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

Updated October 2023

Version 3

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I. Introduction

A. What's new?

This version of the Medicaid and Children's Health Insurance Program Eligibility and Enrollment Data Specifications for Reporting During Unwinding contains two categories of updates:

1. Revisions to previously existing sections to reflect changes due to recently enacted legislation and to incorporate clarifications previously provided informally or in one-on-one technical assistance with states; and
2. A new section, Section IV, with details on how and when states will report the outcomes of previously pending renewals.

For additional details on the specific changes, please see Section V for the Change Log.

B. Background

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. This document provides information on how states report data to CMS about activities related to eligibility redeterminations.

C. About the submission

1. What types of data are being reported?

CMS requires states[2] to report on specific metrics described in the "Unwinding Eligibility and Enrollment Data Reporting Template" (Unwinding Data Report). These metrics are designed to demonstrate a state's progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees. The remainder of this document specifies the metrics and their definitions.

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

States completed a one-time baseline report and are submitting subsequent monthly reports.

[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/sites/default/files/2023-06/fmap-rdctn-repot-medcid-chip-agncs-06302023.pdf.

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

- The baseline report was due by the 8th calendar day of the month in which a state began its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states were allowed to submit by the next business day.
- The monthly report is due by the 8th calendar day of each month. The first monthly report was due by the 8th of the month following the month in which the state began its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.

3. How will the data be submitted?

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

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

States may make corrections to either report (baseline or monthly report) using the same link at which the data was originally submitted. In cases where states are making corrections to their data, CMS requests that states provide information about the reason for the change in the notes section of the metric to support CMS review and interpretation of the data.

States should report on renewals initiated (metric 4) and each renewal disposition (metric 5 and its submetrics) as of the last day of the reporting period. For example, the data included in the June 2023 report should only include renewals initiated in June 2023 and renewal outcomes as of June 30, 2023 for those renewals due in June 2023. States should not make corrections to reflect work completed after the last day of the month of the reporting period.

5. How can questions about data be answered?

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

- States can access help at any time by emailing UnwindingMetricsTA@mathematica-mpr.com.
- For an orientation to the SDIS portal, the unwinding data submission requirements and the metrics, states can review the following materials released in April 2022:
  - Slides: https://www.medicaid.gov/sites/default/files/2022-04/unwinding-data-training-slides.pdf
  - Webinar Recording: https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-learning-collaborative-webinar.mp4

II. Data Specifications: Unwinding Baseline Report

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

Table 1. Summary of Unwinding Baseline Period Reporting Specifications

What is the baseline report?	The baseline report is meant to serve as a starting point to track a state's pending eligibility and enrollment actions that the state will need to address when the state begins its unwinding period. States will be required to report summary data on pending applications, renewals, and fair hearings. States will report Medicaid and CHIP data in this report.[3] Data will **not** be reported separately by program.
How do I submit it?	States will log on to https://sdis.medicaid.gov/user/login to submit their data.
When is it due?	By the 8th calendar day of the month in which a state begins its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.
What if, after submission, I need to change or update data previously reported?	States will be able to update the baseline report at the same link, https://sdis.medicaid.gov/user/login, if they later discover they made a mistake, or if they did not have all of the data they needed to complete the form when it was initially submitted.
What if I have questions not answered in these instructions?	If the state has questions while completing the baseline report, please email the technical assistance help desk at UnwindingMetricsTA@mathematica-mpr.com.

A. Baseline Report Metric Specifications

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

- **Submission Date.** This field will be auto populated with the current date, in the format MM/DD/YYYY. It is due by the 8th calendar day of the month in which a state begins its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.
- **Unwinding Period Start Date.** States will enter the month in which their unwinding period begins in the format MM/YYYY.

1. Baseline Report Metric 1: Application Processing

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

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

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

Metric 1: Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period	
How is the metric defined?	• This metric includes: – All applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. – All applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is the sum of metrics 1a and 1b. • This metric can be reported at the individual or household level.
What is excluded from this metric?	• Applications that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
What is included in the Metric 1 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 1, 1a, or 1b. • If a state reports the application processing metrics at the household level, please note that in the free-text field so that CMS is aware. • This field should be left blank if the state has nothing additional to report.
Metric 1a: Pending MAGI and other non-disability applications	
How is the metric defined?	• This metric includes: – All MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. – All MAGI and other non-disability related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). • This metric is a subset of metric 1. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 1.
What is excluded from this metric?	• Applications for individuals seeking coverage on a MAGI or other non-disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
Metric 1b: Pending disability-related applications	
How is the metric defined?	• This metric includes: – All disability-related applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. ○ All disability-related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). A disability-related application is an application for which the state must make a determination of disability to determine the applicant's eligibility. Disability-related applications are subject to the 90-day timeliness standard at 42 CFR § 435.912(c)(3)(i). • This metric is a subset of metric 1. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 1.

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

2. Baseline Report Metric 2: Renewals

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

Table 3: Baseline Metric 2

Metric 2: Total beneficiaries enrolled as of the end of the month prior to the state's unwinding period	
How is the metric defined?	• This metric includes a count of all beneficiaries or "total caseload," including those receiving full and limited benefits, enrolled in Medicaid or CHIP as of the end of the month prior to the state's unwinding period. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Individuals who applied for Medicaid but have not had an eligibility determination completed because they were granted a reasonable opportunity period consistent with 435.956(b) because their citizenship or immigration status was not verified and who remained enrolled as authorized by section 6008 of the FFCRA in order to claim enhanced temporary FMAP.
What is included in the Metric 2 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • This field should be left blank if the state has nothing additional to report.

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

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

Table 4: Baseline Metric 3

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

4. Baseline Report Metric 4: Medicaid Fair Hearings

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

Table 5: Baseline Metric 4

Metric 4: Total number of Medicaid fair hearings pending more than 90 days at the end of the month prior to the state's unwinding period	
How is the metric defined?	• This metric includes: – All pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 431.224(a), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 431.221(a)(1) as of the end of the month prior to the state's unwinding period. – All pending fair hearings for which the state has not taken action within 90 days from the date the enrollee filed a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) appeal, not including the number of days the enrollee took to subsequently file for a Medicaid fair hearing. – All pending Medicaid fair hearings governed by the rules at 42 CFR part 431 subpart E, not just fair hearings related to eligibility determinations. – For states utilizing Medicaid expansion CHIP, all pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 457.1160(a) or 42 C.F.R. § 457.1260(f), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 457.1130(a) as of the end of the month prior to the state's unwinding period.
What is excluded from this metric?	• Fair hearings for which a final fair hearing decision was issued and a state has taken final administrative action in accordance with 42 CFR 431.244(f). A final fair hearing decision may include a dismissal of the fair hearing request. • Appeals still pending with the managed care plan which have not yet proceeded to a state fair hearing governed by the rules at 42 CFR part 431 subpart E. • Separate CHIP review data.
What is included in the Metric 4 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. For example, please specify if the state is not able to report solely Medicaid fair hearings data and has included separate CHIP reviews in the reported information. • This field should be left blank if the state has nothing additional to report.

III. Data Specifications: Unwinding Monthly Report

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

Table 6: Summary of Unwinding Monthly Period Reporting Specifications

What is the monthly report?	The monthly report is designed to support CMS in tracking the state's progress in addressing pending eligibility and enrollment actions when the state's unwinding period begins. States will be required to report summary data on pending and completed applications and renewals and pending fair hearings. States will report Medicaid and CHIP data in this report.[4] Data will **not** be reported separately by program.
How do I submit it?	States will log on to https://sdis.medicaid.gov/user/login.
When is it due?	By the 8th calendar day of the month following the reporting period. The first monthly report will be due by the 8th of the month following the month in which the state begins its unwinding period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.
What if, after submission, I need to change or update data previously reported?	States will be able to update the monthly report at the same link, https://sdis.medicaid.gov/user/login, if they later discover they made a mistake, or if they did not have all of the data they needed to complete the form when it was initially submitted.
What if I have questions not answered in these instructions?	If the state has questions while completing the monthly report, please email the technical assistance help desk at UnwindingMetricsTA@mathematica-mpr.com.

A. Monthly Report Metric Specifications

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

- **Submission Date.** This field will be auto populated with the current date, in the format MM/DD/YYYY. It is due by the 8th day of the month following the reporting period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.

1. Monthly Report Metrics 1-3: Application Processing

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

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

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

Metric 1: Total pending applications received between March 1, 2020 and the end of the month prior to the state's unwinding period	

How is the metric defined?	• This metric includes:
	  • All applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally-Facilitated Marketplace or a State-Based Marketplace.
	  • All applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person).
	• This metric is the sum of metrics 1a and 1b.
	• This metric is a restatement of metric 1 in the baseline report. If a state identifies pending applications that were previously unaccounted for in the baseline report, that state should include those in this metric along with updating the baseline report.
	• This metric can be reported at the individual or household level as long as reporting is consistent across application processing metrics and reporting periods.

What is excluded from this metric?	• Applications that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.
What is included in the Metric 1 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 1, 1a, or 1b. • If a state reports the application processing metrics at the household level, please note that in the free-text field so that CMS is aware. • This field should be left blank if the state has nothing additional to report.
Metric 1a: Total MAGI and other non-disability applications	

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

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

Metric 1b: Total disability-related applications	
How is the metric defined?	• This metric includes: – All disability-related applications received by the Medicaid and CHIP state agency between March 1, 2020 and the end of the month prior to the state's unwinding period for which a final eligibility determination has not been made. This includes applications received directly by the state and accounts transferred from the Federally Facilitated Marketplace or a State-Based Marketplace. o All disability-related applications received during the timeframe outlined above should be counted, regardless of the modality used for submission as described at 42 C.F.R. §435.907 (e.g., online, by phone, by mail, or in person). A disability-related application is an application for which the state must make a determination of disability to determine the applicant's eligibility. Disability-related applications are subject to the 90-day timeliness standard at 42 CFR § 435.912(c)(3)(i). • This metric is a subset of metric 1. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 1.
What is excluded from this metric?	• Applications for individuals seeking coverage on a disability related basis that were received and completed (i.e., a final eligibility determination was made) before the state begins its unwinding period. • Applications received during the unwinding period.

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

Metric 2: Of those applications included in Monthly Metric 1, the total number of applications completed as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of applications counted in Monthly Metric 1 that have been completed as of the last day in the reporting period covered by this report. • A completed application is one in which a final eligibility determination has been made. • This metric is the sum of metrics 2a and 2b. • This metric can be reported at the individual or household level, as long as reporting is consistent across application processing metrics and reporting periods.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.
What is included in the Metric 2 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 2, 2a, or 2b. • If a state reports the application processing metrics at the household level, please note that in the free-text field so that CMS is aware. • This field should be left blank if the state has nothing additional to report.
Metric 2a: Completed MAGI and other non-disability related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of MAGI and other non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) counted in Monthly Metric 1a that have been completed as of the last day in the reporting period covered by this report. • A completed application is one in which a final eligibility determination has been made and the state has either enrolled an eligible applicant or denied coverage for an individual the agency could not determine to be eligible as of the last day of the reporting period. • This metric is a subset of metric 2. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 2.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.

Metric 2b: Completed disability-related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of disability-related applications counted in Monthly Metric 1b that have been completed as of the last day in the reporting period covered by this report. A disability-related application is an application for which the state must make a determination of disability to determine the applicant's eligibility. Disability-related applications are subject to the 90-day timeliness standard at 42 CFR § 435.912(c)(3)(i). • A completed application is one in which a final eligibility determination has been made and the state has either enrolled an eligible applicant or denied coverage for an individual the agency could not determine to be eligible as of the last day of the reporting period. • This metric is a subset of metric 2. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 2.
What is excluded from this metric?	Applications that have not been completed by the last day of the reporting period covered by this report.

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

Metric 3: Of those applications included in Monthly Metric 1, the total number of applications that remain pending as of the last day of the reporting period	
How is the metric defined?	• This is defined as the **cumulative number** of applications included in Monthly Metric 1 for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of applications that remain pending at the end of the reporting period. • This metric is the sum of metrics 3a and 3b**.** • This metric can be reported at the individual of household level as long as reporting is consistent across application processing metrics and reporting periods. • Once the state has reached a final determination for all pending applications (reported in Monthly Metric 1), states should populate "0" for this metric because no applications remain pending. After a state has completed the processing of all pending applications, no further reporting of application metrics (Month Metrics 1, 2 and 3 and submetrics) is required.
What is excluded from this metric?	Applications completed as of the last day of the reporting period.
What do states include in the Metric 3 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 3, 3a, or 3b. • If a state reports the application processing metrics at the household level, please note that in the free-text field so that CMS is aware. • This field should be left blank if the state has nothing additional to report.
Metric 3a: Pending MAGI and other non-disability applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the cumulative number of MAGI and non-disability related applications (e.g., individuals determined on the basis of being age 65 or older) included in Monthly Metric 1a for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of MAGI and non-disability related applications that remain pending at the end of the reporting period. • This metric is a subset of metric 3. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 3.
What is excluded from this metric?	MAGI and non-disability related applications completed as of the last day of the reporting period.

Metric 3b: Pending disability-related applications as of the last day of the reporting period	
How is the metric defined?	• This is defined as the cumulative number of disability-related applications counted in Monthly Metric 1b for which a final eligibility determination has not been made as of the last day of the reporting period. It represents the remaining balance of disability-related applications that remain pending at the end of the reporting period. A disability-related application is an application for which the state must make a determination of disability to determine the applicant's eligibility. Disability-related applications are subject to the 90-day timeliness standard at 42 CFR § 435.912(c)(3)(i). • This metric is a subset of metric 3. • This metric can be reported at the individual or household level and should correspond to how the state reported Metric 3.
What is excluded from this metric?	Disability-related applications completed as of the last day of the reporting period.

2. Monthly Report Metric 4: Renewals Initiated

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

Table 10: Monthly Metric 4

Metric 4: Total beneficiaries for whom a renewal was initiated in the reporting period	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with a renewal that was initiated between the first and last day of the reporting period. • A renewal is considered "initiated" when a state first begins the *ex parte* process, which is typically when a state begins to check reliable data sources and other available information to renew eligibility based on such reliable and available information. • If a state has a mitigation in place to address *ex parte* renewals, a renewal is initiated based on how the state begins the renewal process under such mitigation (typically when a form is sent). Regardless of how a state expects the renewal process to end, states should report in this metric **all** beneficiaries for whom the state began the renewal process in the reporting period. • **This metric is not cumulative** and should only include data on renewals initiated in the reporting period. • This metric must be reported at the individual level, not the household level.
What is excluded from this metric?	Renewals that were initiated in prior reporting periods as well as those that have not been initiated yet.
What do states include in the Metric 4 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

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

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

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

Metric 5: Total beneficiaries due for a renewal in the reporting period	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with a renewal due, or scheduled for completion, in the reporting period. A renewal is considered due in the month that aligns with the last day of coverage for a cohort (regardless of when the renewal is initiated), **not** the first date that bulk terminations are effective. – For example, a beneficiary who is determined ineligible and whose last day of coverage is June 30, 2023 is considered to have a renewal due in the June reporting period. • **This metric is not cumulative** and should only include data on renewals due in the reporting period, representing beneficiaries whose renewal processes were initiated in a prior month, based on the state's renewal policy. In this context, which renewals are "due" relate to what the state reported in baseline metric 3 (state's timeline for the renewal process). For example, if a state initiated a batch of renewals on March 15th and noted a timeline of 75 days for the renewal process, CMS would consider that batch of renewals "due" at the end of May. • Note: When a state has no renewals due in a reporting period, the state may leave this field blank and include a data note. • This metric is the sum of metrics 5a, 5b, 5c, and 5d. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Renewals that have been initiated but are not due in the reporting period and renewals that have not been initiated.
What do states include in the Metric 5 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.
Metric 5a: Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP at the end of the reporting period. • **This metric is not cumulative** and should only include those beneficiaries renewed and retained in the reporting period. • This metric is a subset of metric 5. • This metric is the sum of metrics 5a(1) and 5a(2). • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Any beneficiary whose renewal was due in the reporting period but their eligibility was not retained in Medicaid or CHIP at the end of the reporting period.
What do states include in the Metric 5a Notes free text field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 5a, 5a(1), or 5a(2).

Metric 5a(1): Number of beneficiaries renewed on an *ex parte*[5] basis	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period on an *ex parte* basis, meaning eligibility was redetermined based on information available to the agency without requiring additional information from the individual. • **This metric is not cumulative;** states will only report on those beneficiaries that were renewed on an *ex parte* basis in the reporting period. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Any beneficiary not renewed through *ex parte* processes whose renewal was due in the reporting period.
Metric 5a(2): Number of beneficiaries renewed using a renewal form	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period using a renewal form. • Some states have an approved mitigation to check and use data sources to renew coverage if they are able to do so after a beneficiary was sent a renewal form, regardless of whether the form was returned. This is referred to as a "back-end *ex parte* renewal." States should include any individuals who were renewed with this mitigation strategy in this metric. • **This metric is not cumulative**; states will only report on those beneficiaries that were renewed using a renewal form in the reporting period. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Any beneficiary not renewed through use of a form in the reporting period.
Metric 5b: Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period and who were determined ineligible for Medicaid or CHIP. This includes all individuals for whom the state has sufficient information to make a determination of ineligibility. • **This metric is not cumulative** and should only include data on beneficiaries determined ineligible for Medicaid or CHIP in the reporting period. • Individuals who request voluntary termination or closure *after* their renewal is initiated should be counted in this metric. Individuals the state verifies as being deceased or no longer a state resident during the renewal process should also be counted in this metric. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Any beneficiary who remained eligible for Medicaid or CHIP coverage, any beneficiary the state redetermines as ineligible based on a change in circumstances in between regular renewals, and any beneficiary who requested voluntary closure *prior* to the initiation of their renewal.
What do states include in the Metric 5b Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

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

Metric 5c: Of the beneficiaries included in Metric 5, the number terminated for procedural reasons (i.e., failure to respond)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period and whose coverage ended because the state has insufficient information to complete an eligibility determination, also known as procedural reasons. • Procedural reasons include instances where a beneficiary fails to return the renewal form or other information necessary to complete a Medicaid or CHIP renewal. • **This metric is not cumulative** and should only include data on beneficiaries whose renewal is due and were terminated from Medicaid or CHIP for procedural reasons in the reporting period. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary who was not terminated for procedural reasons in the reporting period, which includes: – (1) any beneficiary who the state determined ineligible, or verified at renewal as deceased or no longer a state resident; – (2) any beneficiary who was terminated for failure to respond to a request for information related to a change in circumstances in between regular renewals; and – (3) any beneficiary the state would have terminated for a procedural reason, except the termination was not effectuated because of a state's mitigation plan or adoption of strategies that allow the state to hold procedural terminations.
What do states include in the Metric 5c Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.
Metric 5d: Of the beneficiaries included in Metric 5, the number whose renewal was not completed	
How is the metric defined?	• This is defined as the total number of renewals for beneficiaries, including those receiving full or limited benefits, that were due in the reporting period that were not completed or a final eligibility determination had not been made as of the end of the reporting period, also known as "pending renewals." • If the state is holding procedural terminations in a particular month(s), the state should include the beneficiaries whose renewal was due but who are not being procedurally terminated during the reporting period in this metric. • Individuals who were sent advance notice of termination for failure to return their form but return their renewal form before their coverage is terminated should also be reported in this metric. • **This metric is not cumulative** and should only include data on incomplete renewals, including those for whom procedural terminations were held, that were due in the reporting period. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary whose renewal was completed. • Any beneficiary the state has not initiated a renewal regardless of the month the individual's renewal is due.
What do states include in the Metric 5d Notes?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • If the state is holding procedural terminations, please include a note for the relevant month and, if possible, include the number of affected individuals.

Table 12: Monthly Metric 6

Metric 6: Month in which renewals due in the reporting period were initiated	
How is the metric defined?	States will expand a drop-down menu and select the month in which the renewals that were due in the reporting period covered by the report were initiated; this should be based on the state's timeline for the renewal process reported in Baseline Metric 3.

What do states include in the Metric 6 Notes?	• If a state initiates a cohort due in a particular month across multiple months, please include those months in the notes. The portal only permits states to select a single month via the drop-down, however, states can add additional months in the notes. • If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 13: Monthly Metric 7

Metric 7: Number of beneficiaries due for a renewal since the beginning of the state's unwinding period whose renewal has not yet been completed	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, due for renewal whose renewal has been initiated but not been fully processed. This is commonly referred to as the backlog, representing all renewals that have been initiated since a state's unwinding period began and scheduled for completion, but are not complete as of the end of the reporting period. • States that are holding procedural terminations should report the beneficiaries whose renewal was due but for whom the state is holding the procedural termination in this metric until these renewals reach a final disposition. • **This metric is cumulative;** it counts all renewals that have been initiated since the beginning of the state's unwinding period and were due prior to or as of the last day of the reporting period covered by this report (per the state's timeline for the renewal process), but whose renewals were not fully processed as of the last day in the reporting period. • States should be cautious of simply adding the numbers previously reported in 5d, as doing so would not reflect renewals that may have been completed after the month in which it was due. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	All renewals that have been completed, and any renewals the state has not initiated, regardless of when the renewal is due.
What do states include in the Metric 7 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • If the state is holding procedural terminations, please include a note for the relevant month and if possible, include the number of affected individuals.

4. Monthly Report Metric 8: Medicaid Fair Hearings

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

Table 14: Monthly Metric 8

Metric 8: Total number of Medicaid fair hearings pending more than 90 days at the end of the reporting period	
How is the metric defined?	• This metric includes: – All pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 431.224(a), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 431.221(a)(1) as of the end of the reporting period. – All pending fair hearings for which the state has not taken action within 90 days from the date the enrollee filed a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing. – This includes Medicaid fair hearing requests received both before and after the end of the continuous enrollment condition. – All pending Medicaid fair hearings governed by the rules at 42 CFR part 431 subpart E, not just fair hearings related to eligibility determinations. – For states utilizing Medicaid expansion CHIP, all pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 457.1160(a) or 42 C.F.R. § 457.1260(f), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 457.1130(a) as of the end of the reporting period.
What is excluded from this metric?	• Fair hearings for which a final fair hearing decision was issued and a state has taken final administrative action in accordance with 42 CFR 431.244(f). A final fair hearing decision may include a dismissal of the fair hearing request. • Appeals still pending with the managed care plan which have not yet proceeded to a State fair hearing governed by the rules at 42 CFR part 431 subpart E. • Separate CHIP review data.
What do states include in the Metric 8 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. For example, please specify if the state is not able to report solely Medicaid fair hearings data and has included separate CHIP reviews in the reported information. • This field should be left blank if the state has nothing additional to report.

IV. Reporting Outcomes of Previously Pending Renewals

A. Introduction

As states process renewals during the unwinding period, states may not always complete renewals by the renewal due date. These renewals are considered "pending" renewals and are reported in submetric 5d of the monthly renewal report described above. Renewals may be pending by the end of the month for various reasons including, but not limited to: beneficiaries returning renewal forms late in the renewal process, the state holding procedural terminations or other terminations, or the state carrying a backlog of unprocessed renewals.

To understand the disposition of renewals that are initially reported as pending, CMS is revising the reporting requirements to collect these data. Subsections B and C outline the revised reporting requirements.

B. Reporting Schedule

States will provide the updated monthly report with the outcomes of previously pending renewals by the 15th of the month in accordance with the schedule in Table 15 below. For example, the update for the September 2023 monthly report (originally submitted August 8th, 2023) is due to CMS on January 15, 2024. The update will reflect the final disposition of renewals previously reported as pending, as of December 31, 2023.

Table 15 below outlines the reporting schedule for unwinding data reports to collect the outcomes of previously pending renewals.

- Column 1 represents the original monthly report and Column 2 provides the due date of each report.
- Each updated monthly report will contain the dispositions of pending renewals reflected "as of" three full months following the applicable reporting period, as shown in Column 3.
- Lastly, Column 4 provides the due date for each updated report. Should the 15th calendar day fall on a weekend or holiday, states may submit by the next business day.

Please note that states will submit an updated report for March, April, May, June, July, and August 2023 by December 29, 2023; however, each month's data are reflected as of three months after the original reporting period.

Table 15: Timeline for Updating Monthly Reports with Outcomes of Previously Pending Renewals[6]

Column 1	Column 2	Column 3	Column 4
Monthly report	**Original data report due date**	**Updated data report "as of date" for previously pending renewals**	**Updated data report due to CMS**
March (2023)	April 8 (2023)	June 30 (2023)	No later than December 29, 2023
April	May 8	July 31	
May	June 8	August 31	
June	July 8	September 30	
July	August 8	October 31	
August	September 8	November 30	

[6] CMS will provide additional instructions to states for any required reporting after July 2024.

Column 1	Column 2	Column 3	Column 4
Monthly report	**Original data report due date**	**Updated data report "as of date" for previously pending renewals**	**Updated data report due to CMS**
September	October 8	December 31	January 15, 2024
October	November 8	January 31 (2024)	February 15, 2024
November	December 8	February 29	March 15, 2024
December	January 8 (2024)	March 31	April 15, 2024
January (2024)	February 8	April 30	May 15, 2024
February	March 8	May 31	June 15, 2024
March	April 8	June 30	July 15, 2024
April	May 8	July 31	August 15, 2024
May	June 8	August 31	September 15, 2024
June	July 8	September 30	October 15, 2024

C. Specifications for Reporting Outcomes of Previously Pending Renewals

1. What data are being updated?

States will continue to report the monthly metrics, as outlined in Section III above. In addition, for each monthly report, states will update the monthly metric 5 and its submetrics (monthly metrics 5a, 5a(1), 5a(2), 5b, 5c, and 5d), as needed, to reflect the outcomes of renewals previously reported as pending (monthly metric 5d of the original monthly report). As a reminder, metric 5 represents the total number of beneficiaries due for renewal in the reporting period, and the submetrics (5a, 5a(1), 5a(2), 5b, 5c, and 5d) represent the dispositions of those renewals. The submetrics are as follows:

- 5a, total beneficiaries renewed and retained in Medicaid and CHIP
- 5a(1), total beneficiaries renewed on an ex parte basis
- 5a(2), total beneficiaries renewed using a renewal form
- 5b, total beneficiaries determined ineligible for Medicaid or CHIP
- 5c, total beneficiaries who were terminated for procedural reasons
- 5d, total beneficiaries whose renewal was not completed ("pending renewals")

In updating the monthly metrics, states should report the dispositions of pending renewals as of the last day of the third month after the original reporting period. For example, when states update the July monthly report, states should report the status or disposition of previously pending renewals as of October 31. When states update the August monthly report, the state should report the status of previously pending renewals as of November 30. Please see Table 15 for a detailed reporting schedule.

Table 16 below presents an illustrative example of how CMS expects states to update prior monthly reports to incorporate the outcomes of previously pending renewals.

- **Column 2** represents the original monthly report, reflecting outcomes as of the end of the reporting period (July in this example) and showing 200 pending renewals.[7]
- **Column 3** reflects the information states need to collect – the disposition of the 200 renewals reported as pending in Column 2, as of October 31, the last day of the third month after the July reporting period. **States do not report the values shown in Column 3 to CMS.**
- **Column 4** reflects the values states will input into the data collection portal, along with the notes in Column 5.

Table 16: Illustrative Example on How to Update Prior Monthly Reports with Outcomes of Previously Pending Renewals

Column 1	Column 2	Column 3	Column 4	Column 5
Metric	**Original July Monthly Report, as submitted to CMS by August 8**	**Outcomes of 200 previously pending renewals as of October 31**	**Updated July Monthly Report, as submitted to CMS by December 29, 2023**	**Reporting Notes with Updated July Monthly Report, as submitted to CMS by December 29, 2023**
5. Renewals due	1000		1000	
5a. Number renewed and retained in Medicaid or CHIP	550	+100	650	12/29: Outcomes updated to include disposition of previously pending renewals
5a(1). Number renewed on *ex parte* basis	300	+0	300	
5a(2). Number renewed using a renewal form	250	+100	350	12/29: Outcomes updated to include disposition of previously pending renewals
5b. Number determined ineligible for Medicaid or CHIP using a renewal form	200	+50	250	12/29: Outcomes updated to include disposition of previously pending renewals
5c. Number terminated for procedural reasons	50	+50	100	12/29: Outcomes updated to include disposition of previously pending renewals
5d. Number whose renewal was not completed ("pending renewals")	200	-200	0	12/29: Outcomes updated to include disposition of previously pending renewals

[7] For states that have made corrections since the monthly report was first submitted to CMS, Column 2 will be the state's most recent submission.

2. What will the updated data include and not include?

The updates to monthly metric 5 and its submetrics will reflect the disposition of previously pending renewals (5d). Outcomes of pending renewals should be added to the appropriate outcome based on how they were adjudicated: renewed on an *ex parte* basis (5a1), renewed using a renewal form (5a2), determined ineligible for Medicaid or CHIP using a renewal form (5b), or terminated for procedural reasons (5c). Because the updates to the monthly report will report the outcomes of previously pending renewals, these outcomes should be subtracted from the data reported in the pending renewals submetric (5d) in the original monthly report. When a state submits their updated report, only renewals still pending as of the end of the last day of the third month following the end of the applicable reporting period should remain in submetric 5d.

These updates will *not* include a revised outcome for a renewal that reached a final disposition (i.e., reported in monthly metric 5a (including 5a(1) and 5a(2), 5b, or 5c)) as of the end of the original reporting period because the individual experienced a change in circumstances following the renewal. States should also not include outcomes of renewals when an individual returns a form during the reconsideration period.

3. Can states make corrections when submitting the pending renewal data?

Yes. CMS continues to advise states to make corrections in the data collection portal as soon as they are identified, even if such corrections could not be reflected in the public reporting. As part of this effort to collect the outcomes of previously pending renewals, CMS is not asking for states to re-validate previously submitted data. However, the submission of pending renewal data presents the final opportunity for states to make corrections to previously reported data. Any corrections must reflect the status of outcomes (other than those pending) as of the end of the original reporting period. CMS advises states making corrections to use the relevant notes field to provide context to CMS, as the state deems necessary.

4. Where and how will the state provide updated data?

Within the data collection portal, states will overwrite the existing data for metric 5 and its submetrics in the relevant monthly report in order to incorporate the outcomes of previously pending renewals. CMS retains all versions of previously submitted data.

The latest or most recent submission of each report is reflected in the data collection portal; therefore, states will update the most recent submission of each report to reflect the most accurate outcomes for renewals due in the original reporting period.

5. How should a state denote an updated report?

When states update data to share the outcomes of pending renewals, CMS requests that the following note be included in the notes section for metrics 5a, 5b, 5c, 5d in the reporting portal: "[Submission date of the updated report]: Outcomes updated to include disposition of previously pending renewals." Please see Column 5 of Table 16 for an example. As a reminder, the dispositions of previously reported pending renewals should reflect the disposition of the renewal as of the last day of the third month following the applicable reporting period.

D. Frequently Asked Questions

The following questions and answers pertain to the revised data reports that will include outcomes of previously pending renewals due to CMS on the 15th of the month.

1. What is the difference between an "update" and a "correction"?

- CMS is using "update" in this context to refer to changes made to a monthly report to reflect the outcomes of previously pending renewals three months after the original monthly report submission.
- CMS is using "correction" to refer to changes made to a monthly report to revise previously reported data. Such corrections should reflect the status of outcomes as of the end of the original reporting period and may include changes such as fixing typos, correcting data reported for the wrong submetric, or other inaccuracies identified.

2. Which metrics are states expected to update?

- States are only expected to update the outcome metrics: 5a, 5a(1), 5a(2), 5b, 5c, and 5d. CMS would not generally expect changes to metric 5, renewals due in the reporting period, unless the state is also reporting corrections (see question 3 below).

3. What, if anything, should states include in the notes field for updates and corrections?

- When states update data to report outcomes of previously pending renewals, CMS asks that the following be included in the notes section for metrics 5a, 5b, 5c, 5d in the reporting portal: "[Date]: Outcomes updated to include disposition of previously pending renewals."
- If the state is also making corrections, please also add to the notes for relevant metrics: "The data also reflect corrections not previously reported."

4. The state identified an issue that required reinstating coverage for beneficiaries who were reported as procedurally terminated. How should these reinstatements be reflected as a correction or an update?

- Reinstatements of coverage following a termination should not be included as a correction nor an update.

5. How should the state reflect the status of individuals who were procedurally terminated, but returned their renewal form during the reconsideration period?

- The revised reporting requirement detailed in Section IV is intended to only collect the outcomes for individuals whose renewals were previously reported as pending. Individuals who returned their renewal form during the reconsideration period would have already been terminated for procedural reasons, and thus should not be included as part of this update.
- If the state is tracking the number of individuals that return renewal forms during the reconsideration period and their outcomes, and would like to share this information with CMS, please feel free to include it in the notes field for metric 5c.

6. Should the state reflect the status of individuals who completed a renewal, but later experienced a change in circumstance?

- No. The purpose of metrics 5 (and its submetrics), 6, and 7 of the unwinding data report is to collect the outcomes for individuals' unwinding-related renewals. As such, the state should not update the status of outcomes for individuals for whom the state previously determined eligible to

reflect the result of a redetermination based on a change in circumstances that occurs after the renewal.

7. What if my state is unable to report the dispositions of previously pending renewals as described in Section IV of this document?
   - If a state is unable to fulfill these reporting requirements, please notify CMS by sending an email to UnwindingMetricsTA@mathematica-mpr.com as soon as possible for technical assistance.

V. Change Log

Table 17: Change Log

No.	Change	Date
1	Updated baseline report submission due date, consistent with COVID-19 Unwinding FAQs released by CMS in October 2022	12/2022
2	Added additional reporting guidance when submission date falls on holiday or weekend	12/2022
3	Added guidance that states should note in the free-text field if they are reporting application processing metrics at the household level	12/2022
4	Added definition of disability-related application, consistent with COVID-19 Unwinding FAQs released by CMS in October 2022	12/2022
5	Added context related to the Consolidated Appropriations Act, 2023	10/2023
6	Removed guidance around selecting “unable to report” for all metrics	10/2023
7	Added guidance around Medicaid fair hearings that should be included and excluded in the unwinding metric reports	10/2023
8	Clarified expectations around reporting metrics at the household vs. individual level	10/2023
9	Clarified guidance for metric 5b (beneficiaries determined ineligible for Medicaid or CHIP) to remove language around transfers to the Marketplace	10/2023
10	Removed “annual” from specifications for reporting Medicaid renewals initiated and outcomes	10/2023
11	Removed “prepopulated” from specifications for reporting metric 5a(2) (beneficiaries renewed using a renewal form)	10/2023
12	Added guidance for state reporting related to mitigation strategies	10/2023
13	Added Chapter IV with guidance for reporting pending renewals	10/2023