Medicaid and CHIP Eligibility and Enrollment Performance Indicators

Data Dictionary

Updated May 20, 2014

1. CALL VOLUME Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
1		Total Call Center Volume	The total number of calls received by each call center during the calendar month. The top-line total should equal the sum of the call volume at each individual call center reported.

2. CALL CENTER WAIT TIME Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
2		Average Call Center Wait Time	The average wait time in whole minutes for calls received by each call center during the calendar month. If the state tracks wait time in seconds, round increments of 0 to 29 seconds down to the nearest whole minute, and round increments of 30 to 59 seconds up to the nearest whole minute. If the average wait time is less than 29 seconds, enter 0 and provide an explanation in the data limitations field. If average wait time cannot be provided, leave this field blank (missing) and provide an explanation in the data limitations field. The top-line total should be calculated as the weighted average of each individual call center's wait time during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average wait time = call center 1 average wait time * (call center 1 volume/call center total volume) + call center 2 average wait time * (call center 2 volume/call center total volume) + call center 3 average wait time * (call center 3 volume/call center total volume)

3. ABANDONMENT RATE Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
3		Average Call Center Abandonment Rate	For each call center or helpline reported in Indicator 1, the abandonment rate equals the number of calls abandoned by caller (numerator) divided by total call volume (denominator). The acceptable range for this number is between 0 and 1, with a zero value representing 0% (no calls abandoned), a value of 0.5 representing 50% (half of calls are abandoned), and a value of one representing 100% (all calls abandoned). The top-line total should be calculated as the weighted average of each individual call center's abandonment rate during the calendar month. The weighting should be based on the call volumes reported in Indicator 1, "Total Call Center Volume." For example, if a state reported data for 3 call centers in Indicator 1, the weighted average for the call center wait time should be: Call center total average abandonment = call center 1 average abandonment rate * (call center 1 volume/call center total volume) + call center 2 average abandonment rate * (call center 2 volume/call center total volume) + call center 3 average. abandonment rate * (call center 3 volume/call center total volume)

4. THIS INDICATOR WAS WEEKLY AND HAS BEEN REMOVED

5. NUMBER OF APPLICATIONS RECEIVED Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
5a		Total Applications Received	Total number of applications received by any state agency with the authority to make Medicaid/CHIP eligibility determinations, including the Medicaid agency, a separate CHIP agency (if one exists in the state), and a state-based marketplace (if one exists in the state) during the calendar month. Applications for both MAGI and non-MAGI populations should be included. Report applications received through all doorways, including those received by a separate CHIP agency or state-based marketplace (SBM), and not just applications received directly by the Medicaid agency. Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred) Indicator 5a should equal the sum of indicators 5b, 5h, and 5n. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

5b		Applications Received by Medicaid Agency	Total number of applications received by the Medicaid agency during the calendar month, including applications for both Medicaid and CHIP (if the state does not have a separate CHIP agency). Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). Indicator 5b should equal the sum of the applications received by Medicaid Agency, by channel (indicators 5c, 5d, 5e, 5f, and 5g). Applications received via an integrated online Marketplace/Medicaid/CHIP portal should not be reported in this indicator; they should be reported in indicator 5n. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5c	Applications Received by Medicaid Agency, by Channel	Online Applications Received by Medicaid Agency	Applications received by Medicaid agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be reported. Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5d		Mail Applications Received by Medicaid Agency	Paper applications received by the Medicaid agency that the applicant mailed to the Medicaid agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5e		In-person Applications Received by Medicaid Agency	Applications that an applicant submitted in-person to a Medicaid agency or caseworker. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

5f		Phone Applications Received by Medicaid Agency	Applications that an applicant submitted to the Medicaid agency by answering questions from a call center or hotline agent. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5g		Other Applications Received by Medicaid Agency	All other applications received by the Medicaid agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications. Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

5h		Applications Received by CHIP Agency	Total number of applications received by a separate CHIP agency during the calendar month, if there is a separate CHIP agency. If the state does not have a separate CHIP agency, leave the field blank (to indicate this is non-applicable). Indicator 5h should equal the sum of applications received by CHIP Agency, by channel (indicators 5i, 5j, 5k, 5l and 5m). Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5i	Applications Received by CHIP Agency, by Channel	Online Applications Received by CHIP Agency	Applications received by separate CHIP agency that the applicant filled out and submitted through a web portal or website. Online applications that have been initiated but not yet submitted should not be reported. Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5j		Mail Applications Received by CHIP Agency	Paper applications received by the separate CHIP agency that the applicant mailed to the separate CHIP agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5k		In-person Applications Received by CHIP Agency	Applications that an applicant submitted in-person to a separate CHIP agency or caseworker. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

5l		Phone Applications Received by CHIP Agency	Applications that an applicant submitted to the separate CHIP agency by answering questions from a call center or hotline agent. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5m		Other Applications Received by CHIP Agency	All other applications received by the separate CHIP agency that cannot be classified as online, mail, in-person, or phone applications. If this is a non-zero value, the data limitations field must include an explanation describing these applications. Accounts transferred from the FFM are not included in this indicator, and should be instead be reported under indicator 6 (Number of Electronic Accounts Transferred). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
5n		Applications Received by SBM	Total number of applications requesting financial assistance that have been received by the SBM during the calendar month, including applications received via an integrated online Marketplace/Medicaid/CHIP portal. Applications not requesting financial assistance should be excluded. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

6. NUMBER OF ELECTRONIC ACCOUNTS TRANSFERRED Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
6a		Total Account Transfers Received from the FFM	Total number of accounts electronically transferred from the FFM to the Medicaid/CHIP agency during the calendar month. SBMs should not report transfers. Accounts moving between a new integrated system and a legacy system should not be included. An account is defined as the set of application and verification data necessary to make an eligibility determination for an insurance affordability program as required in §435.1200. Only electronic account transfers should be included; case referrals should not be included if an electronic account transfer is not made. This indicator should include both assessments and determinations of eligibility made by the FFM before transfer to the Medicaid/CHIP agency during the calendar month, as well as non-MAGI referrals and requests for a full Medicaid determination. This indicator should be left as blank (indicating "not applicable") for all reports until the state begins to receive FFM account transfers. Accounts in the 'flat file' should not be counted (as the accounts will be subsequently transferred through electronic account transfer). Indicator 6a may be less than the sum of indicators 6e through 6h. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
~~6b~~		~~Transfers Received from FFM~~	INDICATOR REMOVED (included in indicator 6a).
~~6c~~		~~Transfers Received from Non-Integrated SBM~~	INDICATOR REMOVED.

~~6d~~		~~Transfers Received from an Unknown Source~~	INDICATOR REMOVED.
6e	By Transfer Type	Determined Account Transfers Received	Total number of electronic accounts during the calendar month in which an individual received a final determination that they were eligible for Medicaid or CHIP from the FFM before account transfer to the state. This indicator only applies to states that have delegated responsibility to the FFM to conduct eligibility determinations ("determination" states). Accounts transfers reported in this indicator should be mutually exclusive from accounts transfers reported in 6f. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
6f		Assessed Account Transfers Received	Total number of electronic accounts transferred to the Medicaid/CHIP agency without a final determination of eligibility during the calendar month, including transfer accounts assessed as eligible by the FFM as well as those initially assessed as ineligible but for which a request for full determination was made. This indicator does not apply to states that have delegated responsibility to the FFM to conduct eligibility determinations ("determination" states) and should be left blank by these states. Accounts transfers reported in this indicator should be mutually exclusive from accounts transfers reported in 6e. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

6g		Request for Full Determination Transfers Received	The total number of electronic account transfers during the calendar month in which an individual was initially assessed as ineligible for Medicaid or CHIP, but the applicant requested a transfer to the agency for a full determination. Individuals who were assessed as eligible for Medicaid or CHIP before their account was transferred should not be included in this category. This indicator may include account transfers also counted in 6e or 6f. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
6h		Transfers of Unknown Type Received	Total number of electronic accounts transferred during the calendar month that are not captured in Indicators 6e, 6f, and 6g. If this is a non-zero value, the data limitations field must include any relevant information about the source(s) of these transfers. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
~~6i~~		~~Total Transfer Accounts Sent~~	INDICATOR REMOVED.
6j		Total Transfer Accounts Sent to FFM	Total number of accounts electronically transferred from the Medicaid/CHIP agency to the FFM during the calendar month. All SBMs should leave all fields in this section blank ("not applicable"). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
6k		Transfers to Non-Integrated SBM Systems	Total number of accounts electronically transferred from the Medicaid/CHIP agency to an SBM with a non-integrated eligibility determination system during the calendar month. Most SBMs (those with integrated eligibility systems for the SBM and Medicaid/CHIP programs) should leave this indicator blank ("not applicable"). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

7 NUMBER OF RENEWALS Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
7a		Number of Renewals up for Annual Redetermination	Total number of annual renewals that came up for redetermination by the Medicaid or CHIP agency during the calendar month. These data should include annual renewals only, and exclude beneficiaries redetermined due to a change in circumstances. All annual renewals that came up for redetermination should be included, regardless of the disposition (including pending, determined eligible, determined ineligible, and/or ineligible due to failure to return documentation). If a state has a waiver granted under section 1115 or section 1902(e)(14)(A) of the Social Security Act to delay renewals in 2013 and 2014, those renewals should be reported in the month in 2014 in which the renewal actually occurs, not in the month that the renewal would have occurred without the waiver. Indicator 7a should equal the sum of subindicators for Medicaid MAGI Renewals (7b), Medicaid non-MAGI Renewals (7c), CHIP Renewals (7d), and Renewals of Unknown Type (7e). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
7b	By Determination Type	Medicaid MAGI renewals	Total number of Medicaid (i.e. funded under Title XIX of the Social Security Act) renewals that came up for annual redetermination during the calendar month and will be redetermined under MAGI rules. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
7c		Medicaid Non-MAGI Renewals	Total number of Medicaid (i.e. funded under Title XIX of the Social Security Act) renewals that came up for annual redetermination during the calendar month and will be redetermined under non-MAGI rules. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

7d		CHIP Renewals	Total number of CHIP (i.e., funded under Title XXI of the Social Security Act, including through MCHIP programs) renewals that came up for annual redetermination during the calendar month. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
7e		Renewals of Unknown Type	Total number of renewals that came up for annual redetermination during the calendar month but cannot be classified as Medicaid MAGI, Medicaid non-MAGI, or CHIP renewals. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

8. TOTAL ENROLLMENT Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
8a		Total Medicaid Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month, including those with retroactive, conditional, and presumptive eligibility. This indicator is a point-in-time count of total program enrollment, and not solely a count of those newly enrolled during the calendar month. Include only those individuals who are eligible for comprehensive benefits (i.e., emergency Medicaid, family planning-only coverage and limited benefit dual eligible individuals should not be included). Medicaid 1115 Waiver populations should be included as long as the benefits are comprehensive. All individuals whose coverage is funded under title XXI of the Social Security Act, including through MCHIP programs are excluded from this indicator. Indicator 8a should equal the sum of Medicaid MAGI enrollees (indicator 8b) and Medicaid non-MAGI enrollees (indicator 8e). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
8b	Medicaid MAGI enrollment	Total MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month who are in an eligibility group that is subject to the MAGI determination rules. Indicator 8b should equal the sum of indicators 8c and 8d. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

8c		MAGI Child Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month who are children and who are in an eligibility group that is subject to the MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
8d		MAGI Adult Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month, who are not children, and who are in an eligibility group that is subject to the MAGI determination rules. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
8e	Medicaid non-MAGI enrollment	Total Non-MAGI Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month who are in an eligibility group that is subject to non-MAGI determination rules. Indicator 8e should equal the sum of indicators 8f and 8g. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
8f		Non-MAGI Child Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month who are children and who are in an eligibility group that is subject to non-MAGI determination rules. A state should use its definition of "child" as included in its Medicaid or CHIP state plan. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
8g		Non-MAGI Adult Enrollees	Total unduplicated number of individuals enrolled in Medicaid (i.e. funded under title XIX of the Social Security Act) as of the last day of the calendar month who are not children and who are in an eligibility group that is subject to non-MAGI determination rules. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

8h		Total CHIP Enrollees	Total unduplicated number of individuals enrolled in CHIP (i.e., funded under Title XXI of the Social Security Act, including through MCHIP programs) as of the last day of the calendar month, including those with retroactive, conditional, and presumptive eligibility. CHIP children in a premium grace period should be included, while CHIP children subject to a waiting period or premium lock-out period are considered eligible but not enrolled and should be excluded. Include only those individuals who are eligible for comprehensive benefits. This indicator is a point-in-time count of total program enrollment, and not solely a count of those newly enrolled during the calendar month. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

9. TOTAL NUMBER OF INDIVIDUALS DETERMINED ELIGIBLE Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
9a		Total Medicaid Eligible	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month. This count should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) are not included in this indicator. All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. If an individual receives a MAGI and then a non-MAGI determination, both of these separate determinations should be counted. Indicator 9a should equal the sum of indicators 9b (Medicaid MAGI Eligibility Determinations) and 9c (Medicaid Non-MAGI Eligibility Determinations). Indicator 9a should equal the sum of indicators 9d (Medicaid Eligibility Determined at Application), 9g (Medicaid Eligibility at Annual Renewal), 9h(Medicaid Eligible via Administrative Determination), and 9i (Medicaid Eligible via Other Method). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

9b	By Determination Type	Medicaid MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under MAGI rules during the calendar month. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9c		Medicaid non-MAGI Eligibility Determinations	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under non-MAGI rules during the calendar month. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

9d	By Reason for Determination	Medicaid Eligibility Determined at Application	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. Indicator 9d should equal the sum of indicators 9e (Medicaid Eligibility at Application under MAGI Rules) and 9f (Medicaid Eligibility at Application under non-MAGI Rules). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9e		Medicaid Eligibility at Application under MAGI Rules	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9f		Medicaid Eligibility at Application under non-MAGI Rules	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under non-MAGI rules during the calendar month based on applications for coverage submitted to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9g		Medicaid Eligibility Determined at Annual Renewal	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) at annual renewal under either MAGI or non-MAGI rules during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the indicator for "Medicaid Eligible via Other Method" (9i). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

9h		Medicaid Eligible via Administrative Determination	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) during the calendar month without submitting an application, under the process by which a state determines a cohort of individuals eligible through targeted enrollment strategies outlined in CMS guidance issued on May 17, 2013. This includes enrolling certain SNAP participants and parents of CHIP beneficiaries without requiring an application. Unless your state has been approved by CMS to make this type of determination, leave this field blank (not applicable). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9i		Medicaid Eligible via Other Method	Total number of individuals determined eligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under both MAGI and non-MAGI rules during the calendar month that are not captured in Indicators 9d, 9g, and 9h. This number should include redeterminations made outside of the annual renewal process (for instance, due to a self-reported change in circumstance). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9j		Total CHIP Eligible	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). All determinations made in the calendar month should be included, even if the individual will not be enrolled into the program during the calendar month or is found retroactively eligible. Include determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include determinations made on accounts assessed by the FFM and transferred to Medicaid for final determination. Do not include final eligibility determinations made by the FFM and transferred to Medicaid for enrollment. Indicator 9j should equal the sum of indicator 9k (Determined CHIP Eligible at Application), indicator 9l (Determined CHIP Eligible at Annual Renewal), and indicator 9m (All Others Determined CHIP Eligible). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

9k	By Reason for Determination	Determined CHIP Eligible at Application	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month that follows the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include accounts assessed as eligible and transferred from the FFM. Do not include accounts determined eligible by the FFM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9l		Determined CHIP Eligible at Annual Renewal	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) at annual renewal during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the indicator for "All Others Determined CHIP Eligible" (9m). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
9m		All Others Determined CHIP Eligible	Total number of individuals determined eligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month who are not captured in Indicators 9k and 9l. This includes redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

10. TOTAL NUMBER OF INDIVIDUALS DETERMINED INELIGIBLE Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
10a		Total Medicaid Ineligible	Total number of individuals determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month. This number should include determinations following an initial application as well as all redeterminations (triggered by either the annual renewal process or other change in circumstances). Include final determinations made by any state agency, including the Medicaid agency, a separate CHIP agency, and an SBM. Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. Individuals who are determined ineligible for Medicaid and ineligible for CHIP should be counted both in the number of individuals determined ineligible for Medicaid under this indicator and in the number of individuals ineligible for CHIP under indicator 10g. Individuals who request disenrollment during the calendar month should not be included in this indicator. Indicator 10a should equal the sum of indicator 10b (Ineligibility Established) and indicator 10c (Eligibility Cannot be Established). Indicator 10a should equal the sum of indicator 10d (Ineligible at Application), 10e (Ineligible at Annual Renewal), and 10f (Ineligible via Other Application Type). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

10b	By Determination Reason	Medicaid Determination – Ineligibility Established	Total number of individuals determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10c		Medicaid Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month because they failed to complete or return renewal forms or other required documentation, or who were lost to follow up. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

10d	By Type of Determination	Medicaid Determination – Ineligible at Application	Total number of individuals determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under either MAGI or non-MAGI rules during the calendar month as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10e		Medicaid Determination – Ineligible at Annual Renewal	Total number of individuals who, during the calendar month, were determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) at annual renewal under either MAGI or non-MAGI rules. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the indicator for "Medicaid Determination – Ineligible via Other Application Type" (10f). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10f		Medicaid Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for Medicaid (i.e. funded under title XIX of the Social Security Act) under both MAGI and non-MAGI rules during the calendar month who are not captured in Indicators 10d and 10e. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

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

10h	By Determination Reason	CHIP Determination – Ineligibility Established	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month based on information known to the state agency making the determination (for instance, individuals determined ineligible due to death, aging out, citizenship status, changes in household composition, or higher income). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10i		CHIP Determination – Eligibility Cannot be Established	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month because they failed to complete or return renewal forms or other required documentation, or who were lost to follow up. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10j	By Determination Type	CHIP Determination – Ineligible at Application	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month as a result of the applicant submitting an application for coverage to any state agency (Medicaid, CHIP, or the SBM). Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM Include individuals determined ineligible by a state agency after their account was assessed and transferred from the FFM. Do not include final eligibility determinations made by the FFM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
10k		CHIP Determination – Ineligible at Annual Renewal	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) at annual renewal during the calendar month. Individuals redetermined outside of the annual renewal process (for example, due to a change in circumstance) should not be reported here, as they are captured in the indicator for "CHIP Determination – Ineligible via Other Application Type" (10l). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

10l		CHIP Determination – Ineligible via Other Application Type	Total number of individuals determined ineligible for CHIP (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) during the calendar month who are not captured in Indicators 10j and 10k. This could include redeterminations made outside of the annual renewal process (for instance, due to a change in circumstance). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

11. NUMBER OF PENDING APPLICATIONS OR REDETERMINATIONS Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
11a	Pending at Medicaid Agency	Number Pending at Medicaid Agency	Total number of applications and redeterminations pending at Medicaid agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redetermination (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Online applications that have been initiated but not yet submitted to the Medicaid agency should not be reported. If the Medicaid agency administers eligibility for the CHIP program, then pending CHIP applications and redeterminations should be included in this count. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
11b		Pending at Medicaid Agency Type	States where the number of pending applications and redeterminations reported in Indicator 11a is of individuals should report "I" in this field. States where the reported number is of pending cases that may include a mix of individuals and households should report "A" in this field.

11c	Pending at Separate CHIP Agency	Number Pending at CHIP Agency	Total number of applications and redeterminations pending at the separate CHIP agency as of the last day of the month. This includes all applications that have been received by the agency (regardless of the date of application) and outstanding redetermination (regardless of when the individual came up for renewal), but which have not yet been determined as of the last day of the month. Online applications that have been initiated but not yet submitted to the separate CHIP agency should not be reported. If the state does not have a separate CHIP agency, this Indicator and Indicator 11d should be left blank (NA). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
11d		Pending at Separate CHIP Agency Type	States where the number of pending applications and redeterminations reported in Indicator 11c is of individuals should report "I" in this field. States where the reported numbers is of pending cases that may include a mix of individuals and households should report "A" in this field.

12. PROCESSING TIME FOR DETERMINATIONS Reporting Period: Calendar Month Reporting Frequency: Monthly, year round			
Indicator Number	**Data Breakout**	**Variable Name**	**Description**
12a		Median Processing Time – All Medicaid Determinations	For all applicants (regardless of date of application) who received a determination at application (as reported through indicators 9d and 10d) from the Medicaid agency in the calendar month, report the median number of calendar days elapsed between the date the Medicaid agency received the initial application (start date) and the day the determination at initial application was made (end date). The set of determinations included in the calculation of median processing time for this measure includes Medicaid and CHIP determinations made by the Medicaid agency; MAGI and non-MAGI determinations; and determinations where the applicants was determined eligible as well as those where the applicant was determined ineligible. All determinations within the calendar month should be included, regardless of when the application was submitted. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination. Determinations made by the Medicaid agency on transfer applications received from the FFM are included. The date that the Medicaid agency received the account transfer is the start date and the day of the determination is the end date. This indicator only applies to determinations at application, and does not apply to determinations at annual renewal, change in circumstance, or via other method. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12b	Type of Medicaid Determination	Median Processing Time – MAGI Determinations	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made using MAGI rules. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12c		Median Processing Time – non-MAGI Determinations	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made using non-MAGI rules. No CHIP determinations (i.e. funded under Title XXI of the Social Security Act, including through MCHIP programs) should be included in this calculation. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12d	Source of Medicaid Application	Median Processing Time – Direct Application	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that the applicant submitted directly to the state, including applications submitted directly to an SBM. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12e		Median Processing Time – Transfer Application from FFM	The median processing time, in days, as defined in Indicator 12a, but only for the set of final determinations that the Medicaid agency made on Medicaid or CHIP applications that were transferred to it by the FFM. States with an SBM should leave this field blank ("not applicable"). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12f	Number of Medicaid MAGI Determinations, by Processing Time	Less than 24 Hours	The number of final determinations made by the Medicaid agency using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. This includes determinations made by the Medicaid agency on transfer applications received from the FFM. The sum of this Indicator and Indicators 12h, 12i, 12j, and 12k should equal the sum of indicator 9e (Medicaid Eligibility at Application under MAGI Rules) and the total number of ineligibility determinations at initial application that the Medicaid agency made under MAGI rules in the previous month (i.e. the portion of indicator 10d that were determined under MAGI rules). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12g		24 Hours – 7 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12h		8 Days – 30 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12i		31 Days – 45 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12j		More than 45 Days	The number of final determinations made by the Medicaid agency using MAGI rules that occurred more than 45 days after the date that the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12k	Number of Medicaid non-MAGI Applications, by Processing Time	Less than 30 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred within 30 days of the date that the application was received by the agency. This includes determinations made by the Medicaid agency on transfer applications received from the FFM. The sum of this Indicator and Indicators 12l, 12m, 12n, and 12o should equal the sum of indicator 9f (Medicaid Eligibility at Application under Non-MAGI Rules) and the total number of ineligibility determinations at initial application that the Medicaid agency made under Non-MAGI rules in the previous month (i.e. the portion of indicator 10d that were determined under MAGI rules). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12l		31 – 60 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred between 31 and 60 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12m		61 – 90 Days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred between 60 and 90 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12n		More than 90 days	The number of final determinations made by the Medicaid agency using non-MAGI rules that occurred more than 90 days after the date that the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12o		Median Processing Time – separate CHIP Agency	For all applicants (regardless of date of application) who received a final determination from the separate CHIP agency in the calendar month, report the median number of calendar days elapsed between the date the agency received the application (start date) and the day the final determination was made (end date). The set of determinations included in the calculation of median processing time for this measure includes both determinations where the applicants was determined eligible as well as those where the applicant was determined ineligible. All determinations within the calendar month should be included, regardless of when the application was submitted. If multiple household members applied on a single application, the processing time should be calculated and reported separately for each individual who received a determination. Individuals with presumptive eligibility should not be included in this Indicator, as they have not yet received a final determination. This includes determinations made by the separate CHIP agency on transfer applications received from the FFM. This indicator only applies to determinations at application, and does not apply to determinations at annual renewal, change in circumstance, or via other method. In states without a separate CHIP agency, this indicator as well as indicators 12p and 12q should be left blank (not applicable). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12p	Source of CHIP Application	Median Processing Time – Direct Application	The median processing time in days as defined in Indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that the applicant submitted directly to the state. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12q		Median Processing Time – Transfer Application from FFM	The median processing time in days as defined in Indicator 12o, but only for the set of final determinations that the separate CHIP agency made on applications that were transferred to it by the FFM. States that share an integrated eligibility system with the SBM should leave this field blank (not applicable). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12r	Number of CHIP Applications, by Processing Time	Less than 24 Hours	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred within 24 hours of the time that the application was received by the agency. The sum of this Indicator and Indicators 12s, 12t, 12u, and 12v, should equal the total number of determinations at initial application that the separate CHIP agency made under MAGI rules in the previous month. This includes determinations on transfer applications that the separate CHIP agency received from the FFM, SBM, or Medicaid agency. In states without a separate CHIP agency, this Indicator and Indicators 12s, 12t, 12u, and 12v should be left blank (not applicable). When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12s		24 Hours – 7 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 24 hours and 7 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.

12t		8 Days – 30 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 8 and 30 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12u		31 Days – 45 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred between 31 and 45 days of when the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.
12v		More than 45 Days	The number of final determinations made by the separate CHIP agency using MAGI rules that occurred more than 45 days after the date that the application was received by the agency. When the state submits data for this indicator for the current reporting month, the state is also required to update the data on this indicator for the prior month.