



Medicaid and CHIP Eligibility and Enrollment Performance Indicators

Data Dictionary

Effective ~~June~~September 30, 2026

1. CALL VOLUME

Reporting Period: Calendar Month

Reporting Frequency: Monthly, ~~year-round~~year-round

Indicator Number	Data Breakout	Variable Name	Description
1a		Total Call Center Volume	The total number of calls received by each call center during the calendar month. Include all calls received by each call center including calls handled by an interactive voice response (IVR) system, calls handled by a live agent, and calls abandoned before reaching a live agent. The total call center volume should equal the sum of the call volume at each individual call center reported. States may define “call center” as any call center, hotline or combination of hotlines that take a significant number of calls regarding Medicaid or CHIP. Call centers and help lines that take calls in the following areas should be included if they receive a significant volume of calls and the agency can accurately track and report call volume: questions about Medicaid or CHIP eligibility; taking over-the-phone applications; questions about enrollment, including enrollment into Medicaid/CHIP managed care plans; renewal-related questions; and local or county-based phone lines that handle inquiries about both health and human services programs. If the “call center” is not a traditional call center, or receives calls for other human services programs, please include that information in the data limitation. Report data for all calls received, including those that can be handled solely by an automatic system.



1. CALL VOLUME

Reporting Period: Calendar Month

Reporting Frequency: Monthly, ~~year-round~~year-round

Indicator Number	Data Breakout	Variable Name	Description
1b		Individual Call Center Volumes	The subset of calls reported in sub-indicator 1a received by each individual call center during the calendar month. Report this indicator for each call center in the state, even if there is only one. If the state has more than 10 call centers that receive Medicaid/CHIP related calls, it should consolidate the call centers into “main” call centers, if appropriate. For example, if MCO X has three total call centers, then the state should combine these call centers into one “MCO X” call center and report combined data from the three call centers. The state should contact CMS with any questions or concerns.



2. CALL CENTER WAIT TIME

Reporting Period: Calendar Month

Reporting Frequency: Monthly, ~~year-round~~ year-round

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Indicator Number	Data Breakout	Variable Name	Description
2a		Average Call Center Wait Time	For each call center or helpline reported in Indicator 1, the average wait time in whole minutes measured from the time each call connects to the call center to the time the call is answered by a live agent (if the call is answered by an agent) or the time the caller ends the call (if the call is not answered by an agent). For each call, wait time should include the time the caller spends navigating through the IVR as well as the time spent waiting in the queue to speak to an agent. All calls received by each call center during its hours of operation should be included for the calendar month. If the state tracks wait time in seconds, round increments of 0 to 29 seconds down to the nearest whole minute, and round increments of 30 to 59 seconds up to the nearest whole minute. If the average wait time is less than 29 seconds enter 0 and provide an explanation in the data limitations field. If average wait time cannot be provided, leave this field blank (missing/null) and provide an explanation in the data limitations field. The top-line total should be calculated as the weighted average of each individual call center's wait time during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total weighted average wait time = $\text{call center 1 average wait time} * (\text{call center 1 volume} / \text{call center total volume}) +$ $\text{call center 2 average wait time} * (\text{call center 2 volume} / \text{call center total volume}) +$ $\text{call center 3 average wait time} * (\text{call center 3 volume} / \text{call center total volume})$
2b		Call Center Wait Times (for each individual call center)	The average wait time in whole minutes for calls received by each individual call center during its hours of operation, for the calendar month. Report this indicator for each call center in the state, even if there is only one. If the state has more than 10 call centers that receive Medicaid/CHIP related calls, it should consolidate the call centers into "main" call centers, if appropriate. For example, if MCO X has three total call centers, then the state should combine these call centers into one "MCO X" call center and



		report combined data from the three call centers. The state should contact CMS with any questions or concerns.
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3. ABANDONMENT RATE Reporting Period: Calendar Month Reporting Frequency: Monthly, year-roundyear-round			
Indicator Number	Data Breakout	Variable Name	Description
3a		Average Call Center Abandonment Rate	For each call center or helpline reported in Indicator 1, the abandonment rate equals the number of calls abandoned by the caller (numerator) divided by total call volume (denominator). Calls abandoned by the caller at any time prior to reaching a live agent should be counted as abandoned calls, including those abandoned while navigating the IVR system or while in queue to speak to a live agent. States should select the appropriate footnote option, if one exists, that is applicable to their data (e.g., "Calls handled to completion by the automated system are counted as abandoned calls"). The acceptable range for this number is between 0 and 1, with a zero-valuezero-value representing 0% (no calls abandoned), a value of 0.5 representing 50% (half of calls are abandoned), and a value of one representing 100% (all calls abandoned). The top-line total should be calculated as the weighted average of each individual call center's abandonment rate during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total weighted average abandonment = call center 1 average abandonment rate * (call center 1 volume/call center total volume) + call center 2 average abandonment rate * (call center 2 volume/call center total volume) + call center 3 average. abandonment rate * (call center 3 volume/call center total volume)
3b		Individual Call Center Abandonment Rate (for each	The abandonment rate for each individual call center or helpline reported in Indicator 1. The abandonment rate equals the number of calls abandoned by caller (numerator) divided by total call volume (denominator).

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		individual call center)	Report this indicator for each call center in the state, even if there is only one. If the state has more than 10 call centers that receive Medicaid/CHIP related calls, it should consolidate the call centers into “main” call centers, if appropriate. For example, if MCO X has three total call centers, then the state should combine these call centers into one “MCO X” call center and report combined data from the three call centers. The state should contact CMS with any questions or concerns.
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4. Percent Eligible at Applications for Adult Group or 1115 Demo

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round
THIS INDICATOR WAS WEEKLY AND HAS BEEN REMOVED

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<u>Indicator Number</u>	<u>Data Breakout</u>	<u>Variable Name</u>	<u>Description</u>
<u>4a</u>		<u>Percent of total eligible applications</u>	<u>Among individuals who received a final eligibility determination at application in the month: Percentage who were determined eligible for the Adult Group or an 1115 demonstration that provides MEC (Minimum Essential Coverage) as required by the Affordable Care Act and demonstrated compliance with Community Engagement</u>
		<u>Number of total eligible applications subject to CE</u>	<u>The total number of people individuals who were determined eligible as part of the population expected to demonstrate compliance with CE</u>

5. NUMBER OF APPLICATIONS RECEIVED

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
5a		Total Applications Received	Total number of applications received by any state agency with the authority to make Medicaid/CHIP eligibility determinations, including the Medicaid agency, a separate CHIP agency (if one exists in the state), and a state-based marketplace (if one exists in the state) during the calendar month. The unit of measurement for this indicator is the number of applications, not individuals. Applications should be counted in the reporting period in which they are received. Applications for both MAGI and non-MAGI populations should be included. Report applications received through all doorways, including those received by a separate CHIP agency or any applications requesting financial assistance for health insurance



			coverage that are received by the state-based marketplace (SBM), and not just applications received directly by the Medicaid agency. If the state uses a combined application for some or all Medicaid applicants that also screens individuals for other social service programs (such as SNAP), these applications should be included whenever the Medicaid program or CHIP is among the programs the person is being evaluated for. If the state has separate applications for different Medicaid populations (e.g., a family Medicaid application and an ABD application), all applications should be included in these indicators.
5a (continued)			Exclusions for this indicator: • Accounts transferred from the FFM. Account transfers should be reported under Indicator 6 (Number of Electronic Accounts Transferred). • Individuals who enter a state's eligibility determination system via an administrative data transfer rather than by submitting an application (e.g., SSI recipients who are auto-enrolled into Medicaid; ELE determinations; and transfers from an existing 1115 demonstration to eligibility groups under a SPA resulting from changes in state eligibility categories) • Individuals who receive a redetermination at annual renewal or outside the annual renewal process (for example, due to change in circumstance). Sub-indicator 5a should equal the sum of sub-indicators applications received by Medicaid agency (sub-indicator 5b), applications received by CHIP agency (sub-indicator 5h), and applications received by SBM (sub-indicator 5n).
5b		Applications Received by Medicaid Agency	Total number of applications received by the Medicaid agency during the calendar month. If the state has an integrated application for Medicaid and CHIP and these applications are entered into a single eligibility and enrollment system, include the total number of applications received for Medicaid and CHIP in this indicator, even if the state has a separate CHIP agency. The unit of measurement for this indicator is the number of applications, not individuals. Applications should be counted in the reporting period in which they are received. Applications for both MAGI and non-MAGI populations should be included. If the state has separate applications for different Medicaid populations (e.g., a family Medicaid application and an ABD application), all applications should be included in these indicators. If the state uses a combined application for some or all Medicaid applicants



			that also screens individuals for other social service programs (such as SNAP), these applications should be included when Medicaid or CHIP is among the programs the person is being evaluated for. Exclusions for sub-indicator 5a apply to sub-indicator 5b. Applications received via an integrated online Marketplace/Medicaid/CHIP portal should not be reported in this indicator; they should be reported in sub-indicator 5n. Sub-indicator 5b should equal the sum of the applications received by Medicaid agency, by channel (sub-indicators 5c, 5d, 5e, 5f, and 5g).
5c	Applications Received by Medicaid Agency, by Channel	Online Applications Received by Medicaid Agency	Applications received by Medicaid agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be reported. Refer to sub-indicator 5b for inclusion and exclusion criteria.
5d		Mail Applications Received by Medicaid Agency	Paper applications received by the Medicaid agency that the applicant mailed to the Medicaid agency. Refer to sub-indicator 5b for inclusion and exclusion criteria.
5e	Applications Received by Medicaid Agency, by Channel	In-person Applications Received by Medicaid Agency	Applications that an applicant submitted in-person to a Medicaid agency or caseworker. Refer to sub-indicator 5b for inclusion and exclusion criteria.
5f		Phone Applications Received by Medicaid Agency	Applications that an applicant submitted to the Medicaid agency by answering questions from a call center or hotline agent. Refer to sub-indicator 5b for inclusion and exclusion criteria.
5g		Other Applications Received by Medicaid Agency	All other applications received by the Medicaid agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications. Refer to sub-indicator 5b for inclusion and exclusion criteria.
5h		Applications Received by CHIP Agency	Total number of applications received by a separate CHIP agency during the calendar month. If the state does not have a separate CHIP agency and a separate CHIP application and eligibility and enrollment system, leave the field blank (to indicate this is



			non-applicable). States with a single, streamlined Medicaid and CHIP application and eligibility and enrollment system should report all applications received in sub-indicators 5b-5g, even if they have a separate CHIP agency, and should leave sub-indicator 5h blank. Applications should be counted in the reporting period in which they are received. Exclusion for sub-indicator 5a apply to sub-indicator 5h. Sub-indicator 5h should equal the sum of applications received by CHIP agency, by channel (sub-indicators 5i, 5j, 5k, 5l and 5m).
5i	Applications Received by CHIP Agency, by Channel	Online Applications Received by CHIP Agency	Applications received by separate CHIP agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be reported. Refer to sub-indicator 5h for inclusion and exclusion criteria.
5j		Mail Applications Received by CHIP Agency	Paper applications received by the separate CHIP agency that the applicant mailed to the separate CHIP agency. Refer to sub-indicator 5h for inclusion and exclusion criteria.
5k		In-person Applications Received by CHIP Agency	Applications that an applicant submitted in-person to a separate CHIP agency or caseworker. Refer to sub-indicator 5h for inclusion and exclusion criteria.
5l		Phone Applications Received by CHIP Agency	Applications that an applicant submitted to the separate CHIP agency by answering questions from a call center or hotline agent. Refer to sub-indicator 5h for inclusion and exclusion criteria.
5m		Other Applications Received by CHIP Agency	All other applications received by the separate CHIP agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications. Refer to sub-indicator 5h for inclusion and exclusion criteria.
5n		Applications Received by SBM	Total number of applications requesting financial assistance for health insurance coverage that have been received by the SBM during the calendar month, including applications received via an integrated online Marketplace/Medicaid/CHIP portal.



		Requests for financial assistance for health insurance coverage include requests for Advanced Premium Tax Credit (APTC), Medicaid, and CHIP. Applications not requesting financial assistance should be excluded.
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6. NUMBER OF ELECTRONIC ACCOUNTS TRANSFERRED Reporting Period: Calendar Month Reporting Frequency: Monthly, year-round			
Indicator Number	Data Breakout	Variable Name	Description
6a		Total Account Transfers Received from the FFM	Total number of accounts electronically transferred from the FFM to the Medicaid/CHIP agency during the calendar month. SBMs should not report transfers. Accounts moving between a new integrated system and a legacy system should not be included. An account is defined as the set of application and verification data necessary to make an eligibility determination for an insurance affordability program as required in §435.1200. Only electronic account transfers should be included; case referrals should not be included if an electronic account transfer is not made. This indicator should include both assessments and determinations of eligibility made by the FFM before transfer to the Medicaid/CHIP agency during the calendar month, as well as non-MAGI referrals and requests for a full Medicaid determination. Sub-indicator 6a may be less than the sum of sub-indicators 6e through 6h.
6b		Transfers Received from FFM	INDICATOR REMOVED (included in sub-indicator 6a).
6e		Transfers Received from Non-Integrated SBM	INDICATOR REMOVED.



6. NUMBER OF ELECTRONIC ACCOUNTS TRANSFERRED

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
6d		Transfers Received from an Unknown Source	INDICATOR REMOVED.
6e	By Transfer Type	Determined Account Transfers Received	Total number of electronic accounts during the calendar month in which an individual received a final determination that they were eligible for Medicaid or CHIP from the FFM before account transfer to the state. This indicator only applies to states that have delegated responsibility to the FFM to conduct eligibility determinations ("determination" states).
6f		Assessed Account Transfers Received	Total number of electronic accounts transferred to the Medicaid/CHIP agency without a final determination of eligibility during the calendar month, including transfer accounts assessed as eligible by the FFM as well as those initially assessed as ineligible but for which a request for full determination was made. This indicator does not apply to states that have delegated responsibility to the FFM to conduct eligibility determinations ("determination" states) and should be left blank by these states.
6g		Request for Full Determination Transfers Received	The total number of electronic account transfers during the calendar month in which an individual was initially assessed or determined as ineligible for Medicaid or CHIP, but the applicant requested a transfer to the agency for a full determination. Individuals who were assessed or determined as eligible for Medicaid or CHIP before their account was transferred should not be included in this category. This indicator may include account transfers also counted in sub-indicator 6e or sub-indicator 6f.
6h		Transfers of Unknown Type Received	Total number of electronic accounts transferred during the calendar month that are not captured in sub-indicators 6e, 6f, and 6g. If this is a non-zero value, the data limitations field must include any relevant information about the source(s) of these transfers.
6i		Total Transfer Accounts Sent	INDICATOR REMOVED.



6. NUMBER OF ELECTRONIC ACCOUNTS TRANSFERRED

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
6j		Total Transfer Accounts Sent to FFM	Total number of accounts electronically transferred from the Medicaid/CHIP agency to the FFM during the calendar month. All SBMs should leave all fields in this section blank ("not applicable").
6k		Transfers to Non-Integrated SBM Systems	Total number of accounts electronically transferred from the Medicaid/CHIP agency to an SBM with a non-integrated eligibility determination system during the calendar month. Most SBMs (those with integrated eligibility systems for the SBM and Medicaid/CHIP programs) should leave this indicator blank ("not applicable").



7. NUMBER OF RENEWALS
Reporting Period: Calendar Month
Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
7a		Number of Renewals up for Annual Redetermination	Total number of annual renewals that came up for redetermination by the Medicaid or CHIP agency during the calendar month. These data should include annual renewals only, and exclude beneficiaries redetermined due to a change in circumstances or a program change. All annual renewals that came up for redetermination should be included, regardless of the disposition (including pending, determined eligible, determined ineligible, and/or ineligible due to failure to return documentation). All Medicaid and CHIP enrollees who were due for annual renewal in the calendar month should be included, including individuals with limited benefit packages and individuals with comprehensive benefit packages. The unit of measurement for this indicator is the number of individuals, not households. If a state is only able to report renewals at the household level, the state should document in the free-text data limitation field. Sub-indicator 7a should equal the sum of renewals by determination type (sub-indicators 7b, 7c, 7d, and 7e).
7b	By Determination Type	Medicaid MAGI renewals	Total number of Medicaid (i.e. funded under Title XIX of the Social Security Act) renewals that came up for annual redetermination during the calendar month and will be redetermined under MAGI rules. Refer to sub-indicator 7a for inclusion and exclusion criteria.
7c		Medicaid Non-MAGI Renewals	Total number of Medicaid (i.e. funded under Title XIX of the Social Security Act) renewals that came up for annual redetermination during the calendar month and will be redetermined under non-MAGI rules. Refer to sub-indicator 7a for inclusion and exclusion criteria.
7d		CHIP Renewals	Total number of CHIP (i.e., funded under Title XXI of the Social Security Act, including through MCHIP programs) renewals that came up for annual redetermination during the calendar month. Refer to sub-indicator 7a for inclusion and exclusion criteria.



7. NUMBER OF RENEWALS

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
7e	By Determination Type	Unknown Type	Total number of renewals that came up for annual redetermination during the calendar month but cannot be classified as Medicaid MAGI, Medicaid non-MAGI, or CHIP renewals. Refer to sub-indicator 7a for inclusion and exclusion criteria.



8. TOTAL ENROLLMENT

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
8a		Total Medicaid Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) and eligible for comprehensive benefits as of the last day of the calendar month, including those with retroactive, conditional, and presumptive eligibility. This indicator is a point-in-time count of program enrollment, and not solely a count of those newly enrolled during the calendar month. Include only those individuals who are eligible for comprehensive benefits, which is defined as coverage that qualifies as Minimum Essential Coverage (MEC). Individuals eligible for only limited benefits, such as emergency Medicaid, family planning-only coverage and limited benefit dual eligible individuals should not be included. Medicaid 1115 Demonstration populations should be included as long as the benefits are comprehensive. Pregnant women and dually eligible individuals should be included as long as they receive comprehensive benefits. All individuals whose coverage is funded under Title XXI of the Social Security Act, including through MCHIP programs, are excluded from this sub-indicator. Sub-indicator 8a should equal the sum of Medicaid MAGI enrollees (sub-indicator 8b) and Medicaid non-MAGI enrollees (sub-indicator 8e). When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.
8b	Medicaid MAGI Enrollment	Total MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month who are in an eligibility group that is subject to the MAGI determination rules. Sub-indicator 8b should equal the sum of MAGI child enrollees (sub-indicator 8c) and MAGI adult enrollees (sub-indicator 8d). Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.



8. TOTAL ENROLLMENT

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
8c	Medicaid MAGI Enrollment	MAGI Child Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month who are children and who are in an eligibility group that is subject to the MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan. Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.
8d		MAGI Adult Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month, who are not children, and who are in an eligibility group that is subject to the MAGI determination rules. Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated.
8e	Medicaid non-MAGI Enrollment	Total Non-MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month who are in an eligibility group that is subject to non-MAGI determination rules. Sub-indicator 8e should equal the sum of non-MAGI child enrollees (sub-indicator 8f) and non-MAGI adult enrollees (sub-indicator 8g). Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.



8. TOTAL ENROLLMENT

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
8f	Medicaid non-MAGI Enrollment	Non-MAGI Child Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month who are children and who are in an eligibility group that is subject to non-MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan. Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.
8g		Non-MAGI Adult Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under Title XIX of the Social Security Act) as of the last day of the calendar month who are not children and who are in an eligibility group that is subject to non-MAGI determination rules. Refer to sub-indicator 8a for inclusion and exclusion criteria. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.
8h		Total CHIP Enrollees	Total unduplicated number of individuals enrolled in CHIP (i.e., funded under Title XXI of the Social Security Act, including through MCHIP programs) as of the last day of the calendar month, including those with retroactive, conditional, and presumptive eligibility. CHIP children in a premium grace period should be included, while CHIP children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and should be excluded. Include only those individuals who are eligible for comprehensive benefits, defined as coverage that qualifies as MEC. Pregnant women covered by CHIP should be included as long as they receive comprehensive benefits. This sub-indicator is a point-in-time count of program enrollment, and not solely a count of those newly enrolled during the calendar month. When the state submits data for this sub-indicator for the current reporting month, the state is also required to update the data on this sub-indicator for the prior month's updated report.



Any state and the District of Columbia that elects to provide coverage to 1) the adult group described in 42 § C.F.R. 435.119 under the state plan or 2) to certain individuals generally described at § 435.119 who are enrolled in a section 1115 demonstration that provides minimum essential coverage (MEC) to such population (“applicable 1115 waiver”) must apply community engagement requirements described in section 1902(xx) of the Social Security Act (the Act) as a condition of eligibility for applicants or beneficiaries. In accordance with § 435.562, these states must report data in the monthly reports about the final determination on applications for individuals who were specified excluded individuals described in § 435.554 or applicable individuals in § 435.551 at application. CMS collects this data through sub-indicators 9n, 9o, 9p, 10m, 10n, and 10o of the monthly report. States begin reporting sub-indicators 9n, 9o, 9p, 10m, 10n, and 10o for the reporting month the community engagement requirement under section 1902(xx) of the Act is effective in the state. States that do not provide Medicaid to applicable individuals described in section 1902(xx) of the Act do not need to report sub-indicators 9n, 9o, 9p, 10m, 10n, and 10o to CMS.

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9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9a		Total Medicaid Eligible	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month. This count should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) are not included in this indicator. All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted. Individuals determined eligible at application or annual renewal who receive a subsequent determination due to a change in circumstance should have both determinations counted separately. Sub-indicator 9a should equal the sum of eligible determinations by determination type (sub-indicators 9b and 9c). Sub-indicator 9a should equal the sum of sub-indicator 9d (Medicaid Eligibility Determined at Application), sub-indicator 9g (Medicaid Eligibility at Annual Renewal), sub-indicator 9h (Medicaid Eligible via Administrative Determination), and sub-indicator 9i (Medicaid Eligible via Other Method).



9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9b	By Determination Type	Medicaid MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under MAGI rules during the calendar month. Refer to sub-indicator 9a for inclusion and exclusion criteria.
9c		Medicaid non-MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under non-MAGI rules during the calendar month. Refer to sub-indicator 9a for inclusion and exclusion criteria.
9d	By Reason for Determination	Medicaid Eligibility Determined at Application	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. Sub-indicator 9d should equal the sum of sub-indicator 9e (Medicaid Eligibility at Application under MAGI Rules) and sub-indicator 9f (Medicaid Eligibility at Application under non-MAGI Rules). Refer to sub-indicator 9a for inclusion and exclusion criteria.
9e		Medicaid Eligibility at Application under MAGI Rules	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. Refer to sub-indicator 9a for inclusion and exclusion criteria.



9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9f	By Reason for Determination	Medicaid Eligibility at Application under non-MAGI Rules	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under non-MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. Refer to sub-indicator 9a for inclusion and exclusion criteria.
9g		Medicaid Eligibility Determined at Annual Renewal	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) at annual renewal under either MAGI or non-MAGI rules during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the sub-indicator for "Medicaid Eligible via Other Method" (9i). Refer to sub-indicator 9a for inclusion and exclusion criteria.
9h		Medicaid Eligible via Administrative Determination	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) during the calendar month without submitting an application, under the process by which a state determines a cohort of individuals eligible through targeted enrollment strategies outlined in CMS guidance issued on May 17, 2013. This includes enrolling certain SNAP participants and parents of CHIP beneficiaries without requiring an application. Unless your state has been approved by CMS to make this type of determination, leave this field blank (not applicable). Refer to sub-indicator 9a for inclusion and exclusion criteria.



9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9i	By Reason for Determination	Medicaid Eligible via Other Method	Total number of individuals determined eligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under both MAGI and non-MAGI rules during the calendar month that are not captured in sub-indicators 9d, 9g, and 9h. This number should include redeterminations made outside of the annual renewal process (for instance, due to a self-reported change in circumstance). This number should also include administrative determinations for any individuals who did not submit an application for coverage, including SSI beneficiaries and certain Express Lane Eligibility (ELE) new enrollees. The data limitations field should include a description of any determinations reported in this field. Refer to sub-indicator 9a for inclusion and exclusion criteria.
9j		Total CHIP Eligible	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include CHIP determinations made on accounts assessed by the FFM and transferred to the state agency for final determination. Do not include final CHIP eligibility determinations made by the FFM and transferred to the state agency for enrollment. Individuals determined eligible at application or annual renewal who receive a subsequent determination due to a change in circumstance should have both determinations counted separately in the month in which each occurs. Sub-indicator 9j should equal the sum of sub-indicator 9k (Determined CHIP Eligible at Application), sub-indicator 9l (Determined CHIP Eligible at Annual Renewal), and sub-indicator 9m (All Others Determined CHIP Eligible).



9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9k	By Reason for Determination	Determined CHIP Eligible at Application	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month that follows the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. Refer to sub-indicator 9j for inclusion and exclusion criteria.
9l		Determined CHIP Eligible at Annual Renewal	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) at annual renewal during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the sub-indicator for "All Others Determined CHIP Eligible" (9m). Refer to sub-indicator 9j for inclusion and exclusion criteria.
9m		All Others Determined CHIP Eligible	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month who are not captured in sub-indicator 9k and sub-indicator 9l. This includes redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). Refer to sub-indicator 9j for inclusion and exclusion criteria.

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9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month
Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9ne	By Community Engagement at Applications	Number of individuals determined eligible, who are determined to be a specified excluded individual	Total number of individuals who applied and were determined eligible for the Medicaid adult group described in § 435.119 or an applicable 1115 waiver; and were determined to be a specified excluded individual at application as described in § 435.554. Total number of individuals determined to be specified excluded individuals and eligible for Medicaid eligible for Medicaid under Community Engagement as a result of being specified excluded individuals as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This count should include determinations following an initial application. Please, exclude redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) are not included in this indicator. All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted. Individuals determined eligible at application or Semi-annual renewal who receive a subsequent determination due to a change in circumstance should have both determinations counted separately.

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9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month
Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
908		Number of individuals demonstrating community engagement or meeting a mandatory exception.	Total number of individuals who applied and were determined eligible for the Medicaid adult group described in § 435.119 or an applicable 1115 waiver and demonstrated community engagement (in accordance with § 435.552) or were deemed to have demonstrated community engagement based on a mandatory exception (in accordance with § 435.552) as described in § 435.552 and § 435.553.
		Number of individuals determined eligible who are applicable individuals and either demonstrated community engagement or were deemed to have demonstrated community engagement by meeting a mandatory exception.	Total number of individuals determined eligible for Medicaid under Community Engagement as a result of demonstrating community engagement or a mandatory exception for specified excluded individuals as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This count should include determinations following an initial application. Please, exclude redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) are not included in this indicator. All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted. Individuals determined eligible at application or Semi-annual renewal who receive a subsequent determination due to a change in circumstance should have both determinations counted separately.

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9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE

Reporting Period: Calendar Month
Reporting Frequency: Monthly, year-round

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Indicator Number	Data Breakout	Variable Name	Description
9pe		Number of individuals determined eligible who are applicable individuals and were deemed to have demonstrated community engagement by meeting a short-term hardship exception	Total number of individuals who applied and were determined eligible for the Medicaid adult group described in § 435.119 or an applicable 1115 waiver and were deemed to have demonstrated community engagement for one or more months based on a short-term hardship exception described in § 435.555. Total number of individuals determined eligible for Medicaid under Community Engagement as a result of short term hardship exception as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This count should include determinations following an initial application. Please, exclude redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) are not included in this indicator. All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted. Individuals determined eligible at application or Semi-annual renewal who receive a subsequent determination due to a change in circumstance should have both determinations counted separately.

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10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10a		Total Medicaid Ineligible	Total number of individuals determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible due to not meeting program eligibility requirements as well as those for whom the agency was not able to obtain enough information to make an eligibility determination (procedural denials). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who are determined ineligible for Medicaid and ineligible for CHIP should be counted both in the number of individuals determined ineligible for Medicaid under this indicator and in the number of individuals ineligible for CHIP under sub-indicator 10g. Individuals who request disenrollment during the calendar month should not be included in this indicator. Sub-indicator 10a should equal the sum of sub-indicator 10b (Ineligibility Established) and sub-indicator 10c (Eligibility Cannot be Established). Sub-indicator 10a should equal the sum of sub-indicator 10d (Ineligible at Application), sub-indicator 10e (Ineligible at Annual Renewal), and sub-indicator 10f (Ineligible via Other Application Type).



10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10b	By Determination Reason	Medicaid Determination – Ineligibility Established	Total number of individuals determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income). Refer to sub-indicator 10a for inclusion and exclusion criteria.
10c		Medicaid Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month because the state did not have sufficient information to determine ineligibility (procedural denials). Potential reasons that a state would not be able to definitively establish ineligibility include: applicants failed to complete or return renewal forms or other required documentation, or renewing households who were lost to follow up. Refer to sub-indicator 10a for inclusion and exclusion criteria.
10d	By Type of Determination	Medicaid Determination – Ineligible at Application	Total number of individuals determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Refer to sub-indicator 10a for inclusion and exclusion criteria.



10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10e	By Type of Determination	Medicaid Determination – Ineligible at Annual Renewal	Total number of individuals who, during the calendar month, were determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) at annual renewal under either MAGI or non-MAGI rules. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the sub-indicator for “Medicaid Determination – Ineligible via Other Application Type” (10f). Refer to sub-indicator 10a for inclusion and exclusion criteria.
10f		Medicaid Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for Medicaid (i.e. funded under Title XIX of the Social Security Act) under both MAGI and non-MAGI rules during the calendar month who are not captured in sub-indicator 10d and sub-indicator 10e. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). Refer to sub-indicator 10a for inclusion and exclusion criteria.



10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10g		Total CHIP Ineligible	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible for CHIP due to not meeting program eligibility requirements as well as those for whom the agency was not able to obtain enough information to make an eligibility determination (procedural denials). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who are determined ineligible for Medicaid and ineligible for CHIP should be counted both in the number of individuals determined ineligible for Medicaid and in the number of individuals ineligible for CHIP. Individuals determined eligible for Medicaid who do not receive a CHIP denial should not be included in this sub-indicator. Individuals who request disenrollment or are disenrolled for failure to make premium payments during the calendar month should not be included in this indicator. Similarly, children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and should also be excluded from this sub-indicator. Sub-indicator 10g should equal the sum of sub-indicator 10h (Ineligibility Established) and sub-indicator 10i (Eligibility cannot be Established). Sub-indicator 10g should equal the sum of sub-indicator 10j (Ineligible at Application), sub-indicator 10k (Ineligible at Annual Renewal), and sub-indicator 10l (Ineligible via Other Application Method).



10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10h	By Determination Reason	CHIP Determination – Ineligibility Established	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income). Refer to sub-indicator 10g for inclusion and exclusion criteria.
10i		CHIP Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month because the state did not have sufficient information to determine ineligibility. Potential reasons that a state would not be able to definitively establish ineligibility include: applicants failed to complete or return renewal forms or other required documentation, or renewing households were lost to follow up. Refer to sub-indicator 10g for inclusion and exclusion criteria.
10j	By Determination Type	CHIP Determination – Ineligible at Application	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Refer to sub-indicator 10g for inclusion and exclusion criteria.



10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10k	By Determination Type	CHIP Determination – Ineligible at Annual Renewal	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) at annual renewal during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the sub-indicator for “CHIP Determination – Ineligible via Other Application Type” (10l). Refer to sub-indicator 10g for inclusion and exclusion criteria.
10l		CHIP Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month who are not captured in sub-indicator 10j and sub-indicator 10k. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). Refer to sub-indicator 10g for inclusion and exclusion criteria.

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10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10m	By Community Engagement at Application	Number of individuals determined ineligible for failure to meet CE, an exclusion or an exception due to not meeting the community engagement requirement	Total number of individuals who applied and were determined eligible for the Medicaid adult group described in § 435.119 or applicable 1115 waiver except community engagement: - and were determined ineligible for Medicaid due to not meeting failure to demonstrate compliance with the the community engagement requirement - Individuals who did not meet the Medicaid community engagement requirement are those for whom the state had sufficient information to determine that the individual was not a specified excluded individual or was an applicable individual who did not demonstrate or was deemed to have demonstrated community engagement, as described in § 435.551 - § 435.5575 Total number of individuals determined ineligible for Medicaid as a result for failure to meet Community Engagement, an exclusion, or an exception requirement as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This number should include determinations following an initial application. Exclude all redeterminations. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who request disenrollment during the calendar month should not be included in this indicator.

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10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10n		Number of individuals determined ineligible for procedural reasons	Total number of individuals determined ineligible for Medicaid for procedural reasons under community engagement who otherwise met program eligibility criteria (for example, income and residency-) but did not provide sufficient information necessary for the state to determine if the individual was a specified excluded individual or was an applicable individual who demonstrated or was deemed to have demonstrated community engagement as described in § 435.551 - § 435.557, as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This number should include determinations following an initial application. Exclude all redeterminations. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who request disenrollment during the calendar month should not be included in this indicator.

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10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
10o		Number of individuals determined ineligible for all other reasons	Total number of individuals determined ineligible for Medicaid for all other reasons (excluding failure to demonstrate CE as described in § 435.552 - § 435.555 and procedural reasons) under community engagement as determined by Section 71119 of the WFTC legislation amended Section 1902 of the Social Security Act. This number should include determinations following an initial application. Exclude all redeterminations. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who request disenrollment during the calendar month should not be included in this indicator.

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11. NUMBER OF PENDING APPLICATIONS OR REDETERMINATIONS

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
11a	Pending at Medicaid Agency	Number Pending at Medicaid Agency	Total number of applications and redeterminations pending at Medicaid agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redeterminations (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Include all pending applications and renewals in the queue that are not complete for any reason, including due to outstanding verification items on the part of the applicant or renewing household. Online applications that have been initiated but not yet submitted to the Medicaid agency should not be reported. Account transfers that received a final determination from the FFM (in FFM determination states) should also be excluded. If the state has an integrated application and eligibility and enrollment system for Medicaid and CHIP, then all pending Medicaid and CHIP applications and redeterminations should be included in this count.
11b		Pending at Medicaid Agency Type	States where the number of pending applications and redeterminations reported in sub-indicator 11a is of individuals should report "I" in this field. States where the reported number is of pending cases that may include a mix of individuals and households should report "A" in this field.
11c	Pending at Separate CHIP Agency	Number Pending at CHIP Agency	Total number of applications and redeterminations pending at the separate CHIP agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redetermination (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Online applications that have been initiated but not yet submitted to the separate CHIP agency should not be reported. If the state does not have a separate CHIP agency, or if the state has an integrated application and eligibility and enrollment system for Medicaid and CHIP, then all pending Medicaid and CHIP applications and redeterminations should be included in this count, and this sub-indicator and sub-indicator 11d should be left blank.



11. NUMBER OF PENDING APPLICATIONS OR REDETERMINATIONS

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
11d	Pending at Separate CHIP Agency	Pending at Separate CHIP Agency Type	States where the number of pending applications and redeterminations reported in sub-indicator 11c is of individuals should report "I" in this field. States where the reported number is of pending cases that may include a mix of individuals and households should report "A" in this field.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12a		Median Processing Time at Medicaid Agency – All Determinations at Application	For all applicants (regardless of date of application) who received a determination at application (as reported through sub-indicator 9d and sub-indicator 10d) from the Medicaid agency in the calendar month, report the median number of calendar days elapsed between the date the Medicaid agency received the initial application (start date) and the day the determination at initial application was made (end date). The set of determinations included in the calculation of median processing time for this measure includes Medicaid and CHIP determinations made by the Medicaid agency; MAGI and non-MAGI determinations; and determinations where the applicant was determined eligible as well as those where the applicant was determined ineligible. All final determinations made within the calendar month should be included, regardless of when the application was submitted. If the state has an integrated Medicaid and CHIP application and eligibility and enrollment system, all Medicaid and CHIP determinations made at application should be reported in this sub-indicator, and sub-indicators 12o–12v should be left blank. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination. Determinations made by the Medicaid agency on transfer applications received from the FFM are included. The date that the Medicaid agency received the account transfer is the start date and the day of the determination is the end date. Final eligibility determinations made by the FFM and transferred to the state should be excluded. This sub-indicator only applies to determinations at application, and does not apply to determinations at annual renewal, change in circumstance, or via other method.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12b	Type of Determination	Median Processing Time at Medicaid Agency – MAGI Determinations at Application	The median processing time, in days, as defined in sub-indicator 12a, but only for the set of final determinations that the Medicaid agency made using MAGI rules. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12c		Median Processing Time at Medicaid Agency – non-MAGI Determinations at Application	The median processing time, in days, as defined in sub-indicator 12a, but only for the set of final determinations that the Medicaid agency made using non-MAGI rules. No CHIP determinations (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) should be included in this calculation. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12d	Source of Application	Median Processing Time at Medicaid Agency – Direct Application	The median processing time, in days, as defined in sub-indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that the applicant submitted directly to the state, including applications submitted directly to an SBM. Refer to sub-indicator 12a for inclusion and exclusion criteria.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12e	Source of Application	Median Processing Time at Medicaid Agency – Transfer Application from FFM	The median processing time, in days, as defined in sub-indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that were transferred to it by the FFM. States with an SBM should leave this field blank (“not applicable”). Refer to sub-indicator 12a for inclusion and exclusion criteria.
12f	Number of MAGI Determinations at Application, by Processing Time at Medicaid Agency	Less than 24 hours	The number of final determinations made by the Medicaid agency on applications using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. This includes determinations made by the Medicaid agency on transfer applications received from the FFM. Refer to sub-indicator 12a for inclusion and exclusion criteria. The sum of this sub-indicator and sub-indicators <u>12f, 12g, 12h, 12i, and 12j</u>, and 12k should equal the sum of sub-indicator 9e (Medicaid Eligibility at Application under MAGI Rules) and the total number of ineligibility determinations at initial application that the Medicaid agency made under MAGI rules in the previous month (i.e. the portion of sub-indicator 10d that were determined under MAGI rules).
12g		24 Hours – 7 Days	The number of final determinations made by the Medicaid agency on applications using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12h		8 Days – 30 Days	The number of final determinations made by the Medicaid agency on applications using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12i	Number of MAGI Determinations at Application, by Processing Time at Medicaid Agency	31 Days – 45 Days	The number of final determinations made by the Medicaid agency on applications using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12j		More than 45 Days	The number of final determinations made by the Medicaid agency on applications using MAGI rules that occurred more than 45 days after the date that the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12k	Number of non-MAGI Determinations at Application, by Processing Time at Medicaid Agency	Less than 30 Days	The number of final determinations made by the Medicaid agency on applications using non-MAGI rules that occurred within 30 days of the date that the application was received by the agency. This includes determinations made by the Medicaid agency on transfer applications received from the FFM. Refer to sub-indicator 12a for inclusion and exclusion criteria. The sum of this sub-indicator and sub-indicators 12k, 12l, 12m, and 12n, and 12o should equal the sum of sub-indicator 9f (Medicaid Eligibility at Application under Non-MAGI Rules) and the total number of ineligibility determinations at initial application that the Medicaid agency made under Non-MAGI rules in the previous month (i.e. the portion of sub-indicator 10d that were determined under non-MAGI rules).
12l		31 – 60 Days	The number of final determinations made by the Medicaid agency on applications using non-MAGI rules that occurred between 31 and 60 days of when the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.

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12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12m	Number of non-MAGI Determinations at Application, by Processing Time at Medicaid Agency	61 – 90 Days	The number of final determinations made by the Medicaid agency on applications using non-MAGI rules that occurred between 60 and 90 days of when the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.
12n		More than 90 days	The number of final determinations made by the Medicaid agency on applications using non-MAGI rules that occurred more than 90 days after the date that the application was received by the agency. Refer to sub-indicator 12a for inclusion and exclusion criteria.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12o		Median Processing Time at CHIP Agency	For all applicants (regardless of date of application) who received a final determination from the separate CHIP agency in the calendar month, report the median number of calendar days elapsed between the date the agency received the application (start date) and the day the final determination was made (end date). The set of determinations included in the calculation of median processing time for this measure includes both determinations where the applicant was determined eligible as well as those where the applicant was determined ineligible. All determinations within the calendar month should be included, regardless of when the application was submitted. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination. This includes determinations made by the separate CHIP agency on transfer applications received from the FFM. This indicator only applies to determinations at application, and does not apply to determinations at annual renewal, change in circumstance, or via other method. In states without a separate CHIP agency, and in states with an integrated Medicaid and CHIP application and eligibility and enrollment system, all Medicaid and CHIP determinations should be reported in sub-indicators 12a–12n, and this indicator as well as sub-indicators 12p–12v should be left blank (not applicable).



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12p	Source of CHIP Application	Median Processing Time at CHIP Agency – Direct Application	The median processing time in days as defined in sub-indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that the applicant submitted directly to the state. Refer to sub-indicator 12o for inclusion and exclusion criteria.
12q		Median Processing Time at CHIP Agency – Transfer Application from FFM	The median processing time in days as defined in sub-indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that were transferred to it by the FFM. States that share an integrated eligibility system with the SBM should leave this field blank (not applicable). Refer to sub-indicator 12o for inclusion and exclusion criteria.
12r	Number of CHIP Determinations at Application, by Processing Time at CHIP Agency	Less than 24 Hours	The number of final determinations made by the separate CHIP agency on applications using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. The sum of this sub-indicator and sub-indicators <u>12r</u> , 12s, 12t, 12u, and 12v, should equal the total number of determinations at initial application that the separate CHIP agency made under MAGI rules in the previous month. This includes determinations on transfer applications that the separate CHIP agency received from the FFM, SBM, or Medicaid agency. In states without a separate CHIP agency, this sub-indicator and sub-indicators 12s, 12t, 12u, and 12v should be left blank (not applicable). Refer to sub-indicator 12o for inclusion and exclusion criteria.
12s		24 Hours – 7 Days	The number of final determinations made by the separate CHIP agency on applications using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency. Refer to sub-indicator 12o for inclusion and exclusion criteria.



12. PROCESSING TIME FOR DETERMINATIONS AT APPLICATION

Reporting Period: Calendar Month

Reporting Frequency: Monthly, year-round

Indicator Number	Data Breakout	Variable Name	Description
12t	Number of CHIP Determinations at Application, by Processing Time at CHIP Agency	8 Days – 30 Days	The number of final determinations made by the separate CHIP agency on applications using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency. Refer to sub-indicator 12o for inclusion and exclusion criteria.
12u		31 Days – 45 Days	The number of final determinations made by the separate CHIP agency on applications using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency. Refer to sub-indicator 12o for inclusion and exclusion criteria.
12v		More than 45 Days	The number of final determinations made by the separate CHIP agency on applications using MAGI rules that occurred more than 45 days after the date that the application was received by the agency. Refer to sub-indicator 12o for inclusion and exclusion criteria.