Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding

February 23, 2022

Contents

I. Introduction

A. Background

The ongoing COVID-19 outbreak and implementation of federal policies to address the public health emergency (PHE) have disrupted routine Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) eligibility and enrollment operations. Medicaid and CHIP enrollment has grown to historic levels due in large part to the continuous enrollment requirements that states implemented as a condition of receiving a temporary 6.2 percentage point federal medical assistance percentage increase under section 6008 of the Families First Coronavirus Response Act (P.L. 116-127). States will have a large volume of eligibility and enrollment actions to complete when the PHE ends, and the Centers for Medicare & Medicaid Services (CMS) released State Health Official letter #22-00X, "Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency," which outlines timelines and guidance for states to restore routine operations in a manner that promotes continuity of coverage for eligible individuals and facilitates seamless coverage transitions for those who become eligible for other insurance affordability programs (e.g., Marketplace).

B. About the submission

1. What types of data are being reported?

CMS will require states[1] to report on specific metrics described in the "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report). These metrics are designed to demonstrate a state's progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees, consistent with the guidance outlined in SHO #22-00X. The remainder of this document specifies the metrics and their definitions.

2. How frequently and when will the data be reported?

States will complete a one-time baseline report and subsequent monthly reports.

- The baseline report is due at the end of the month prior to the month in which the state's unwinding period begins.
- The monthly report will be due on the 8th calendar day of each month. The first monthly report will be due on the 8th of the month following the month in which the state begins its unwinding period.

3. How will the data be submitted?

These reports will be submitted to CMS using the same portal in which states enter their Performance Indicator (PI) data (https://sdis.medicaid.gov/user/login). This portal is set up to accept submissions from those with PI submission credentials. States may use the Unwinding Data Report excel workbook as a planning tool to review the metrics before submitting their baseline and monthly reports through the PI portal.

[1] Throughout this document, "states" refers to states, the District of Columbia, and the U.S. Territories.

4. What if the state is unable to submit data as defined in this specification document?

There is a check box under the majority of metrics on both report forms labeled, "Unable to Report." If a state is unable to report a metric as defined, please check this box and include in the notes section for that metric an explanation of why the state cannot report the metric. CMS may follow up to further discuss.

5. Can the data reported be changed after it has been submitted?

If states later discover they made a mistake or if they have additional data to report, states will be able to update either report (baseline or monthly report) using the same link at which the data was originally submitted.

6. How can questions about data be answered?

We realize that states may have questions or need help as they review the metrics in the reports and reporting specifications.

- States can access help at anytime by emailing UnwindingMetricsTA@mathematica-mpr.com.
- CMS will also be hosting an all-state webinar in which they will review the metrics and how to submit their Unwinding Data Report; the webinar will be recorded and posted on Medicaid.gov so that states can access it at any time.

II. Data Specifications: Unwinding Baseline Report

This chapter provides detailed instructions on how to complete the Unwinding Baseline Report. Table 1 summarizes key details about baseline reporting. Step-by-step descriptions of each of the metrics, and how to compute them, are found below.

Table 1. Summary of Unwinding Baseline Period Reporting Specifications

What is the baseline report?	The baseline report is meant to serve as a starting point to track a state's pending eligibility and enrollment actions that the state will need to address when the state begins its unwinding period. States will be required to report summary data on pending applications, renewals, and fair hearings. States will report Medicaid and CHIP data in this report.[2] Data will **not** be reported separately by program.
How do I submit it?	States will log on to https://sdis.medicaid.gov/user/login to submit their data.
When is it due?	At the end of the month prior to the month in which the state's unwinding period begins
What if, after submission, I need to change or update data previously reported?	States will be able to update the baseline report at the same link, https://sdis.medicaid.gov/user/login, if they later discover they made a mistake, or if they did not have all of the data they needed to complete the form when it was initially submitted.
What if I have questions not answered in these instructions?	If the state has questions while completing the baseline report, please email the technical assistance help desk at UnwindingMetricsTA@mathematica-mpr.com.

A. Baseline Report Metric Specifications

The baseline report begins with asking states to submit two key pieces of information:

- **Submission Date.** This field will be auto populated with the current date, in the format MM/DD/YYYY. It is due no later than the end of the month prior to the month in which the state's unwinding period begins.
- **Unwinding Period Start Date.** States will enter the month in which their unwinding period begins in the format MM/YYYY.

1. Baseline Report Metric 1: Application Processing

States must report the total number of pending applications that the state received between March 1, 2020, and the end of the month prior to the state's unwinding period. This information will be broken out by (1) pending MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older), and (2) pending disability-related applications (e.g., individuals who apply for Medicaid on the basis of a disability). Table 2 provides instructions for how to report these metrics.

Table 2: Baseline Metrics 1, 1a, and 1b

Metric 1: Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period	
How is the metric defined?	• This metric includes: • All applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received

[2] Note that Baseline Metric 4, Medicaid Fair Hearings, will only include data on Medicaid fair hearings and not separate CHIP reviews.

	directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. • All applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is the sum of metrics 1a and 1b.
What is excluded from this metric?	• Applications that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
What is included in the Metric 1 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 1, 1a, or 1b. • This field should be left blank if the state has nothing additional to report.
Metric 1a: Pending MAGI and other non-disability applications	
How is the metric defined?	• This metric includes: • All MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. • All MAGI and other non-disability related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is a subset of metric 1.
What is excluded from this metric?	• Applications for individuals seeking coverage on a MAGI or other non-disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
Metric 1b: Pending disability-related applications	
How is the metric defined?	• This metric includes: • All disability-related applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. • All disability-related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is a subset of metric 1.
What is excluded from this metric?	• Applications for individuals seeking coverage on a disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.

2. Baseline Report Metric 2: Renewals

States must report the total number of beneficiaries enrolled as of the end of the month prior to the state's unwinding period. Table 3 provides instructions for how to report this metric.

Table 3: Baseline Metric 2

Metric 2: Total beneficiaries enrolled as of the end of the month prior to the state's unwinding period	
How is the metric defined?	This metric includes a count of all beneficiaries or "total caseload," including those receiving full and limited benefits, enrolled in Medicaid or CHIP as of the end of the month prior to the state's unwinding period.
What is excluded from this metric?	Individuals who applied for Medicaid but have not had an eligibility determination completed because they were granted a reasonable opportunity period consistent with 435.956(b) because their citizenship or immigration status was not verified and who

	remained enrolled as authorized by section 6008 of the FFCRA in order to claim enhanced temporary FMAP.
What is included in the Metric 2 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

3. Baseline Report Metric 3: State's Policy for Completing Renewals

States must report their policy for completing renewals. Table 4 provides instructions for how to report this metric.

Table 4: Baseline Metric 3

Metric 3: State's timeline for the renewal process	
How is the metric defined?	This metric includes the number of days in the state's renewal processing period, which is the time from the day a renewal process is initiated to when a final eligibility determination is expected.

4. Baseline Report Metric 4: Medicaid Fair Hearings

States must report Medicaid fair hearings that have been pending more than 90 days as of the end of the month prior to the state's unwinding period. Table 5 provides instructions for how to report this metric.

Table 5: Baseline Metric 4

Metric 4: Total number of Medicaid fair hearings pending more than 90 days at the end of the month prior to the state's unwinding period	

How is the metric defined?	• This metric includes:
	  • All pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 431.224(a), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 431.221(a)(1) as of the end of the month prior to the state's unwinding period.
	  • All pending fair hearings for which the state has not taken action within 90 days from the date the enrollee filed a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) appeal, not including the number of days the enrollee took to subsequently file for a Medicaid fair hearing.
	  • For states utilizing Medicaid expansion CHIP, all pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 457.1160(a) or 42 C.F.R. § 457.1260(f), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 457.1130(a) as of the end of the month prior to the state's unwinding period.

What is excluded from this metric?	• Fair hearings for which a final fair hearing decision was issued and a state has taken final administrative action in accordance with 42 CFR 431.244(f). A final fair hearing decision may include a dismissal of the fair hearing request. • States should exclude separate CHIP review data from this metric.
What is included in the Metric 4 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. For example, please specify if the state is not able to report solely Medicaid fair hearings data and has included separate CHIP reviews in the reported information. • This field should be left blank if the state has nothing additional to report.

III. Data Specifications: Unwinding Monthly Report

This chapter provides detailed instructions on how to complete the Unwinding Monthly Report. Table 6 summarizes key details about monthly reporting. Step-by-step descriptions of each of the metrics, and how to compute them, are found below.

Table 6: Summary of Unwinding Monthly Period Reporting Specifications

What is the monthly report?	The monthly report is designed to support CMS in tracking the state's progress in addressing pending eligibility and enrollment actions when the state's unwinding period begins. States will be required to report summary data on pending and completed applications and renewals and pending fair hearings. States will report Medicaid and CHIP data in this report.[3] Data will **not** be reported separately by program.
How do I submit it?	States will log on to https://sdis.medicaid.gov/user/login.
When is it due?	The 8th calendar day of the month following the report month
What if, after submission, I need to change or update data previously reported?	States will be able to update the monthly report at the same link, https://sdis.medicaid.gov/user/login, if they later discover they made a mistake, or if they did not have all of the data they needed to complete the form when it was initially submitted.
What if I have questions not answered in these instructions?	If the state has questions while completing the monthly report, please email the technical assistance help desk at UnwindingMetricsTA@mathematica-mpr.com.

A. Monthly Report Metric Specifications

The monthly report begins with asking states to submit one key piece of information:

- **Submission Date.** This field will be auto populated with the current date, in the format MM/DD/YYYY. It is due no later than by the 8th day of the month following the reporting period.

1. Monthly Report Metrics 1-3: Application Processing

Metric 1 and its sub-metrics are the same metrics reported on the baseline report. States must report the total number of pending applications that the state received between March 1, 2020, and the end of the month prior to the state's unwinding period; if these metrics have not changed, they will be the same as the data the state reported in the baseline report. Additionally, in the monthly reports, states will report on number of applications completed and those that remain pending as of the last day in the reporting period covered by the report. Tables 7-9 provide instructions for how to report these metrics.

Table 7: Monthly Metrics 1, 1a, and 1b

Metric 1: Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period	
How is the metric defined?	• This metric includes: • All applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally-Facilitated Marketplace or a State-Based Marketplace.

[3] Note that Monthly Metric 8, Medicaid Fair Hearings, will only include data on Medicaid fair hearings and not separate CHIP reviews.

	• All applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is the sum of metrics 1a and 1b.
What is excluded from this metric?	• Applications that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
What is included in the Metric 1 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 1, 1a, or 1b. • This field should be left blank if the state has nothing additional to report.
Metric 1a: Total MAGI and other non-disability applications	

How is the metric defined?	• This metric includes:
	  • All MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace.
	  • All MAGI and other non-disability related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person).
	• This metric is a subset of metric 1.

What is excluded from this metric?	• Applications for individuals seeking coverage on a MAGI or other non-disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
Metric 1b: Total disability-related applications	

How is the metric defined?	• This metric includes:
	  • All disability-related applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace.
	  • All disability-related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person).
	• This metric is a subset of metric 1.

What is excluded from this metric?	• Applications for individuals seeking coverage on a disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.

Table 8: Monthly Metrics 2, 2a, and 2b

Metric 2: Of those applications included in Monthly Metric 1, the total number of applications completed as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of applications counted in Monthly Metric 1 that have been completed as of the last day in the reporting period covered by this report. • A completed application is one in which a final eligibility determination has been made. • This metric is the sum of metrics 2a and 2b.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.
What is included in the Metric 2 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 2, 2a, or 2b. • This field should be left blank if the state has nothing additional to report.

Metric 2a: Completed MAGI and other non-disability related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) counted in Monthly Metric 1a that have been completed as of the last day in the reporting period covered by this report. • A completed application is one in which a final eligibility determination has been made and the state has either enrolled an eligible applicant or denied coverage for an individual the agency could not determine to be eligible as of the last day of the reporting period. • This metric is a subset of metric 2.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.
Metric 2b: Completed disability-related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of disability-related applications counted in Monthly Metric 1b that have been completed as of the last day in the reporting period covered by this report. • A completed application is one in which a final eligibility determination has been made and the state has either enrolled an eligible applicant or denied coverage for an individual the agency could not determine to be eligible as of the last day of the reporting period. • This metric is a subset of metric 2.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.

Table 9: Monthly Metrics 3, 3a, and 3b

Metric 3: Of those applications included in Monthly Metric 1, the total number of applications that remain pending as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of applications included in Monthly Metric 1 for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of applications that remain pending at the end of the reporting period. • This metric is the sum of metrics 3a and 3b**.**
What is excluded from this metric?	Applications completed as of the last day of the reporting period.
What do states include in the Metric 3 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 3, 3a, or 3b. • This field should be left blank if the state has nothing additional to report.
Metric 3a: Pending MAGI and other non-disability applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of MAGI and non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) included in Monthly Metric 1a for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of MAGI and non-disability related applications that remain pending at the end of the reporting period. • This metric is a subset of metric 3.
What is excluded from this metric?	MAGI and non-disability related applications completed as of the last day of the reporting period.
Metric 3b: Pending disability-related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of disability-related applications counted in Monthly Metric 1b for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of disability-related applications that remain pending at the end of the reporting period. • This metric is a subset of metric 3.
What is excluded from this metric?	Disability-related applications completed as of the last day of the reporting period.

2. *Monthly Report Metric 4: Renewals Initiated*

States must report on the number of renewals initiated in the monthly reports. Table 10 provides instructions for how to report this metric.

Table 10: Monthly Metric 4

Metric 4: Total beneficiaries for whom a renewal was initiated in the reporting period	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with an annual renewal that was initiated between the first and last day of the reporting period. • An annual renewal is considered "initiated" when a state first begins the *ex parte* process. • **This metric is not cumulative** and should only include data on renewals initiated in the reporting period.
What is excluded from this metric?	Annual renewals that were initiated in prior reporting periods as well as those that have not been initiated yet.
What do states include in the Metric 4 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

3. *Monthly Report Metrics 5-7: Renewals and Outcomes*

States must report on the number of beneficiaries due for renewal and the final disposition of renewals in the monthly reports. Tables 11-13 provide instructions for how to report these metrics.

Table 11: Monthly Metrics 5, 5a, 5a(1), 5a(2), 5b, 5c, and 5d

Metric 5: Total beneficiaries due for a renewal in the reporting period	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with an annual renewal due in the reporting period. • **This metric is not cumulative** and should only include data on renewals due in the reporting period, representing beneficiaries whose annual renewal processes were initiated in a prior month, based on the state's renewal policy. In this context, which renewals are "due" relate to what the state reported in baseline metric 3 (state's timeline for the renewal process). For example, if a state initiated a batch of renewals on March 15th and noted a timeline of 75 days for the renewal process, CMS would consider that batch of renewals "due" at the end of May. ◦ Note: depending on what the state reported in baseline metric 3 (state's timeline for the renewal process), it may report 0 for the first two to three months of monthly reporting because renewals that have been initiated are not yet due. • This metric is the sum of metrics 5a, 5b, 5c, and 5d.
What is excluded from this metric?	Annual renewals not due in the reporting period.
What do states include in the Metric 5 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.
Metric 5a: Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose annual renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP at the end of the reporting period. • **This metric is not cumulative** and should only include those beneficiaries renewed and retained in the reporting period. • This metric is a subset of metric 5. • This metric is the sum of metrics 5a(1) and 5a(2).
What is excluded from this metric?	Any beneficiary not retained in Medicaid or CHIP at the end of the reporting period.

What do states include in the Metric 5a Notes free text field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 5a, 5a(1), or 5a(2). • This field should be left blank if the state has nothing additional to report.
Metric 5a(1): Number of beneficiaries renewed on an *ex parte*[4] basis	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose annual renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period on an *ex parte* basis, meaning eligibility was redetermined based on information available to the agency without requiring additional information from the individual. • **This metric is not cumulative;** states will only report on those beneficiaries that were renewed on an *ex parte* basis in the reporting period. • This metric is a subset of metric 5a.
What is excluded from this metric?	Any beneficiary not renewed through *ex parte* processes in the reporting period.
Metric 5a(2): Number of beneficiaries renewed using a pre-populated renewal form	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose annual renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period using a pre-populated form. • **This metric is not cumulative**; states will only report on those beneficiaries that were renewed using a pre-populated renewal form in the reporting period. • This metric is a subset of metric 5a.
What is excluded from this metric?	Any beneficiary not renewed through use of a pre-populated form in the reporting period.
Metric 5b: Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP (and transferred to the Marketplace)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose annual renewal was due in the reporting period who were determined ineligible for Medicaid or CHIP and were transferred to the Marketplace in the reporting period. • **This metric is not cumulative** and should only include data on beneficiaries determined ineligible for Medicaid or CHIP and transferred to the Marketplace in the reporting period. • This metric is a subset of metric 5.
What is excluded from this metric?	Any beneficiary who remained eligible for Medicaid or CHIP coverage or who was not transferred to the Marketplace.
What do states include in the Metric 5b Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.
Metric 5c: Of the beneficiaries included in Metric 5, the number terminated for procedural reasons (i.e., failure to respond)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose annual renewal was due in the reporting period that were determined ineligible for Medicaid or CHIP for procedural reasons in the reporting period. • Procedural reasons include instances where a beneficiary fails to provide information necessary to complete a Medicaid or CHIP redetermination. • **This metric is not cumulative** and should only include data on beneficiaries that were determined ineligible for Medicaid or CHIP for procedural reasons in the reporting period. • This metric is a subset of metric 5.
What is excluded from this metric?	Any beneficiary who was not terminated for procedural reasons in the reporting period.
What do states include in the Metric 5c Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

[4] An *ex parte* renewal is sometimes referred to as auto renewal, passive renewal, or administrative renewal and is described at 42 CFR 435.916(a)(2).

Metric 5d: Of the beneficiaries included in Metric 5, the number whose renewal was not completed	
How is the metric defined?	• This is defined as the total number of annual renewals for beneficiaries, including those receiving full or limited benefits, that were due in the reporting period that were not completed or a final eligibility determination had not been made as of the end of the reporting period. • **This metric is not cumulative** and should only include data on renewals due in the reporting period. • This metric is a subset of metric 5.
What is excluded from this metric?	Any beneficiary whose renewal was completed.
What do states include in the Metric 5d Notes?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

Table 12: Monthly Metric 6

Metric 6: Month in which renewals due in the reporting period were initiated	
How is the metric defined?	• States will expand a drop-down menu and select the month in which the renewals that were due in the reporting period covered by the report were initiated; this should be based off of the state's timeline for the renewal process reported in Baseline Metric 3.
What do states include in the Metric 6 Notes?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

Table 13: Monthly Metric 7

Metric 7: Number of beneficiaries due for a renewal since the beginning of the state's unwinding period whose renewal has not yet been completed	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, due for renewal whose renewal has been initiated but not been fully processed. • **This metric is cumulative;** it counts all renewals that have been initiated since the beginning of the state's unwinding period and were due prior to or as of the last day of the reporting period covered by this report (per the state's timeline for the renewal process), but whose renewals were not fully processed as of the last day in the reporting period. • States should be cautious of simply adding the numbers previously reported in 5d, as doing so would not reflect renewals that may have been completed after the month in which it was due.
What is excluded from this metric?	All renewals that have been completed.
What do states include in the Metric 7 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

4. Monthly Report Metric 8: Medicaid Fair Hearings

States must report Medicaid fair hearings that have been pending more than 90 days at the end of the reporting period. Table 14 provides instructions for how to report this metric.

Table 14: Monthly Metric 8

Metric 8: Total number of Medicaid fair hearings pending more than 90 days at the end of the reporting period	
How is the metric defined?	• This metric includes: • All pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 431.224(a), for which the state has not taken final administrative action within 90 days of the date the agency received a request for

	a fair hearing in accordance with 42 C.F.R. § 431.221(a)(1) as of the end of the reporting period. • All pending fair hearings for which the state has not taken action within 90 days from the date the enrollee filed a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing. • This includes Medicaid fair hearing requests received both before and after the end of the continuous enrollment requirement. • For states utilizing Medicaid expansion CHIP, all pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 457.1160(a) or 42 C.F.R. § 457.1260(f), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 457.1130(a) as of the end of the reporting period.
What is excluded from this metric?	• This metric excludes fair hearings for which a final fair hearing decision was issued and a state has taken final administrative action in accordance with 42 CFR 431.244(f). A final fair hearing decision may include a dismissal of the fair hearing request. • States should exclude separate CHIP review data from this metric.
What do states include in the Metric 8 Notes field?	• If a state deviates from the specifications above or has any additional context that impacts the data they feel CMS should be aware of, they should use the free text field to report that information in narrative format. For example, please specify if the state is not able to report solely Medicaid fair hearings data and has included separate CHIP reviews in the reported information. • This field should be left blank if the state has nothing additional to report.