	9.83	0.75
Pennsylvania	425.67	106.99	26.14	1.92
Puerto Rico	220.62	170.95	3.69	0.99
Rhode Island	482.67	214.80	19.34	2.13
South Carolina	230.49	183.92	12.99	1.31
South Dakota	597.07	299.03	35.59	1.90
Tennessee	297.81	132.93	15.19	1.37
Texas	428.80	265.83	25.64	2.45
Utah	374.29	168.03	17.80	2.32
Virginia	333.61	130.07	20.62	1.51
Virgin Islands	62.46	18.47	6.80	0.00
Vermont	100.49	62.72	3.25	0.12
Washington	217.49	94.74	12.55	0.76
Wisconsin	318.56	144.37	22.83	1.16
West Virginia	247.53	99.38	14.78	0.52
Wyoming	399.29	161.22	0.24	0.00

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

Note: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021.

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

State	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of services delivered through telehealth per 100,000 Medicaid and CHIP beneficiaries during the PHE	Average monthly rate of services delivered through telehealth per 100,000 beneficiaries under age 19 during the PHE
United States	2,591.97	1,759.84	10,512.62	8,944.02
Alaska	4,081.31	3,007.19	9,124.36	7,809.57
Alabama	2,882.11	2,818.36	5,822.23	5,756.40
Arkansas	2,501.17	3,089.57	7,911.59	11,546.77
Arizona	2,823.08	1,866.26	21,594.34	21,265.91
California	1,647.96*	962.94*	7,841.59	7,066.85
Colorado	2,084.07	1,399.05	11,492.71	11,395.74
Connecticut	4,689.89	2,830.58	21,557.69	23,437.26
District of Columbia	2,733.17*	1,590.83*	35,597.45	17,886.16
Delaware	2,112.44	1,477.67	15,739.33	10,545.52
Florida	1,945.96	1,506.71	9,064.19	9,636.54
Georgia	1,984.53	1,629.21	8,940.89	8,394.48
Hawaii	1,608.04	927.94	5,086.20	2,412.44
Iowa	2,655.93	1,972.26	10,910.10	7,799.97
Idaho	2,955.84	1,853.82	12,403.91	8,836.27
Illinois	1,891.19	806.61	4,901.19	2,924.94
Indiana	2,390.22	1,574.39	13,860.96	10,792.38
Kansas	2,147.70	1,630.11	13,982.90	12,683.66
Kentucky	3,514.81	2,337.77	14,473.46	11,843.46
Louisiana	4,198.86	2,477.27	13,205.81	14,100.92
Massachusetts	3,770.97	2,567.22	27,691.44	25,935.41
Maryland	3,198.54	1,879.69	15,347.46	14,257.71
Maine	2,467.96*	2,180.96*	22,147.65*	23,389.98*
Michigan	2,680.59	1,280.58	14,004.46	9,072.10
Minnesota	3,384.25	2,145.83	21,710.47	15,267.59
Missouri	2,464.82	1,572.20	7,094.19	5,053.91
Mississippi	3,280.22	3,036.59	8,661.77	8,526.22
Montana	1,554.69	1,126.82	12,747.30	10,120.84
North Carolina	2,486.47	2,346.92	8,022.77	9,722.55
North Dakota	1,548.75*	1,293.67*	7,782.76*	7,021.04*
Nebraska	1,982.62	1,601.99	10,758.24	7,675.26
New Hampshire	3,647.30	3,247.09	26,996.70	21,124.11
New Jersey	5,250.29	2,860.83	9,893.97	4,120.07

Appendix

State	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries during the PHE	Average monthly rate of COVID-19 tests or testing-related services paid by Medicaid and CHIP per 100,000 beneficiaries under age 19 during the PHE	Average monthly rate of services delivered through telehealth per 100,000 Medicaid and CHIP beneficiaries during the PHE	Average monthly rate of services delivered through telehealth per 100,000 beneficiaries under age 19 during the PHE
New Mexico	3,540.91	1,935.29	11,445.54	11,241.66
Nevada	2,154.07	1,180.73	10,049.28	6,849.53
New York	3,806.94	2,280.75	6,343.12	3,754.90
Ohio	3,500.28	1,809.65	16,968.30	11,820.49
Oklahoma	2,475.65	2,329.70	11,165.32	11,050.45
Oregon	2,118.21	1,173.19	14,922.68	10,487.76
Pennsylvania	2,269.69	1,253.37	6,998.04	4,945.57
Puerto Rico	2,849.08	1,867.86	5,053.61	4,320.73
Rhode Island	2,556.08	1,709.77	9,299.28	6,436.37
South Carolina	2,038.89	2,008.55	5,163.33	6,418.27
South Dakota	2,551.24	2,228.75	6,045.51	4,272.93
Tennessee	2,795.25	2,276.31	8,613.78	8,148.45
Texas	1,984.63	1,912.99	9,957.43	9,734.59
Utah	2,162.94*	1,556.95*	5,581.37*	2,441.94*
Virginia	1,498.56	1,032.35	8,701.78	7,681.09
Virgin Islands	788.16	366.15	697.23	252.58
Vermont	489.08	277.93	3,490.40	1,403.00
Washington	2,742.30	1,609.52	9,094.14	7,067.44
Wisconsin	2,374.77	1,619.58	10,289.61	7,371.64
West Virginia	2,983.12	2,077.40	10,289.85	5,806.05
Wyoming	2,429.90	2,026.90	9,743.20	6,876.02

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

Note: These data are preliminary. Data are sourced from the T-MSIS Analytic Files v5 in DataConnect (formerly AREMAC), using final action claims. They are based on April T-MSIS submissions with services through the end of March. 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 March are incomplete, results are only presented through February 28, 2021. The PHE period includes data for March 2020 through February 2021.