Medicaid and CHIP Unwinding: Data Sources and Metrics Definitions Overview

Last updated: April 2024

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I. Introduction

The Centers for Medicare & Medicaid Services (CMS) is releasing monthly data and information required under section 1902(tt)(1) of the Social Security Act (the Act), which was added by section 5131(b) of subtitle D of title V of division FF of the Consolidated Appropriations Act, 2023 (P.L. 117-328) (CAA, 2023).[1] Section 1902(tt)(1) requires that, for each month occurring during the period that begins on April 1, 2023, and ends on June 30, 2024, states submit to CMS (on a timely basis), and CMS makes public, certain monthly data about activities related to eligibility redeterminations conducted during that same period, including information about call center operations and transitions to Marketplace coverage. CMS is also providing information on changes in Medicaid, the Children's Health Insurance Program (CHIP), and Marketplace enrollment; state operational data; more robust renewal distribution metrics; and as available, additional data on transitions to other forms of coverage beyond the Marketplace. To produce each monthly report CMS will consolidate data from multiple data sources across the agency. This document provides information on the data sources used to produce the publicly reported unwinding metrics in each report, how CMS plans to define each metric, and how the metrics in the reports can and cannot be compared with each other.

II. Summary of Updates

This section provides a history of the updates made to the Medicaid and CHIP unwinding data sources and metrics definitions.

Table 1. Summary of Updates

Section	Description	Report Version
Definitions and Methodology for Metrics in the Marketplace Medicaid Unwinding Report – HealthCare.gov Marketplace data	After the first month of reporting, the Marketplace Medicaid Unwinding Report includes, for each metric, the net total number of consumers in each reporting month and the cumulative total across all months.	August 2023
Data Sources and Reports: Separate CHIP Report and Separate CHIP Data Collection Form	Added the Separate CHIP Report and the Preliminary Medicaid and CHIP Renewal Outcomes report to the list of products, and the Separate CHIP Data Collection Form to the list of data sources.	September 2023
Data Sources and Reports: Medicaid and CHIP Eligibility and Enrollment Performance Indicators	Updated language to describe how data are refreshed over time and added references to the new Preliminary Medicaid and CHIP Renewal Outcomes report.	September 2023
Data Sources and Reports: T-MSIS Analytic Files (TAF)	Added detail on how TAF data are used in the context of the Marketplace Medicaid Unwinding Report and Separate CHIP Report. Added a description of data quality reviews done for the Separate CHIP data.	September 2023

[1] For more information on the reporting requirements in section 1902(tt)(1) of the Act (added by the Consolidated Appropriations Act, 2023), please visit the CMS State Health Official Letter (SHO#23-002): https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf, and Frequently Asked Questions released on June 30, 2023, at https://www.medicaid.gov/federal-policy-guidance/downloads/fmap-rdctn-repot-medcid-chip-agncs-06302023.pdf.

Section	Description	Report Version
Cautions in Comparing and Combining Metrics	Added a section on comparing HealthCare.gov data with HealthCare.gov Transitions data.	September 2023
Metric Definitions and Calculations: Medicaid and CHIP CAA Reporting Metrics, Medicaid and CHIP Unwinding Operations Snapshot, and Separate CHIP Report	Added the Separate CHIP enrollment metric.	September 2023
Metric Definitions and Calculations: Marketplace Medicaid Unwinding Report	Added definitions and methodology for the HealthCare.gov Transitions Data. Updated the definition of "Marketplace consumers with previous Medicaid or CHIP enrollment" (the population for the HealthCare.gov data) to add conditions related to policy end dates and application submission dates.	September 2023
Data Sources Used for Unwinding Reports	Updated Table 2 to reflect that the National Summary of Renewal Outcomes expanded to display data from HealthCare.gov Marketplace, State-Based Marketplace, and Basic Health Program Operational Data.	April 2024
Data Sources and Reports: Medicaid and CHIP Unwinding Monthly Reports	Added language describing the process for capturing and reporting updated renewal data, including the outcomes of pending renewals.	April 2024
Data Sources and Reports: State-Based Marketplace and Basic Health Program Operational Data	Updated state list to include Virginia which transitioned from using the HealthCare.gov platform to the State-Based Marketplace eligibility and enrollment platform in Plan Year 2024.	April 2024
Cautions in Comparing and Combining Metrics	Added a section describing state renewal timeline considerations for interpreting renewal data.	April 2024

III. Data Sources and Reports

Six data sources are used to produce the publicly reported unwinding data metrics. The metrics will be documented in the following seven reports:

- Medicaid and CHIP CAA Reporting Metrics (tables)
- National Summary of Renewal Outcomes (PDF and tables)
- Medicaid and CHIP Unwinding Operations Snapshot (PDF)
- Marketplace Medicaid Unwinding Report (tables)
- Separate CHIP Report (tables)
- Preliminary Medicaid and CHIP Renewal Outcomes (tables)
- Updated Medicaid and CHIP Renewal Outcomes Report (tables)

For further information on these reports, please refer to the Medicaid and CHIP Unwinding Data page, on Medicaid.gov.

Each data source used to produce the publicly reported metrics is described more fully below, and Table 2 provides a mapping of each data source to the unwinding reports and metrics that use the data.

A. Medicaid and CHIP Eligibility and Enrollment Performance Indicators
B. Medicaid and CHIP Unwinding Monthly Reports
C. Transformed Medicaid Statistical Information System (T-MSIS) Analytic Files (TAF)
D. HealthCare.gov Marketplace operational data
E. State-based Marketplace (SBM) and Basic Health Program (BHP) operational data
F. Separate CHIP Data Collection Form

A. Medicaid and CHIP Eligibility and Enrollment Performance Indicators

Since 2013, every state, including the District of Columbia, has submitted monthly information on key Medicaid and CHIP operations—including call center operations, Modified Adjusted Gross Income (MAGI) application processing, and enrollment—through the Eligibility and Enrollment Performance Indicator (PI) data collection. The full set of data elements reported in the PI data, along with definitions for each data element, is available on Medicaid.gov.[2]

Per CMS guidance on state submission of PI data, preliminary PI data covering state activity during the reporting month is due from states on the 8th day after the end of the reporting month.[3] Along with each PI measure, states can report on any known data limitations or deviations from the data collection specifications. CMS reviews each preliminary report after it is submitted and contacts states with follow-up questions on the data as needed. States can submit updated or corrected data in a final submission through the 8th day of the month after they submit preliminary PI data. For example, on June 8, the state would submit data covering the May reporting period and would also update and re-submit data covering the April reporting period.

Given states' long-standing experience with collecting and reporting PI data and how quickly the information is available in state eligibility systems, these data are generally accurate and reliable for most indicators in most states. In some cases, the data are not fully comparable between states given differences in state operations. For call center data, there is wide variation in how states operate their call centers. Therefore, it is difficult to make comparisons with call center data. In July 2023, CMS is releasing the call center data publicly for the first time, and users should review the state-specific data notes included in the Medicaid and CHIP CAA Reporting Metrics tables.

All metrics based on PI data are released with data notes specific to metric, state, and month. These data notes are sourced from information states share as part of their PI data submission, as well as from state-confirmed data notes identified through CMS outreach to states about trends in their submitted PI data.

[2] See: https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/performance-indicator-technical-assistance/index.html.

[3] https://www.medicaid.gov/medicaid/downloads/overview-of-performance-indicator-project.pdf.

The data notes in these Unwinding data products may be more complete than what is released in other data products based on PI data due to the inclusion of state-confirmed data notes from outreach.[4]

The Medicaid and CHIP Unwinding Operations Snapshot and Medicaid and CHIP CAA Reporting Metrics tables posted on Medicaid.gov serve as a point-in-time snapshot highlighting key state preliminary PI data and are not refreshed to reflect any state updates to their preliminary PI data. Any state updates made to their preliminary PI data, including changes that impact corresponding data note citations, are reflected in the Data.Medicaid.gov version of the Medicaid and CHIP CAA Metrics Reporting table, which is refreshed with each monthly data release.

B. Medicaid and CHIP Unwinding Monthly Reports

States are required to submit specific metrics about Medicaid and CHIP renewals initiated and completed for a given month as states restore normal eligibility and enrollment operations following the end of the Medicaid continuous enrollment condition, using the "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report), among other data. The metrics were designed to allow CMS to monitor states' progress processing renewals when the state's unwinding period begins consistent with the guidance outlined in the CMS State Health Official Letter (SHO) #22-001[5] and some of these metrics also satisfy certain reporting requirements outlined in section 1902(tt)(1) of the Act, as described in SHO #23-002.[6] The data reporting template for the monthly Unwinding Data Report is available on Medicaid.gov[7] along with specifications and technical assistance materials.[8]

Within the Unwinding Data Report, the Unwinding Monthly Report metrics collect information on renewals initiated during the state's unwinding period and the disposition of those renewals. States typically take several months to process renewals for a cohort due for renewal in a given month from the time the state initiates a renewal on an *ex parte* basis, sends renewal forms to those whose renewal cannot be completed on an *ex parte* basis, processes returned forms, and sends an eligibility determination notice including any advance notice of adverse action, as appropriate. During the renewal process, states may determine an individual continues to be eligible (either on an *ex parte* basis or based on information returned on a renewal form), determine an individual is ineligible and terminate coverage based on information returned on the form, or terminate coverage for procedural reasons if a beneficiary fails to return their renewal form or other required information. In some cases, states may not be able to complete a renewal in the month it is due, and the renewal is considered pending. States with renewal mitigation strategies may initiate and complete renewals using processes that affect how outcomes are

[4] CMS includes information on PI data limitations as part of its MAGI application processing time reports, available at https://www.medicaid.gov/state-overviews/medicaid-modified-adjusted-gross-income-childrens-health-insurance-program-application-processing-time-report/index.html, and as part of the public release of PI indicators available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

[5] See: https://www.medicaid.gov/federal-policy-guidance/downloads/sho22001.pdf.

[6] See https://www.medicaid.gov/federal-policy-guidance/downloads/sho23002.pdf.

[7] See: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-data-reporting/index.html.

[8] See: https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-specifications.pdf and https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-training-slides.pdf.

reflected in the data.[9] The Unwinding Data Report does not collect information on outcomes related to redeterminations based on changes in circumstances that may occur between regularly scheduled renewals, including terminations from coverage that may occur due to a beneficiary's death or changes in state residency.

States submitted their first Unwinding Monthly Report based on the month the state began its unwinding period, which was February 2023, March 2023, or April 2023 (depending on the state). States do not report an Unwinding Monthly Report about renewals initiated prior to their state-specific unwinding period. States report renewal data in the Unwinding Monthly Reports based on cohorts of individuals whose renewal is due in given month. States report renewal outcomes for all individuals in the month in which renewals for the cohort are due, which tends to be the month before individuals determined ineligible are disenrolled. Depending on a state's renewal processing timeline, state reports may not include renewal outcome data in the first several months of reporting. CMS released a renewal timeline chart to demonstrate when states expect their initial cohort of unwinding renewals to be completed.[10]

States may not always complete all renewals in the month they are due. CMS refers to these renewals that are due but not completed in a reporting month as "pending" renewals. Since March 2023, approximately 20 percent of renewals have remained pending after their renewal due date. Renewals may be pending by the end of the month they are due for a number of reasons including, but not limited to:

1. Beneficiaries returning renewal forms late in the renewal process, leaving little time for the state to complete processing,
2. The state holding procedural disenrollments and/or other disenrollments (e.g. by adopting CMS-approved strategies to delay procedural disenrollments for one month while conducting outreach), or
3. The state being unable to process all renewals received before the end of the month in which they are due.

CMS renewal data specifications[11] require states to update and submit to CMS their monthly renewal outcome metrics - metric 5 data and its submetrics (monthly metrics 5a, 5a(1), 5a(2), 5b, 5c, and 5d) - after the original monthly report submission. These "updated" data, featured in the Updated Renewal Outcomes Report, reflect the outcomes of renewals previously reported as pending (monthly metric 5d of the original monthly report) as of three months after the renewal was due.

The "original" data featured in the Updated Renewal Outcomes Report reflect the same data states submitted to CMS in their monthly renewal data report that were published in CMS' Medicaid and CHIP

[9] See: https://www.medicaid.gov/resources-for-states/downloads/sum-st-mit-strat-comply-medi-renew-req.pdf.

[10] See: https://www.medicaid.gov/resources-for-states/downloads/ant-2023-time-init-unwin-reltd-ren-06292023.pdf.

[11] See CMS renewal data specifications: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/data-reporting-tools/index.html

CAA Reporting Metrics spreadsheets.[12]

The submission and review schedule for the monthly Unwinding Data Report parallels the PI data collection. State Medicaid and CHIP agencies submit their monthly Unwinding Data Report on the 8th day after the end of the reporting month and can provide information on data limitations or deviations from the reporting specifications. CMS reviews each report after it is submitted and works with states to understand any data limitations and ensure the data are complete and accurate.

The Unwinding Data Report is a new data collection effort that began with the start of unwinding. As a result, states may report occasionally erroneous or mis-specified data, particularly in early months of reporting. While states are receiving regular technical assistance in reporting, some data errors or limitations may appear in the Medicaid and CHIP CAA Reporting Metrics. Further, state strategies and mitigations in place during unwinding may impact how states capture information about renewal outcomes in the data set. For example, states with an *ex parte* mitigation strategy that allows the state to use data sources to complete a renewal after a form is sent may report those renewals as completed based on return of a renewal form and underreport the number of individuals renewed on an *ex parte* basis. The metrics from this data source include data limitation notes that are sourced from information states share as part of their Unwinding Data Report submission, as well as limitations shared by states during targeted CMS outreach about their data and from state mitigation plans.

State Medicaid and CHIP renewal initiation and disposition data that appear in the Medicaid and CHIP CAA Reporting Metrics table posted on Medicaid.gov and Data.Medicaid.gov are not refreshed. Updates states make to correct previously reported renewal data or to reflect the updated disposition of previously pending renewals are reflected as "updated" renewal data that appear in the Updated Renewal Outcomes Report and are also posted on Data.Medicaid.gov.

State Medicaid and CHIP renewal initiation and disposition data that appear in the Preliminary Medicaid and CHIP Renewal Outcomes table posted on Medicaid.gov reflect state-submitted data that has not undergone CMCS' data quality review process. State Medicaid and CHIP renewal initiation and disposition data that has undergone CMCS' data quality review process is reflected in the Medicaid and CHIP CAA Reporting metrics table posted on Medicaid.gov and Data.Medicaid.gov. Therefore, there may be differences in the renewal metric values published in the Preliminary Medicaid and CHIP Renewal Outcomes table and the Medicaid and CHIP CAA Reporting Metrics table.

C. T-MSIS Analytic Files (TAF)

States have been submitting data monthly through the Transformed Medicaid Statistical Information System (T-MSIS) data collection process since 2015. States report the latest information available from state systems in their T-MSIS submissions, including individual-level data about enrollees, their Medicaid- and CHIP-covered services, diagnoses and health conditions, and information on providers and managed

[12] The Medicaid and CHIP CAA Reporting Metrics spreadsheets, as well as the Updated Renewal Outcomes Reports, are posted at: https://www.medicaid.gov/resources-for-states/coronavirus-disease-2019-covid-19/unwinding-and-returning-regular-operations-after-covid-19/data-reporting/monthly-data-reports/index.html

care plans. Information on the full set of data elements reported in T-MSIS, including data reporting specifications and the T-MSIS data dictionary, is available on Medicaid.gov.[13]
Consistent with current T-MSIS submission guidance and to maintain system currency, states should report information into T-MSIS on the eligibility, claims, and financial data in their systems by the end of the month following the reporting month. For example, most states submit T-MSIS data covering the individuals enrolled in the program in April at some point between May 10 and May 31.[14] Consistent with current practice, states can continue to make updates to the information for that reporting period in subsequent monthly T-MSIS submissions. However, analyses of historic T-MSIS data have shown that enrollment information is overwhelmingly complete in its first monthly submission and relatively few changes are made to enrollment records in subsequent reporting periods.[15]

Each month, the T-MSIS data are converted into the T-MSIS Analytic Files (TAF), which are optimized for monitoring and research purposes. The production of the TAF occur in the month following most states' T-MSIS submission. For example, T-MSIS data covering individuals enrolled in the program in April is reported by states in May, and the TAF data for the April period are first produced in June. The TAF data for the April period will then be updated every month for the next 13 months, incorporating any new or changed T-MSIS data related to the April period. States can continue to update data beyond that period, but updates will not necessarily be reflected in the TAF data.

The Separate CHIP Report uses TAF data for a given month that have been updated at least once after the T-MSIS initial submission. For example, the April enrollment counts use TAF data produced in August from T-MSIS data submitted in July, corresponding to the June reporting period. The Separate CHIP Report's notes include the specific TAF production month used for each of the enrollment months. If a state has not submitted T-MSIS data for a given enrollment month at least twice before the TAF is produced, the Separate CHIP Report uses data submitted through the Separate CHIP Data Collection Form, rather than TAF. Unless otherwise noted, the Separate CHIP Report does not restate previous enrollment months with each release.

The Marketplace Medicaid Unwinding Report also uses TAF data. For additional information about the TAF production month used for the report, please see the Marketplace Medicaid Unwinding Report's notes. The publicly reported unwinding metrics that use TAF data (as shown in Table 2) rely exclusively on

[13] See: https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/index.html.

[14] In recent FAQs, CMS explained that while CMS generally does not consider states to be out of compliance with T-MSIS submission timelines until their data submissions are behind by two or more months, this longer time frame would likely create significant issues for certain unwinding-related reporting, and thus states should submit T-MSIS data on a monthly basis before the last day of the subsequent month. Information related to the timeline for T-MSIS submissions will likely be included in a forthcoming rule about section 1902(tt) of the Act, but meanwhile, CMS would not take enforcement action if states make a good-faith effort to meet the timeline described in the FAQs. See https://www.medicaid.gov/federal-policy-guidance/downloads/fmap-rdctn-repot-medcid-chip-agncs-06302023.pdf.

[15] A review of 2019 eligibility data found that 97% of the individuals who would ever be reported as enrolled in a certain month were reported as enrolled in the first T-MSIS submission covering that reporting period. Fewer than 0.5% of enrollees reported as enrolled during the first T-MSIS submission covering a reporting period were later updated to show disenrollment in an earlier month. There is some state variation observed in how quickly eligibility data are complete.

the Annual Demographic & Eligibility (ADE) TAF data file.[16] Virtually all states have high-quality and complete information on the individuals enrolled in Medicaid and CHIP in the TAF ADE. However, a known data quality limitation may affect the metrics in the Marketplace Medicaid Unwinding Report. In some limited cases, states may not submit into T-MSIS a Social Security Number (SSN) for some enrollees or may submit a "temporary" SSN value that does not reflect a real SSN assigned by the Social Security Administration. This is most common for individuals who do not have an SSN at the time their eligibility was determined, including infants and non-citizens. Because SSN is used to identify Marketplace applicants who link to individuals reported as enrolled or leaving Medicaid and CHIP in the unwinding metrics, incomplete or unreliable SSN data may affect counts of the number of Marketplace consumers linked to Medicaid and CHIP enrollees.

In addition, CHIP code data quality issues will impact the separate CHIP enrollment metric. States may use CHIP funds (from Title XXI of the Social Security Act) to expand their Medicaid programs (referred to as Medicaid expansion CHIP, or M-CHIP); create a program separate from their existing Medicaid programs (referred to as separate CHIP, or S-CHIP); or adopt a combination of both approaches. The T-MSIS CHIP code is used to identify whether a beneficiary was enrolled in Medicaid, M-CHIP, or S-CHIP during each month of the year. CMS reviews the TAF enrollment by CHIP code and ensures that it aligns with the state's CHIP program type. CMS also compares the TAF total CHIP enrollment (M-CHIP and S-CHIP) to the Performance Indicator CHIP enrollment, which includes M-CHIP and S-CHIP enrollment. Although the two numbers are not directly comparable, CMS performs reasonableness checks. If TAF data are unavailable or of insufficient quality, the Separate CHIP Report uses state-submitted data from the Separate CHIP Data Collection Form (described in Section F below).

D. HealthCare.gov Marketplace Operational Data

The Marketplaces that use the HealthCare.gov platform accept applications for health coverage from consumers in states that do not run SBMs on their own eligibility and enrollment platform. Consumers submit an application to the Marketplace, and the application is where eligibility and financial assistance determinations are made for a Qualified Health Plan (QHP) and financial assistance in the form of advance payment of the premium tax credit (APTC) and/or cost-sharing reductions (CSRs) and for MAGI-based Medicaid and CHIP. Consumers requesting coverage and financial assistance will generally receive one of two determinations:

1. **QHP eligibility.**[17] Consumers determined eligible for a QHP can select a Marketplace plan and may be eligible for APTC and/or CSRs. Plan selections will only become coverage for consumers who effectuate their coverage by paying their first monthly premium. CMS learns about effectuations and cancellations over time via data reconciliation with issuers; the HealthCare.gov Marketplace Medicaid

[16] The codebook with all data elements and valid values for the TAF ADE is available at https://www2.ccwdata.org/documents/10280/19022436/codebook-taf-demographic-eligibility.pdf. The technical documentation that provides information on how the TAF ADE is constructed and the enrollment measures that can be measured with the file is available at https://www.resdac.org/TAF-data-quality-resources/TAFTechGuide-DEF.

[17] For details on who may qualify for QHP coverage, please refer to https://www.healthcare.gov/quick-guide/eligibility/.

Unwinding Report includes plan selections that were not cancelled (either confirmed effectuated or an unknown effectuation status) as of the reporting cutoff date.

2. **MAGI-based Medicaid/CHIP eligibility.** States that rely on the HealthCare.gov Marketplace for determinations of eligibility for Marketplace coverage may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, the HealthCare.gov Marketplace makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, transmits the account information to the state via secure electronic file, and the state's Medicaid or CHIP agency makes the final determination of Medicaid or CHIP eligibility. In determination states, states delegate the authority to the HealthCare.gov Marketplace to make the final MAGI-based Medicaid and CHIP eligibility determination and the HealthCare.gov Marketplace transmits Medicaid and CHIP eligible accounts via secure electronic file to the state's Medicaid or CHIP agency for enrollment. Consumers ultimately determined eligible for Medicaid/CHIP are not eligible to receive financial assistance with a QHP.

Generally, when an individual is determined ineligible for Medicaid or CHIP by the state agency, a state Medicaid or CHIP agency sends the individual's account information via secure electronic file to the HealthCare.gov Marketplace in a process referred to as an inbound account transfer. The HealthCare.gov Marketplace then conducts outreach to the individual(s) on the transferred account, encouraging them to apply for coverage. The inbound account transfer process is triggered if one of the following occurs:

- An individual not currently enrolled in Medicaid or CHIP applies for Medicaid or CHIP coverage at the state agency and the state agency denies eligibility but assesses that the individual might be eligible for a QHP.
- A current Medicaid or CHIP beneficiary loses coverage after being found ineligible for Medicaid/CHIP for a non-procedural reason (e.g., having a household income that exceeds Medicaid or CHIP eligibility criteria) following a state redetermination and the state assesses that the individual might be eligible for a QHP.
- An applicant or Medicaid or CHIP beneficiary has been determined ineligible for Medicaid or CHIP on the basis of MAGI but is being evaluated for Medicaid coverage on a non-MAGI basis.
- A child is determined ineligible for CHIP during a CHIP waiting period.
- An individual is determined ineligible for Medicaid or CHIP by the state agency based on immigration status but is lawfully present in the United States.

States that rely on the HealthCare.gov Marketplace for determinations of eligibility for Marketplace coverage should not send inbound account transfers for individuals whose coverage has been terminated for procedural or administrative reasons, such as a failure to respond to a request for additional information to verify eligibility.[18]

[18] For additional information on the account transfer process and coordination between state Medicaid and CHIP agencies and the FFM, see CMCS Informational Bulletin - Coordination of Eligibility and Enrollment between Medicaid, CHIP and the Federally Facilitated Marketplace (FFM or "Marketplace"). July 25, 2016, available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib072516.pdf.

In preparation for Medicaid unwinding, CMS analyzed different streams of administrative data submitted by state Medicaid and CHIP agencies. The analyses suggest that, for a number of reasons, inbound account transfers do not specifically identify individuals losing or ineligible for coverage and include individuals who remain enrolled in Medicaid or CHIP. Therefore, CMS must rely on Medicaid and CHIP administrative enrollment data submitted via T-MSIS to determine when an account transfer is associated with an individual who lost Medicaid or CHIP.

To identify individuals losing or potentially losing Medicaid or CHIP, the metrics use SSN to match consumers across HealthCare.gov Marketplace application, policy, and inbound account transfer data and TAF. If a consumer is matched from HealthCare.gov Marketplace application, policy, or inbound account transfer data to TAF from the start of unwinding or later, they are included in the HealthCare.gov Marketplace Medicaid Unwinding Report. CMS is matching across these datasets for the first time and anticipates needing additional time to investigate findings coming from the combination of these data.

The HealthCare.gov Marketplace application, policy, and inbound account transfer data are immediately available, but due to the TAF lag, the HealthCare.gov Marketplace will not be able to report on whether a HealthCare.gov Marketplace consumer lost Medicaid or CHIP until a few months following the coverage loss date. Also, not every consumer who is matched from HealthCare.gov Marketplace data to TAF will lose Medicaid or CHIP in the month they are reported in, and some consumers in the report may never lose Medicaid or CHIP. For example, states must send accounts to the HealthCare.gov Marketplace for individuals determined ineligible for Medicaid on a MAGI basis following a renewal, even when the individual may continue to be eligible for partial non-MAGI-based Medicaid benefits. Additionally, most completed HealthCare.gov applications include SSN data that allows linkage to TAF, but an SSN is not required for all individuals, and some consumers do not report this information on the application, or TAF may not have an SSN for the consumer, which may limit the ability to match consumers from the FFM to TAF.

E. State-Based Marketplace and Basic Health Program Operational Data

States that operate state-based Marketplaces (SBMs) using their own eligibility and enrollment platforms or a Basic Health Program (BHP) submit metrics to CMS following a monthly timeline starting in May 2023 and concluding in July 2024, about account transfers (if applicable), applications, eligibility, QHP plan selections, and BHP enrollments for consumers who lose Medicaid/CHIP coverage due to a redetermination process.[19] These metrics satisfy the SBM reporting requirements outlined in the CAA, 2023 and are described in the Priority Metrics guide and template available on Medicaid.gov.[20]

[19] For plan year 2024, California, Colorado, Connecticut, District of Columbia, Idaho, Kentucky, Maine, Maryland, Massachusetts, Minnesota, Nevada, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, Vermont, Virginia, and Washington operate SBMs using their own eligibility and enrollment platform. Minnesota and New York operate BHPs. All other states have Marketplaces that use the federal platform for the purposes of making QHP eligibility and financial assistance determinations.

[20] See: https://www.medicaid.gov/resources-for-states/downloads/sbe-medicaid-chip-con-unwind-metrics-reprt-guide.pdf. Please note that the SBM reporting requirements described in the Priority Metrics guide and in this document specify that SBMs are required to report data limited to information that is the result of a Medicaid or CHIP redetermination or renewal, versus all Medicaid and CHIP applications. The CMS State Health Official Letter (SHO#23-

SBMs must submit their monthly Priority Metrics report on the 8th calendar day of the month for the reporting period ending on the last day of the month prior. Depending on a state's Medicaid unwinding period and renewal processing timeline, not all SBMs will include renewal outcome data in the first several months of reporting. CMS reviews each report after it is submitted and contacts states with follow-up questions on the data as needed. States are able to resubmit or update the data following the initial submission.

SBMs have different operational processes and eligibility systems for handling QHP, Medicaid, and CHIP eligibility determinations. While CMS works with SBMs to align the metric definitions across the Marketplaces, there can be limitations and anomalies among the SBM data due to different SBM system capabilities. States are asked to report on any known data limitations or deviations from the data collection specifications. Additionally, although CMS provides technical assistance to SBMs and conducts data validations on the reports received from the SBMs, CMS is reliant on the SBMs to report accurate data. Any known data limitations will be identified in each monthly Marketplace Medicaid Unwinding Report.

States with SBMs either operate an integrated eligibility platform or a non-integrated eligibility platform. Those with integrated eligibility systems determine eligibility for MAGI Medicaid/CHIP and QHP/APTC within the same system. Those with separate systems transfer the accounts or applications of individuals who lose Medicaid or CHIP coverage to the SBM to determine eligibility for enrollment in a QHP. Since the model employed by a SBM affects data reporting, the following provides more information on the operational aspects of each model.

1. Integrated eligibility system

SBMs that operate an integrated eligibility platform share one MAGI rules engine with the state Medicaid/CHIP agency that determines MAGI-based Medicaid/CHIP and QHP/APTC eligibility for all new and renewal applications. These systems will conduct Medicaid/CHIP renewals and will automatically make a determination for QHP/APTC if a consumer is determined ineligible for limited or full benefit Medicaid or CHIP. Individuals determined eligible for a QHP will be notified of their new eligibility determination and asked to select a plan. Some SBMs will make automatic plan assignments into a QHP for these or a subset of individuals and provide a notification of options regarding active selection of an alternative plan and/or, if applicable, making the first month's premium payment. SBMs with integrated eligibility systems are also able to identify and report consumers who independently apply to a SBM as having a loss of Medicaid or CHIP coverage. Additionally, some integrated SBMs may process eligibility determinations for consumers who lose Medicaid or CHIP coverage due to procedural reasons. SBMs in Plan Year 2024 that operate an integrated eligibility system for purposes of reporting are: California, Connecticut, District of Columbia, Kentucky, Massachusetts, Maryland, Minnesota, New York, Rhode Island, Vermont, and Washington.

002) did not clearly specify this distinction and instead suggested that the reporting elements would apply to Marketplace activity resulting from all Medicaid or CHIP applications.

2. Non-integrated eligibility system (account transfer)

SBMs that operate an account transfer process have separate MAGI rules engines from the state Medicaid/CHIP agency to process eligibility determinations for QHP/APTC following the Medicaid/CHIP agency's renewal process. The Medicaid/CHIP agency will conduct Medicaid/CHIP renewals and a consumer determined ineligible for limited or full benefit Medicaid or CHIP due to being over income or other appropriate reason will be transferred to the SBM. Some non-integrated SBMs receive an account transfer that includes full application information and are able to make an eligibility determination for QHP/APTC without requesting additional information from the consumer. These consumers will be notified of their new eligibility determination and asked to select a plan. Some non-integrated SBMs receive partial application information and must contact the consumer to complete an application. Consumers who subsequently submit an application to the SBM and are matched to an account transfer are reported. SBMs in Plan Year 2024 that operate a non-integrated eligibility system or account transfer process for purposes of reporting are: Colorado, Idaho, Maine, New Jersey, New Mexico, Nevada, Pennsylvania, and Virginia.

F. Separate CHIP Data Collection Form

When separate CHIP enrollment from TAF data is unavailable or of insufficient data quality, states submit a Separate CHIP Data Collection Form to report the number of individuals enrolled in a separate CHIP program at any point during the month. States are told to exclude individuals enrolled in both Medicaid and separate CHIP in the same month.

Table 2. Data Sources Used for Unwinding Reports

Data source(s)	Report(s)	Metrics
Performance Indicators	Medicaid and CHIP CAA Reporting Metrics (tables), Medicaid and CHIP Unwinding Operations Snapshot (PDF), and National Summary of Renewal Outcomes (PDF and tables)	• Total Medicaid and CHIP enrollment (the sum of Performance Indicator data element 8a and 8h) • Total applications received (Indicator 5a) • Percentage of MAGI determinations at application processed in over 45 days (ratio of Performance Indicator data element 12j divided by the sum of data elements 12f-12j) • Total call center volume (Indicator 1) • Average call center wait time (Indicator 2) • Average call center abandonment rate (Indicator 3)
Medicaid and CHIP Unwinding Monthly Report	Medicaid and CHIP CAA Reporting Metrics (tables), National Summary of Renewal Outcomes (PDF and tables), Preliminary Medicaid and CHIP Renewal Outcomes, and Updated Medicaid and CHIP Renewal Outcomes Report (tables)	• Total number of renewals initiated for Medicaid and CHIP beneficiaries in the month (Metric 4) • Total number of beneficiaries due for renewal in the reporting month (Metric 5) • Total number of beneficiaries due for renewal in the reporting month whose coverage was renewed (Metric 5a) • Total number of beneficiaries renewed on an *ex parte* basis (Metric 5a(1)) • Total beneficiaries renewed based on the return of a renewal form (Metric 5a(2)) • Total number of beneficiaries due for renewal whose coverage was terminated (Metric 5b + 5c) • Total number of beneficiaries determined ineligible for Medicaid and CHIP based on the return on a renewal form (Metric 5b) • Total number of beneficiaries whose coverage was terminated for a procedural or administrative reason (Metric 5c) • Total number of Medicaid and CHIP beneficiaries whose renewal is pending at the end of the reporting month (Metric 5d)

Data source(s)	Report(s)	Metrics

HealthCare.gov Marketplace operational data and T-MSIS Analytic Files (TAF)	Marketplace Medicaid Unwinding Report (tables)	• Marketplace consumers with previous Medicaid or CHIP enrollment
		  ○ Consumers who applied for Marketplace coverage and were determined or assessed Medicaid/CHIP-eligible or potentially Medicaid/CHIP-eligible
		  ○ Consumers who applied for Marketplace coverage and were determined QHP-eligible – total, eligible for financial assistance, and not eligible for financial assistance
		  ○ Consumers who applied for Marketplace coverage and made a QHP selection
		• Marketplace and account transfer consumers whose Medicaid or CHIP coverage was terminated
		  ○ Account transfer consumers who did not submit a Marketplace application
		  ○ Consumers who applied for Marketplace coverage and were determined or assessed Medicaid/CHIP-eligible or potentially Medicaid/CHIP-eligible
		  ○ Consumers who applied for Marketplace coverage and were determined QHP-eligible – total, eligible for financial assistance, and not eligible for financial assistance
		• Consumers who applied for Marketplace coverage and made a QHP selection

Data source(s)	Report(s)	Metrics
SBM and BHP operational data	Marketplace Medicaid Unwinding Report (tables)	• Total consumers on account transfers received by an SBM who had a Medicaid or CHIP coverage denial or termination following renewal • Total consumers applying for coverage on a Marketplace application who had a Medicaid or CHIP coverage denial or termination following renewal • Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and were determined QHP-eligible – total and eligible for financial assistance • Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and made a QHP selection – total and with an automatic QHP selection • Consumers with a Medicaid or CHIP coverage denial or termination following renewal who were determined BHP-eligible • Consumers with a Medicaid or CHIP coverage denial or termination following renewal with a BHP enrollment
Marketplace enrollment data	National Summary of Renewal Outcomes (PDF)	• Total effectuated enrollment in Marketplace coverage, as reported to CMS by FFE and SBE exchanges for payment and IRS reporting purposes.
BHP enrollment data	National Summary of Renewal Outcomes (PDF)	• Total BHP enrollment data is reported to CMS by two states: Minnesota and New York.
TAF and Separate CHIP Data Collection Form	Separate CHIP Report	• Total separate CHIP enrollment

IV. Cautions in Comparing and Combining Metrics

Users of the data products should use caution comparing metrics across sources because the variety of data sources and metric definitions and differences in state operations may result in misleading comparisons. Important cautions for combining or comparing metrics are noted below. Users should also review the data notes posted with the reports before interpreting the data or comparing across states.

Comparing enrollment and renewal data. Total Medicaid and CHIP enrollment and changes in this metric over time are sourced from the PI dataset, which includes only individuals with comprehensive benefits. The total enrollment counts are a net measure of people entering the program and leaving the program during the month. In contrast, the renewal metrics in the Medicaid and CHIP CAA Reporting Metrics include information on all individuals in Medicaid and CHIP undergoing a renewal during unwinding, including those with limited benefit packages such as the Medicare Savings Program (MSP) or family-planning only coverage. As a result of these varying populations and measurements, data users should not expect alignment between the number of renewals that resulted in coverage termination as reported in the Medicaid and CHIP CAA Reporting Metrics and the change in total Medicaid and CHIP enrollment month-over-month as reported in Medicaid and CHIP Eligibility and Enrollment Performance Indicators data products. Over longer periods of time, high rates of terminations that are not matched by declines in state enrollment may reflect Medicaid and CHIP enrollees re-enrolling after their coverage is terminated.

Combining renewal metrics to understand program disenrollment. Unless otherwise noted, renewal outcome metrics reflect the disposition of renewals that were due in the reporting month, and not the outcome of all renewals completed in the month. Some renewals cannot be completed in the month they are due, and when this occurs the renewal will be reflected as pending in the monthly report. While CMS is working on obtaining the disposition of pending renewals in a given month, the outcomes of pending renewals will not be reflected in another reporting month. Some program terminations occur for reasons that fall outside of the renewal process, such as redeterminations based on changes in circumstances in between regular renewals (e.g., change in income, death, change in state residency). Renewals are also typically due in the month before a termination is effectuated, meaning a termination outcome for a renewal will likely be reported a month earlier than it is reflected in enrollment data. For example, renewals due at the end of April that resulted in an ineligible determination would be reported in the April Medicaid and CHIP CAA Reporting Metrics data, but the enrollment decline would not be captured until the May Eligibility and Enrollment Performance Indicator data are reported. For all these reasons, the coverage losses captured by summing the renewal metrics that count terminations are not expected to align with monthly changes in total program enrollment, which are a net measure of both new enrollments and coverage terminations for any reason.

Comparing renewals initiated with renewal outcomes. States typically take several months to complete the renewal process for renewals due in a given month. The renewals reported as initiated in a particular monthly report will reflect renewals for a different cohort of individuals than the disposition of renewals reported in the same monthly report. Some states have different renewal timelines for certain populations. For example, a state may take about 60 days to process renewals for MAGI beneficiaries and 90 days for non-MAGI beneficiaries. As a result, the outcomes reported in a particular monthly report may reflect

renewals initiated across several months that were due in the same month. For these reasons, the number of renewals initiated in a given month is not expected to align with the total number of renewals due for any particular month in all states.

Comparing "original" and "updated" renewal outcomes data. When reviewing the renewal outcomes data in the Updated Renewal Outcomes Report, users should keep in mind:

- The data in the original data columns match the data published in CMS' Medicaid and CHIP Reporting Metrics spreadsheets and do not include any subsequent revisions submitted to CMS.
- States that reported zero pending renewals in the original data did not need to submit an updated report. If a state did not update or correct its monthly data, the state's original values are populated as the updated values in the report and those original values are included in the calculation of the US totals. The "as of" date for the updated renewal data is the month that is three months after the end of the original monthly reporting period. In the original data, the "as of" date is the month in which the renewal was due. For example, in the March 2023 Updated Renewal Outcomes Report, when looking at the "March 2023 Combined (N) tab", the original data are as of March 2023, and the updated data are as of June 2023.

For a variety of reasons, some states could not report the updated renewal data according to the data specifications. The two most common examples of alternative reporting include (1) reporting updated renewal outcomes as of a different date than specified (e.g., reporting the final disposition of previously pending renewals from March 2023 made by August 31, 2023, rather than June 30, 2023, which was 3 months after the renewal was originally due), and (2) updating the eligibility status of all individuals in the cohort to include actions that occur after a renewal is complete (e.g., determinations based on a renewal form returned during the reconsideration period, redeterminations based on changes in circumstances, reinstatements). These reporting variations are noted in the footnotes.

State timeline considerations for interpreting renewal data. Some states' initiation and completion of unwinding renewals will extend beyond their initially planned timelines due to state mitigations, delays in procedural disenrollments, or state adoption of other CMS-approved strategies. As a result, unwinding-related and "regular" renewals (e.g., the second renewal conducted after the end of the Medicaid continuous enrollment condition) will occur at the same time in many states. Starting with the February 2024 reporting period, national renewal data will no longer reflect only work done as part of unwinding processing and will begin to reflect regular renewal processing as well.

Comparing Medicaid and CHIP renewal metrics and Marketplace applications. Not every individual whose Medicaid or CHIP coverage is terminated will need Marketplace coverage; some people will not need Marketplace coverage because they may still be eligible for Medicaid or CHIP, have access to other coverage such as employer-sponsored coverage, or for another reason. Additionally, states do not transfer accounts for all individuals in Medicaid and CHIP who lose coverage at renewal to the HealthCare.gov Marketplace. Individuals whose Medicaid coverage is terminated for procedural reasons (lose coverage due to failure to return their renewal form or information necessary to determine eligibility) are presumed to potentially remain eligible for Medicaid, and states are instructed not to transfer these individuals to the HealthCare.gov Marketplace to avoid delays in returning to Medicaid. In addition, not all

individuals who lose Medicaid and CHIP coverage and whose accounts are transferred to the HealthCare.gov Marketplace will complete an application for coverage at the HealthCare.gov Marketplace. Generally, SBMs also do not receive information about individuals whose Medicaid or CHIP coverage is terminated due to procedural reasons. However, some SBMs with integrated eligibility systems with Medicaid/CHIP may receive and process applications for certain consumers whose coverage was terminated for procedural reasons and are not able to differentiate that population in reporting. See the Marketplace Medicaid Unwinding Report for more information.

Comparing HealthCare.gov Marketplace and SBM data. The HealthCare.gov Marketplace and SBM data are not comparable, and data users should be cautious in making direct comparisons due to differences in eligibility and enrollment system operations and reporting methodology. Further information on the different eligibility and enrollment platform models and processes can be found in the HealthCare.gov Marketplace and SBM operational data sections above. Further information on the reporting methodology for HealthCare.gov Marketplace and SBM states can be found in Tables 4 and 5 below. Additionally, the HealthCare.gov Marketplace data count the cumulative number of unique consumers for each metric across reporting periods, whereas the data reported for SBM states count unique Marketplace activities during the reporting period month in which the relevant activity occurs. SBMs report on the previous full month. The HealthCare.gov Marketplace data are also reported monthly but the date through which the data are reported may not line up with the last date of each month due to data limitations. Reporting months for HealthCare.gov Marketplace data will start on the first Monday of the month and end on the first Sunday of the next month when the last day of the reporting month is not a Sunday.

Comparing HealthCare.gov data with HealthCare.gov Transition data. The HealthCare.gov data and the HealthCare.gov Transition data are not comparable, and data users should be cautious in making direct comparisons due to differences in methodology. The HealthCare.gov data focuses on individuals with previous Medicaid or CHIP enrollment and reports net and total counts of individuals with HealthCare.gov Marketplace activity through the latest reporting month. The HealthCare.gov Transition data focuses specifically on individuals whose Medicaid or CHIP coverage was terminated in a given month and looks prospectively at transitions. The HealthCare.gov Transition data reports on these individuals by the month their Medicaid or CHIP coverage was terminated but will provide updated data for each month to show HealthCare.gov Marketplace activity over time.

V. Metric Definitions and Calculations

The definitions and methodology for calculating all metrics included in the public data reports are listed in Tables 3, 4, 5, and 6 respectively.

A. Medicaid and CHIP CAA Reporting Metrics, Medicaid and CHIP Unwinding Operations Snapshot, Preliminary Medicaid and CHIP Renewal Outcomes, Updated Medicaid and CHIP Renewal Outcomes, and Separate CHIP Report

Table 3. Definitions and Calculations for Metrics Reported in the Medicaid and CHIP CAA Reporting Metrics, and Medicaid and CHIP Unwinding Operations Snapshot, Preliminary Medicaid and CHIP Renewal Outcomes, Updated Medicaid and CHIP Renewal Outcomes, and Separate CHIP Report

Metric	Definition and calculation[1]
Total Medicaid and CHIP enrollment	Total unduplicated number of individuals enrolled in Medicaid (i.e., funded under Title XIX of the Social Security Act) and enrolled in a Medicaid-expansion or separate CHIP (i.e., funded under Title XXI of the Social Security Act) as of the last calendar day of the month. This is a point-in-time count of total program enrollment and not solely a count of those newly enrolled during the month. It includes only individuals who are eligible for comprehensive benefits. Individuals with limited benefit packages such as emergency Medicaid, family planning-only, or limited benefit dually eligible individuals are not included in the count. The metric is the sum of Performance Indicator data element 8a and 8h, as reported by the state.
Total number of Medicaid and CHIP beneficiaries for whom a renewal was initiated in the reporting month (Metric 4)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was initiated during the month. A renewal is considered "initiated" when a state first begins the *ex parte* process, or when a state checks data sources and other available information to attempt to renew eligibility based on the available information without contacting the individual. In cases when a state has a mitigation plan related to *ex parte* renewals, the state initiates the renewal through another process (typically when a renewal form is sent). This metric is not cumulative and includes only the renewals initiated during a single month. This metric is equal to data element 4 in the Unwinding Monthly Reports.

Metric	Definition and calculation[1]
Total number of beneficiaries due for renewal in the reporting month (Metric 5)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal is due, or scheduled for completion, during the month. A renewal is considered due in the month that aligns with the beneficiary's potential last day of coverage, not the first date the termination is effective. It is expected that states will report zero renewals due for two to three months after initiating unwinding-related renewals, when the first set of unwinding-related renewals are not yet due. This metric is not cumulative and includes only renewals due in a single month. It does not include renewals due in previous months that are still pending. This metric is the sum of data elements 5a, 5b, 5c, and 5d in the Unwinding Monthly Reports.
Total number of beneficiaries due for renewal in the reporting month whose coverage was renewed (Metric 5a)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary's Medicaid or CHIP coverage was retained at the completion of the renewal. This metric is not cumulative and includes only those beneficiaries whose renewal was due in the reporting month. Beneficiaries whose renewal was due in a previous month but completed in the reporting month are not included in this metric. This metric is calculated as the sum of data elements 5a(1) and 5a(2) from the Unwinding Monthly Reports.
Total beneficiaries renewed on an *ex parte* basis (i.e., based on available information) (Metric 5a1)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary's Medicaid or CHIP coverage was retained, based on a renewal that was performed on an *ex parte* basis. This means eligibility was redetermined based on information available to the agency without requiring additional information from the individual. This metric is not cumulative and includes only those beneficiaries whose renewal was due in the reporting month and were renewed in the same month. Beneficiaries whose renewal was due in a previous or subsequent month, but *ex parte* determination was made in the reporting month are not included in this metric. This metric is a subset of data element 5a from the Unwinding Monthly Reports.
Total beneficiaries renewed based on the return of a renewal form (Metric 5a2)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary's Medicaid or CHIP coverage was retained after a renewal that was determined using a renewal form. States with mitigation plans related to *ex parte* renewals may reflect individuals renewed via their mitigation strategy in this metric. This metric is not cumulative and includes only those beneficiaries whose renewal was due in the reporting month and were renewed in the same month. Beneficiaries whose renewal was due in a previous month, but the determination was made in the reporting month are not included in this metric. This metric is a subset of data element 5a from the Unwinding Monthly Reports.

Metric	Definition and calculation[1]
Total number of beneficiaries due for renewal in the reporting month whose coverage was terminated (Metric 5b + 5c)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary's coverage for Medicaid or CHIP was terminated. This includes both beneficiaries whose Medicaid or CHIP coverage was terminated for procedural reasons (i.e., failure to return required paperwork) and beneficiaries who were found to be no longer eligible for Medicaid and CHIP. This metric is not cumulative and includes only beneficiaries whose renewal was due in the reporting period and whose Medicaid or CHIP coverage was also terminated in the month the renewal was due. This metric is calculated as the sum of data elements 5b and 5c from the Unwinding Monthly Reports.
Total number of beneficiaries determined ineligible for Medicaid and CHIP based on the return of a renewal form (Metric 5b)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary was determined ineligible for Medicaid or CHIP based on the information returned on the renewal form. This metric is not cumulative and includes only beneficiaries whose renewal was due in the reporting month. Beneficiaries whose renewal was due in a previous month but completed in the reporting month are not included in this metric. This metric is a subset of data element 5 from the Unwinding Monthly Reports.
Total beneficiaries whose coverage was terminated for a procedural or administrative reason (Metric 5c)	Total number of beneficiaries, including those receiving comprehensive or limited benefits, whose renewal was due in the reporting period and the beneficiary's Medicaid or CHIP coverage was terminated for procedural reasons. Procedural reasons include instances where a beneficiary fails to provide the information necessary to complete a Medicaid or CHIP renewal. This metric is not cumulative and includes only beneficiaries whose renewal was due in the reporting month. Beneficiaries whose renewal was due in a previous month but completed in the reporting month are not included in this metric. This metric is a subset of data element 5 from the Unwinding Monthly Reports.
Total number of beneficiaries due for renewal in the reporting month whose renewal was pending at the end of the month (Metric 5d)	Total number of renewals for beneficiaries, including those receiving comprehensive or limited benefits, that were due in the reporting period but were not completed (a final eligibility determination had not been made as of the end of the reporting period or the state is holding procedural terminations in the month). This metric is not cumulative and only includes information on renewals that were due in the reporting month. Pending renewals that were due in previous months are not included. Some states report renewals at the case or household level, so this metric should not be interpreted as counting individuals. This metric is a subset of data element 5 from the Unwinding Monthly Reports.
Total number of applications received	Total number of MAGI and non-MAGI applications received by any state agency with the authority to make Medicaid or CHIP eligibility determinations, including the Medicaid agency or other agency delegated to make Medicaid eligibility determinations, a separate CHIP agency, and an SBM. Accounts transferred from the FFM are not included in this metric. This metric is set equal to the value states report in Performance Indicators data element 5a.

Metric	Definition and calculation[1]
Percentage of MAGI determinations at application processed in over 45 days	The proportion of final determinations on applications made by the Medicaid and CHIP agency using MAGI rules that occurred more than 45 days after the date the application was received by the agency. Determinations made using non-MAGI rules, applications that have not yet received a final determination, and determinations at annual renewal are not included in this metric. This metric is calculated as the ratio of Performance Indicator data element 12j divided by the sum of data elements 12f-12j.
Total call center volume	The total number of calls received by each call center or hotline that serves Medicaid and CHIP applicants or enrollees in the state. Call centers reported in this metric may serve additional state human services program such as SNAP, but the metric excludes calls received by call centers that primarily serve an SBM. The metric is set equal to the value states report in Performance Indicator data element 1.
Average call center wait time (minutes)	The average wait time in whole minutes for calls received by all call centers reported in the metric above. Wait times between 0 and 29 seconds are rounded down to the nearest whole minute, including 0 zero minutes. The metric is set equal to the value states report in Performance Indicator data element 2.
Average call center abandonment rate	The average abandonment rate for all call centers reported in the call center volume metric above. The abandonment rate is calculated as the number of calls abandoned by the caller (numerator) divided by the total call volume (denominator). The metric is set equal to the value states report in Performance Indicator data element 3.
Separate CHIP enrollment	The number of beneficiaries enrolled in a separate CHIP program at any point in the month. When the enrollment is sourced from T-MSIS, it is equal to the number of beneficiaries who have either a CHIP_CD_XX equal to 3, or a CHIP_CD_XX that is missing and an ELGBLTY_GRP_CD_XX between 61 and 68 in the TAF ADE, where XX corresponds to the month number. Children enrolled in both a separate CHIP program and Medicaid in the same month are not included.

[1] For data derived from the Medicaid and CHIP Eligibility and Enrollment Performance Indicators, the definitions of each data element can be found in the Performance Indicator Data Dictionary, available at https://www.medicaid.gov/medicaid/downloads/performance-indicators-datadictionary.pdf. For data derived from the Unwinding Eligibility and Enrollment Report, specifications for reporting are available at: https://www.medicaid.gov/resources-for-states/downloads/unwinding-data-specifications.pdf.

B. Marketplace Medicaid Unwinding Report

The Marketplace Medicaid Unwinding Report examines the flow of individuals from Medicaid and CHIP to the HealthCare.gov Marketplace and SBMs during the unwinding period. The definitions and methodology for calculating the metrics included in the report are captured in Tables 4, 5, and 6.

The HealthCare.gov portions of the Marketplace Medicaid Unwinding Report include State-based Marketplaces that use the Federal eligibility and enrollment platform. The first part of this report, labeled HealthCare.gov, focuses on people who were enrolled in Medicaid or CHIP (both full and partial benefit) in March 2023 or later months, were not enrolled in a Marketplace plan at the start of each state's first reporting month for a full cohort of renewals, and either submitted an application or made a plan selection as of the end of each reporting month (Table 4). These metrics track Marketplace activities each month and cumulative for the entire unwinding period. State data start being reported in the month when the state's first unwinding renewal cohort is due. There may be consumers in these states who apply at the HealthCare.gov Marketplace before this date who will not be included in this report. Consumers who submitted an application to the HealthCare.gov Marketplace but cannot be linked to Medicaid and CHIP administrative enrollment data are not included in these measures.

Starting in September 2023, the Marketplace Medicaid Unwinding Report includes additional HealthCare.gov measures on individuals whose Medicaid or CHIP coverage was terminated in April 2023 or later months[21] and applied at a HealthCare.gov Marketplace or have been sent via secure electronic file to the HealthCare.gov Marketplace via an inbound account transfer (Table 5). This part of the report is labeled HealthCare.gov Transitions. These measures identify individuals based on the month in which they left full benefit Medicaid or CHIP and then tracks these individuals' HealthCare.gov Marketplace activity through the latest HealthCare.gov data included in the report. Therefore, measures will be restated each month to track HealthCare.gov Marketplace progress for these individuals over time.

For SBMs, this report focuses on people who received a Medicaid/CHIP renewal and were determined ineligible for Medicaid or CHIP, and whose accounts and/or applications were received by the SBM in April 2023 or later months.

The definitions and methodology for calculating HealthCare.gov Marketplace metrics included in the Marketplace Medicaid Unwinding Report are in Tables 4 and 5 below. HealthCare.gov Marketplace operational data are organized by week, running from Monday to the following Sunday. As a result, HealthCare.gov reporting months start on the first Monday of the month and end on the first Sunday of the next month when the last day of the reporting month is not a Sunday.

[21] The HealthCare.gov Transition Data for April includes individuals with a last day of Medicaid or CHIP coverage on March 31, 2023.

Table 4. Definitions and Methodology for Metrics in the Marketplace Medicaid Unwinding Report – HealthCare.gov Marketplace Data

Metric	Definition and calculation
Population included in the report	
Marketplace consumers with previous Medicaid or CHIP enrollment	Marketplace consumers who submitted an application to the HealthCare.gov Marketplace on or after the start of each state's first reporting month who can be linked to an enrollment record in TAF that shows Medicaid or CHIP enrollment between March 2023 and the latest reporting month.[1] Consumers counted in this metric must meet these additional conditions: • The consumer had a Marketplace application submitted or a HealthCare.gov Marketplace policy in the April 2023 reporting period or later. • The consumer must link to enrollment records in TAF based on their SSN. Individuals who cannot be linked to a TAF enrollment record are not included in the population. • Only consumers without an active plan selection as of the start of each state's first reporting month are included. An active plan selection is one that is non-cancelled with an end date of December 31. • The consumer requested Marketplace coverage on their application. • The consumer's Marketplace policy must be non-terminated or have an end date after the earlier of their Medicaid or CHIP end date (if one exists), or the end of the reporting month. For example, a consumer with a Marketplace policy that ended on April 30, 2023, and Medicaid or CHIP enrollment that ended in May 2023 would be excluded. • The consumer's Marketplace application must be submitted after the later of April 2, 2023, or the end of their first Medicaid or CHIP enrollment month. For example, a consumer with an application submitted on May 15, 2023, and Medicaid or CHIP enrollment that started on May 1, 2023, would be excluded.
Measures calculated for the population	
Cumulative Total	The cumulative number of unique consumers from the included population who submitted an application to the HealthCare.gov Marketplace on or after the start of each state's first reporting month. Consumers who submitted multiple applications are counted only once. This metric will not equal the sum of the consumers who are determined Medicaid eligible or potentially Medicaid eligible and the consumers who are determined QHP eligible because there are consumers who are ineligible for Medicaid, CHIP, and QHP coverage.

Metric	Definition and calculation
Net Total	The net number of unique consumers from the included population who submitted an application to the HealthCare.gov Marketplace during the reporting month. The net total is equal to the difference between the cumulative counts through a given reporting month and previous reporting month. This metric will not equal the sum of the consumers who are determined Medicaid eligible or potentially Medicaid eligible and the consumers who are determined QHP eligible because there are consumers who are ineligible for Medicaid, CHIP, and QHP coverage.
Consumers who applied for Marketplace coverage and were determined or assessed Medicaid/CHIP-eligible or potential Medicaid/CHIP-eligible	The subset of total HealthCare.gov Marketplace consumers who were determined or assessed by the HealthCare.gov Marketplace as eligible or potentially eligible for Medicaid/CHIP and whose accounts were sent to the state Medicaid agency. These individuals do not receive a determination of QHP eligibility. The HealthCare.gov Marketplace eligibility process determined or assessed the consumer was eligible or potentially eligible for Medicaid or CHIP and therefore not eligible for a QHP through the Marketplace. Determinations or assessments reflect each consumer's status as of the end of each reporting month. Individuals who submitted multiple applications are reported in this metric only once, based on their status as of the end of the reporting month.
Consumers who applied for Marketplace coverage and were determined QHP-eligible	The subset of total HealthCare.gov Marketplace consumers who the HealthCare.gov Marketplace determined as eligible for a QHP.[2] The HealthCare.gov Marketplace eligibility process determined the consumer was eligible for a QHP through the Marketplace. Determinations reflect each consumer's status as of the end of each reporting month. Individuals who submitted multiple applications are reported in this metric only once, based on their status as of the end of the reporting month.
Consumers who applied for Marketplace coverage and were determined QHP-eligible: Eligible for Advance Premium Tax Credit (APTC)	The subset of HealthCare.gov Marketplace consumers who the HealthCare.gov Marketplace determined to be eligible for a QHP (above) and who were also determined eligible for financial assistance in the form of APTCs.[3] Determinations reflect each consumer's status as of the end of each reporting month.
Consumers who applied for Marketplace coverage and were determined QHP-eligible: Not eligible for APTC	The subset of HealthCare.gov Marketplace consumers who the HealthCare.gov Marketplace determined to be eligible for a QHP (above) but who were determined not to be eligible for financial assistance in the form of APTC.[3] Determinations reflect each consumer's status as of the end of each reporting month. Consumers are counted in this metric if they are eligible for $0 APTC. As described in 45CFR 155.305(f) and 26 CFR 1.36B, the maximum household APTC equals the APTC-eligible family members' benchmark plan premium minus the required household contribution, which is based on the household's expected income as a percent of the federal poverty level and an applicable percentage the IRS determines annually. A household is eligible for $0 APTC if their required household contribution is higher than their benchmark plan premium.

Metric	Definition and calculation
Consumers with a QHP selection	The subset of HealthCare.gov Marketplace consumers who the HealthCare.gov Marketplace determined to be eligible for a QHP (above) and who have a QHP selection as of the end of the reporting month. Plan selections counted in this metric include consumers with a non-cancelled medical policy that has an end date on or after the start of each state's first reporting month. The plan selections do not necessarily occur in the same month as the month the individual submitted an application or received a determination of QHP eligibility. Plan selections only become effectuated coverage for consumers that pay their first monthly premium. Plan selections that are not effectuated are cancelled. QHP issuers are responsible for collecting payments and sending cancellations to the HealthCare.gov Marketplace; the HealthCare.gov Marketplace data reflects cancellations only after reconciling data with issuers. While this plan selection metric is net of cancellations that occur through the reporting month, it doesn't represent effectuated enrollments because reconciliation activity may continue beyond the reporting month.

[1] The data used to produce the metrics are organized by week, running from Monday to the following Sunday. As a result, reporting months start on the first Monday of the month and end on the first Sunday of the next month when the last day of the reporting month is not a Sunday. For example, the April 2023 reporting period extends from Monday, April 3 through Sunday, April 30.

[2] The count/percent of consumers who were determined or assessed potentially Medicaid/CHIP-eligible and who were determined QHP eligible will not sum to the total number of consumers due to individuals determined ineligible for Medicaid, CHIP, and QHP coverage.

[3] States using the Federal eligibility and enrollment platform may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, the HealthCare.gov Marketplace makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, and the state's Medicaid or CHIP agency makes the final determination of Medicaid or CHIP eligibility. In determination states, the HealthCare.gov Marketplace makes the final MAGI-based Medicaid and CHIP eligibility determination and transmits eligible applications to the state's Medicaid or CHIP agency.

Table 5. Definitions and Methodology for Metrics in the Marketplace Medicaid Unwinding Report – HealthCare.gov Transitions Data

Metric	Definition and calculation
Populations included in the report	
Marketplace or account transfer consumers whose Medicaid or CHIP coverage was terminated	Marketplace or Account Transfer Consumers are individuals 1) whose full benefit Medicaid or CHIP coverage was terminated; and 2) applied at the HealthCare.gov Marketplace or were sent via secure electronic file to the HealthCare.gov Marketplace in an inbound account transfer. Consumers counted in this metric must meet these additional conditions: • The consumer must link to an enrollment record in TAF and have their last day of full benefit Medicaid or CHIP coverage on or after March 31, 2023. Medicaid or CHIP beneficiaries are considered to have full benefits if the restricted benefits code in TAF was equal to 1, 5, 7, A, B, or D. • The April population includes consumers who had an enrollment record in TAF that shows a last day of Medicaid or CHIP enrollment between March 31, 2023 and April 30, 2023. All other months include consumers who had their last day of Medicaid or CHIP coverage in that month. Beneficiaries are considered to have left Medicaid or CHIP coverage if they have a gap in Medicaid or CHIP enrollment of at least 31 days or a full month within a state, or if they have left Medicaid or CHIP coverage in one state but have coverage through a different source with no break in coverage. • The consumer must have either 1) been sent by a state Medicaid or CHIP via secure electronic file to the HealthCare.gov Marketplace in a process referred to as an inbound account transfer either 2 months before or 4 months after they left Medicaid or CHIP, or 2) submitted a HealthCare.gov application on or after March 6, 2023.[1] • The consumer must link to enrollment records in TAF based on their SSN. In addition, consumers with an inbound account transfer can be linked based on their Medicaid or CHIP member number. Consumers who cannot be linked to a TAF enrollment record are not included in the population.
Account transfer consumers whose Medicaid or CHIP coverage was terminated	This subpopulation is limited to consumers who were sent by a state Medicaid or CHIP agency via secure electronic file to the HealthCare.gov Marketplace in a process referred to as an inbound account transfer either 2 months before or 4 months after they left Medicaid or CHIP.
Marketplace consumers not on account transfer whose Medicaid or CHIP coverage was terminated	This subpopulation is limited to consumers who applied at the HealthCare.gov Marketplace but were not sent by a state Medicaid or CHIP agency via secure electronic file to the HealthCare.gov Marketplace in a process referred to as an inbound account transfer either 2 months before or 4 months after they left Medicaid or CHIP.
Measures calculated for the populations	
Account transfer consumers who did not submit a Marketplace application	The subset of consumers who did not apply at the HealthCare.gov Marketplace but were sent by a state Medicaid or CHIP agency via secure electronic file to the HealthCare.gov Marketplace in a process referred to as an inbound account transfer either 2 months before or 4 months after they left Medicaid or CHIP. This measure is not calculated for the subpopulation of Marketplace consumers not on account transfer whose Medicaid or CHIP coverage was terminated.

Metric	Definition and calculation
Consumers who applied for Marketplace coverage and were determined or assessed Medicaid/CHIP-eligible or potential Medicaid/CHIP-eligible	The subset of unique consumers from each population above who were determined or assessed by the HealthCare.gov Marketplace as eligible or potentially eligible for Medicaid/CHIP and whose accounts were sent to the state Medicaid agency. These individuals do not receive a determination of QHP eligibility. The HealthCare.gov Marketplace eligibility process determined or assessed that the consumer was eligible or potentially eligible for Medicaid or CHIP and therefore not eligible for a QHP through the Marketplace. Determinations or assessments reflect each consumer's status based on the latest HealthCare.gov data included in the report.
Consumers who applied for Marketplace coverage and were determined QHP-eligible	The subset of unique consumers from each population above whom the HealthCare.gov Marketplace determined as eligible for a QHP.[2] The HealthCare.gov Marketplace eligibility process determined the consumer was eligible for a QHP through the Marketplace. Determinations reflect each consumer's status based on the latest HealthCare.gov data included in the report.
Consumers who applied for Marketplace coverage and were determined QHP-eligible: Eligible for Advance Premium Tax Credit (APTC)	The subset of unique consumers from each population above whom the HealthCare.gov Marketplace determined to be eligible for a QHP (above) and who were also determined eligible for financial assistance in the form of APTC.[3] Determinations reflect each consumer's status based on the latest HealthCare.gov data included in the report.
Consumers who applied for Marketplace coverage and were determined QHP-eligible: Not eligible for APTC	The subset of unique consumers from each population above whom the HealthCare.gov Marketplace determined to be eligible for a QHP (above) but who were determined not to be eligible for financial assistance in the form of APTC.[3] Determinations reflect each consumer's status based on the latest HealthCare.gov data included in the report. Consumers are counted in this metric if they are eligible for $0 APTC. As described in 45 CFR 155.305(f) and 26 CFR 1.36B, the maximum household APTC equals the APTC-eligible family members' benchmark plan premium minus the required household contribution, which is based on the household's expected income as a percent of the federal poverty level and an applicable percentage the IRS determines annually. A household is eligible for $0 APTC if their required household contribution is higher than their benchmark plan premium.
Consumers with a QHP selection	The subset of unique consumers from each population above whom the HealthCare.gov Marketplace determined to be eligible for a QHP (above) and who have a QHP selection as of the latest HealthCare.gov data included in the report. Plan selections counted in this metric include consumers with a non-cancelled medical policy with an end date after their Medicaid or CHIP disenrollment date as of the most recent available data. The plan selections do not necessarily occur in the same month as the month the individual submitted an application or received a determination of QHP eligibility. Plan selections only become effectuated coverage for consumers who pay their first monthly premium. Plan selections that are not effectuated are cancelled. QHP issuers are responsible for collecting payments and sending cancellations to the HealthCare.gov Marketplace; the HealthCare.gov Marketplace data reflects cancellations only after reconciling data with issuers.

[1] The data used to produce the metrics are organized by week, running from Monday to the following Sunday. As a result, reporting months start on the first Monday of the month and end on the first Sunday of the next month when the last day of the reporting month is not a Sunday. For example, the April 2023 reporting period extends from Monday, April 3 through Sunday, April 30.

[2] The count/percent of consumers who were determined or assessed potentially Medicaid/CHIP-eligible and who were determined QHP eligible will not sum to the total number of consumers due to individuals determined ineligible for Medicaid, CHIP, and QHP coverage.

[3] States with Marketplaces using the Federal eligibility and enrollment platform may choose to be either a Medicaid/CHIP assessment or Medicaid/CHIP determination state. In assessment states, the HealthCare.gov Marketplace makes an initial assessment of Medicaid and CHIP eligibility based on MAGI, and the state's Medicaid or CHIP agency makes the final determination of Medicaid or CHIP eligibility. In determination states, the HealthCare.gov Marketplace makes the final MAGI-based Medicaid and CHIP eligibility determination and transmits eligible applications to the state's Medicaid or CHIP agency.

Table 6. Definitions and Methodology for Metrics in the Marketplace Medicaid Unwinding Report – SBM Data

Metric	Definition and calculation
Population included in the report	
Marketplace consumers who had a Medicaid or CHIP coverage denial or termination following renewal	Individuals whose Medicaid or CHIP coverage was denied or terminated following a renewal process. This includes consumers on applications received through an integrated Medicaid, CHIP, and Marketplace eligibility system; on account transfers and/or applications received from the Medicaid or CHIP agency in states with non-integrated systems; and on applications the consumer submitted to the Marketplace that are matched to Medicaid or CHIP data or on which the consumer attests to Medicaid or CHIP loss. The population may include certain consumers whose Medicaid or CHIP coverage was terminated due to procedural reasons. The monthly Marketplace Medicaid Unwinding Report only includes consumer data from those SBMs that have Marketplace activities initiated through a Medicaid/CHIP renewal, in which a consumer was determined ineligible for limited or full benefit Medicaid or CHIP, during the relevant reporting period. Depending on a state's Medicaid unwinding period and renewal processing timeline, not all SBMs will have applicable Marketplace activities in the first several months of reporting. SBMs report on all applicable applications received and is not based on the Medicaid/CHIP-defined cohorts of individuals whose renewal is due in given month. See the Marketplace Medicaid Unwinding Report for additional information. The data are not cumulative and count unique Marketplace activities during the reporting period month in which the relevant activity occurs. As such, activities by any one consumer may be included across reporting months. For example, a consumer who submits an application and receives a determination of QHP eligibility may be counted in one month, but their plan selection may be counted in a later month. Updated applications in a reporting month are only counted once. Consumers submitting an updated application in a following month may be counted again in that applicable month if the consumer obtains a new Medicaid/CHIP renewal.
Measures calculated for the population	
Total consumers on account transfers received by an SBM who had a Medicaid or CHIP coverage denial or termination following renewal	The number of consumers on account transfers received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process. This metric only counts account transfers in which the information transferred is not considered a complete application. An account transfer that becomes a complete application within the same reporting month will also be counted in the application metric, although some SBMs will only count it in the application metric. This metric is not cumulative and includes only account transfers received in the reporting month. This metric only applies to non-integrated SBMs that receive incomplete applications through an account transfer process from Medicaid or CHIP.
Total consumers applying for coverage on a Marketplace application who had a Medicaid or CHIP coverage denial or termination following renewal	The number of consumers on submitted applications received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process. This metric is not cumulative and includes only applications received in the reporting month.

Metric	Definition and calculation
Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and were determined QHP-eligible	Individuals on submitted applications received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who were determined eligible for enrollment in a Marketplace medical plan, regardless of whether they applied for or are eligible for financial assistance. This metric is not cumulative and includes only eligibility determinations made in the reporting month.
Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and were determined QHP-eligible with financial assistance	Individuals on submitted applications received by a Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who were determined eligible for enrollment in a Marketplace medical plan and eligible to receive APTC and/or CSRs. This metric is not cumulative and includes only eligibility determinations made in the reporting month.
Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and made a QHP selection	Individuals on submitted applications received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who applied for and were determined eligible for a QHP and selected or were automatically enrolled in a Marketplace medical plan. This metric is not cumulative and includes only non-cancelled QHP selections made in the reporting month.
Consumers with a Medicaid or CHIP coverage denial or termination following renewal who applied for Marketplace coverage and made an automatic QHP selection	Individuals on submitted applications received by a Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who were automatically enrolled into a Marketplace medical plan. This metric only applies to SBMs that make automatic plan assignments for individuals on applications received by the Marketplace. Consumers are provided with options for opting in or opting out, dependent on the SBM, of the plan selection. This metric is not cumulative and includes only automatic QHP selections made in the reporting month.
Consumers with a Medicaid or CHIP coverage denial or termination following renewal who were determined BHP-eligible	Individuals on submitted applications received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who were determined eligible for coverage through a BHP. This metric only applies to SBMs that offer BHP plans. This metric is not cumulative and includes only eligibility determinations made in the reporting month.
Consumers with a Medicaid or CHIP coverage denial or termination following renewal with a BHP enrollment	Individuals on submitted applications received by the Marketplace whose Medicaid or CHIP coverage was denied or terminated following a renewal process and who applied for and were determined eligible for coverage and enrolled in a BHP. This metric only applies to SBMs that offer BHP plans. This metric is not cumulative and includes only BHP enrollments made in the reporting month.