Medicaid and CHIP Performance Indicators

Compendium of State Questions and CMS Answers by Indicator

Updated September 30, 2025

This document compiles previously released questions and answers regarding the Medicaid and CHIP performance indicators. New and updated questions and answers are identified by the symbol, “ * ”.

Table of Contents

General Questions....3
Reporting Logistics....7
Indicators 1, 2, and 3: Total Call Center Volume, Average Call Center Wait Time, and Average Call Center Abandonment Rate....9
~~Indicator 4: Number of Applications Received in Previous Week~~....12
Indicator 5: Number of Applications Received....12
Indicator 6: Number of Electronic Accounts Transferred....15
Indicator 7: Number of Renewals....16
Indicator 8: Total Enrollment....17
Indicators 9 and 10: Total Number of Individuals Determined Eligible or Ineligible....20
Indicator 11: Number of Pending Applications or Redeterminations....26
Indicator 12: Processing Time for Determinations at Application....27

General Questions

1. ***Should these indicators include all applications/determinations/enrollees?***

   Each indicator should include all applications, determinations, and all enrollees receiving comprehensive benefits (meeting the definition of Minimum Essential Coverage) for the state's entire Medicaid and Children's Health Insurance Program (CHIP), including both those processed under modified adjusted gross income (MAGI) and non-MAGI rules. These performance indicators are part of a broader effort to better understand the Medicaid program nationwide. These data give states, the Centers for Medicare & Medicaid Services (CMS), and the public a common understanding of eligibility and enrollment processes within and across all states and all populations.

2. ***Are the indicators the same ones as those reported by the state-based marketplace (SBM)? It looks like the same information.***

   No, these are not the same indicators. The Medicaid and CHIP Performance Indicators were developed to allow CMS and states to monitor the streamlined eligibility and enrollment processes for Medicaid and CHIP programs in every state, regardless of whether or not the state implemented a state-based marketplace (SBM). To the extent possible, CMS has worked to align definitions on the Medicaid and CHIP performance measures with the definitions that the Center for Consumer Information and Insurance Oversight (CCIIO) is using in the metrics it is asking SBMs to report. The close similarity between certain Medicaid/CHIP and SBM measures is a result of this alignment process. However, since not all Medicaid and CHIP enrollees will apply or enroll through SBMs, all state Medicaid and CHIP programs must report the Medicaid and CHIP Performance Indicator data for their program.

3. ***Do the terms "SBM" and "insurance exchange" refer to the same thing?***

   "SBM" stands for "State Based Marketplace," which is another term for the state-based health insurance exchanges. "FFM" stands for "Federally Facilitated Marketplace," which is the term for the insurance exchange run by the federal government.

4. ***Our legacy application or eligibility determination system cannot provide the break-outs you are requesting. Should we wait to submit the data until we are able to provide those break-outs?***

   No, please submit all available data by the reporting deadline of the 8th of each month, and provide other data as it becomes available to you. On a case-by-case basis, an individual state may not be able to report a particular break-out due to system limitations, or may face circumstantial delays in doing so. Please provide more information about any reporting delays or omissions in the data limitations field. As states eligibility and enrollment systems are updated, please incorporate any outstanding data breakouts into your reporting capabilities.

5. ***We are able to accurately report the top-line total and one of the data points within a sub-indicator breakout, but we are not able to accurately provide the***

other data points for this breakout. Should we just report the one data point within the breakout and leave the others blank?

The State Data Information System (SDIS), also known as Socrata or the Performance Indicator (PI) reporting portal, requires that all data points in a sub-indicator breakout sum correctly to the top-line indicator in order for the report to be submitted. For sub-indicator breakouts that include an "other" category (e.g., Medicaid eligible determinations 'via other methods'), please report all data points within the breakout that you're able to accurately measure and report, and report any remaining determinations in the 'other' category so that the breakout sums correctly. Please also include a note in the data limitations explaining what types of determinations are included in the 'other' category. For example, if you are able to accurately report the total number of Medicaid eligible determinations as well as the number of Medicaid determinations that are made at application, but are not able to further distinguish the remaining Medicaid eligible determinations into the required categories ('at annual renewal' and 'via other methods'), please report both the total Medicaid eligible determinations and number of Medicaid determinations that are made at application, and report all remaining Medicaid eligible determinations in the 'via other methods' category. For any sub-indicator breakouts that do not include an "other" category, please contact CMS for guidance.

6. ***What sorts of information should be included in the free-text data limitation fields?***

If you cannot report on an indicator, or you cannot report in a manner that matches the specifications in the data dictionary and this Question and Answer document, you should include a description in the free-text data limitations field. For example, this field should be used to report:

- Any changes in the way the data were calculated or compiled compared to the previous month.
- Any ways in which the state's data depart from the uniform specifications in the data dictionary (available at https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/performance-indicator-technical-assistance/index.html).
- Any relevant program context that would affect interpretation of the data, such as a state policy change that resulted in especially high or low indicator values for that month.
- A description of any eligibility determinations captured in the "other" categories for Indicators 9 and 10 (individuals determined eligible and ineligible, respectively).
- The approximate date by which you expect to be able to report data that is in line with the specifications.
- Sub-indicators are required to sum to top-line indicators to successfully submit the data. In addition, a warning flag will display in the portal if a potential data entry error is present, but warning flags do not prevent report submission. States should review these warning flags carefully (and adjust

their data if an error is present). States should add a note to the data limitations field to convey any relevant context about the reason for a warning flag as needed.

- Please also include descriptive information if your reporting is in line with our specifications, but there is something unique to your state that might cause us to have a question about your data without further explanation.

7. *When states need to use the free-text data limitations field to provide context for their data, does this need to be done each month, even if the context provided will be the same every month?

Within the SDIS system, free-text data limitation information is carried over from month to month for all indicators. As such, the state should review and update, if needed, the free-text data limitation fields to confirm these fields are accurate and relevant to the corresponding report. If the data limitations change in any meaningful way, such as when it becomes possible to report sub-indicator breakout data that had not previously been available, the state should update the free-text data limitations field in the first report to which the change applies.

8. *My state does not have a separate CHIP agency. Do I need to report on any of the CHIP-related indicators?

Yes. The following CHIP-related indicators should be reported for any individual whose coverage is funded under title XXI of the Social Security Act (including through MCHIP programs), regardless of whether or not the state has a separate CHIP agency:

- CHIP Renewals (sub-indicator 7d);
- CHIP Enrollees (sub-indicator 8h);
- CHIP Eligible (sub-indicators 9j–9m); and
- CHIP Ineligible (sub-indicators 10g–10l).

A state with a separate CHIP agency that maintains a separate CHIP application and eligibility and enrollment system will also report on:

- Applications received by CHIP agency (sub-indicator 5h);
- Pending at separate CHIP agency (sub-indicators 11c and 11d); and
- Processing time for CHIP determinations at application by CHIP agency (sub-indicators 12o–12v).

9. *There is one sub-indicator our state is not able to report at this time. Should we leave the field blank, or enter a zero value?

Any sub-indicator that cannot be reported always should be left blank and never filled with a zero value. A zero value is only appropriate when the data point can be measured and the value is known to be zero. For example, if your state has a median processing time of less than 12 hours, it would be correct to report a value of zero days. If, instead, your state cannot measure and report on median processing time, leave the sub-indicator blank until the data can be reported.

10. ***Since some of the indicator definitions have been specified more clearly in the revised data dictionary release, are states expected to go back through their old submissions to correct to new standards?***

    No. As the effective date on the first page of this document, we expect all states to begin reporting in line with these revised specifications for any data that is due on or after that date.

11. ***When data are submitted for the most recent month, the prior month is updated for retroactivity. Which indicators need to be updated for the prior month?***

    The requirement to update data for retroactive coverage applies to Indicator 8 (total enrollment) only. For all other indicators, any corrections to the data (if needed due to methodological updates or data quality issues) should be applied to both the preliminary reports and the updated reports.

Reporting Logistics

1. ***What is the timeline for submitting data?***

   Reporting deadline. Each state, and the District of Columbia, is required to submit data through a preliminary report on **the 8th of every month** for the previous calendar month. If the 8th of the month falls on a weekend, the data are due on the last workday before the 8th (for example, March 8th was a Saturday, so the data were due on the Friday before March 8th, which was March 7th).

   Monthly updated reports. When the state submits data for the previous calendar month, the state must also submit data through an updated report for the month prior to the one currently being reported. The only performance indicator that CMS would expect to regularly change between the preliminary and updated reports is Indicator 8 (total enrollment), due to retroactive enrollment and decisions made on new applications, for which enrollment dates back to the month of application. For all other indicators, changes between the preliminary and updated reports are considered corrections, and these corrections should also be implemented in the preliminary report (at the time of completing the updated report). For example, when submitting the June 2025 preliminary report (on July 8th, 2025), the state should also submit an updated report for its May 2025 data. When submitting its June 2025 preliminary report, the state need not update any data from April 2025 or prior months.

2. ***Which performance indicators are publicly reported?***

   The following performance indicators are publicly reported by CMS monthly, either in their entirety or for select sub-indicators:

   - Indicator 1 (Total Call Center Volume);
   - Indicator 2 (Average Call Center Wait Time);
   - Indicator 3 (Average Call Center Abandonment Rate);
   - Indicator 5 (Number of Applications Received);
   - Indicator 8 (Total Enrollment);
   - Indicator 9 (Total Number of Individuals Determined Eligible); and
   - Indicator 12 (Processing Time for Determinations at Application).

   In the SDIS, each publicly-reported indicator has a drop-down menu which allows states to select applicable footnotes. States should review the list of standardized footnotes and, if applicable, select one or more footnotes to indicate a reporting issue(s) or a change in reporting. These footnotes carry over from month to month and should be reviewed each month (and modified, if needed) to ensure accuracy. States are required to attest that they have reviewed and confirmed the data and footnotes for accuracy before saving and submitting each preliminary and updated report. It is the state's responsibility to ensure the accuracy of all footnotes prior to submission. CMS does not make changes to footnotes prior to publication.

3. ***How should we submit the data to CMS?***

   All data are collected through a web-based portal called SDIS, also known as Socrata or the PI reporting portal. Instructions for entering data in SDIS are available here: https://www.medicaid.gov/medicaid/downloads/medicaidday2reportingsite-stateuserguide.pdf.

   The SDIS is intended to ease the reporting burden on states, provide a clear way to track the most recent version of the data, and allow both states and CMS to directly access current and previous reports in real time. If states experience any issues accessing SDIS or entering or submitting their data, we encourage states to communicate those issues to us at PerformanceindicatorsTA@cms.hhs.gov.

4. ***What are the long-term plans for reporting requirements?***

   The monthly reports will be collected indefinitely. These reports are due on the 8th of each month; if the 8th falls on a weekend, they are due the last working day before the 8th.

5. ***What should I do if I have additional questions?***

   Send an email to PerformanceindicatorsTA@cms.hhs.gov. A member of the CMS Performance Indicator team will follow up with you.

Indicators 1, 2, and 3: Total Call Center Volume, Average Call Center Wait Time, and Average Call Center Abandonment Rate

1. ***Our state does not have a call center, or cannot track call volume and other call statistics because it is handled at the county level where no data are gathered. What should we report in Indicators 1–3?***

   The purpose of the call center indicators is to understand trends in each state's call centers/phone lines that receive public inquiries for Medicaid and CHIP. We understand that call centers vary considerably by state. For the purposes of reporting call center indicators (Indicators 1–3), a "call center" is defined as any call center, hotline or combination of hotlines that take a significant number of calls regarding Medicaid or CHIP. Call centers and help lines that take calls in the following areas should be included if they receive a significant volume of calls and the agency can accurately track and report call volume: questions about Medicaid or CHIP eligibility; taking over-the-phone applications; questions about enrollment, including enrollment into Medicaid/CHIP managed care plans; renewal-related questions; and local or county-based phone lines that handle inquiries about both health and human services programs. If the "call center" is not a traditional call center, or receives calls for other human services programs, please include that information in the data limitation.

   If your state does not currently collect all of the information requested, or there is any other context that would be helpful for CMS to know in interpreting the data, please note the reason for this in the data limitations field that accompanies each indicator. Please describe any context that may over or undercount Indicator 1 (total call center volume). For example, if your call center(s) receives calls for other public programs outside of Medicaid and CHIP, please describe this in the data limitations field.

2. ***Does wait time include the time the caller spends navigating the automated system?***

   Yes. For purposes of reporting Indicator 2 (average call center wait time), "wait time" is defined as the total time a caller spends in the queue before speaking to an agent, including any time spent navigating the Interactive Voice Response (IVR). This specifically measures the time the caller is on hold from the time when they make the call until the agent picks up.

3. ***How should we report calls that were abandoned within the automated system?***

   Total Call Center Volume. Calls abandoned by the caller at any time should be counted in total call volume.

   Average Call Center Wait Time. States should count the amount of time a caller spends navigating through the automated system prior to abandoning the call.

   Average Call Center Abandonment Rate. Calls abandoned by the caller at any time prior to reaching a live agent should be counted as abandoned calls, including those abandoned while navigating the automated system or while in queue to speak to a live agent.

States should select the appropriate footnote, if one exists, that is applicable to their data (e.g., “Calls handled to completion by the automated system are counted as abandoned calls”). If there is no applicable footnote, or if states have additional information about their reporting to convey to CMS, they should include this information in the free-text data limitation field for each applicable indicator.

4. ***How should we include transferred calls in call center data?***

   Total Call Center Volume. If a call is transferred from one call center to another, and the caller does not abandon the call, that call should be counted as a single call in total call volume. If during the transfer the caller hangs ups, is required to hang up, or accidentally hangs up, then that call should be considered two separate calls: 1) from the time the call was initiated to when the call was transferred, and 2) from the start of the transfer to when the call was ended.

   Average Call Center Wait Time. States should count the time a caller spends in various queues, including those after the caller has been transferred, in average wait time.

   Average Call Center Abandonment Rate. If a call is transferred and then abandoned, that call should be counted in the abandonment rate.

   If a transfer meets the criteria for two separate calls, states should calculate total call center volume, average call center wait time, and average call center abandonment rate accordingly.

5. ***If the Medicaid Agency call center and the SBM call center are integrated (i.e., both handle Medicaid and CHIP calls), can the SBM data be reported in the Medicaid & CHIP Performance Indicators?***

   No. Call centers operated or overseen by the SBM should not be included in the Medicaid & CHIP Performance Indicators. Data from these call centers will be reported to CCIIO, and we hope to avoid duplication. If the state is unable to separate SBM data from the Medicaid Agency call center, the state should document this in the free-text data limitation fields for Indicators 1–3.

6. ***In our state, the phone line for Medicaid operates 24/7. In the call volume measure, should we report only the calls that occur within the business hours of 8:00 AM - 6:00 PM, Monday through Friday, or should we include the calls that occur outside of those hours as well?***

   Please report all calls received in Indicator 1 (total center call volume) during the call center’s hours of operation, even if these calls occur outside of regular business hours. This would most accurately depict the volume and state workload of manning the call center. If your state receives calls outside of regular business hours but is unable to report on these calls in Indicator 1, please provide an explanation in the data limitations field.

7. ***Our state has an Automated Response Unit (ARU) that receives and manages many calls automatically without the need to transfer the call to the Call Centers or to talk to an agent. Only a portion of callers find that they need to talk to an agent. In the call volume indicator, should we report data***

for all calls received at the ARU, including those handled automatically, or should we only report calls transferred to the call centers?

Yes, please report data for all calls received at the ARU in Indicator 1 (total call center volume), including those that can be handled solely by an automatic system. This indicator is intended to capture the level of interest in and activity related to Medicaid & CHIP in a state. Therefore, we'd like you to report the total number of calls received during the call center's hours of operation, even if these calls occur outside of regular business hours. Calls handled solely by an automatic system should be excluded from Indicator 2 (average call center wait time) and Indicator 3 (Average call center abandonment rate).

8. ***Should all call center wait times be rounded up or down to the nearest whole minute?***

   Yes. All call center wait times (Indicator 2) should be reported in whole minutes. As an example, if your wait time is 29 seconds, it should be rounded down to zero. If you enter a zero, please note in the data limitations that the wait time is less than 30 seconds. If your wait time is one minute and 29 seconds, it should be rounded down to one minute. If it is one minute and 30 seconds, it should be rounded up to two minutes.

9. ****Should states report call center statistics from managed care plans?***

   If the managed care plans receive a significant volume of calls related to Medicaid or CHIP, then the state should report data from these managed care plans for the call center indicators.

10. ****The state has 15 call centers that handle Medicaid/CHIP related calls. However, there are only 10 call center fields for reporting. How should we report data for the additional call centers?***

    Currently, the SDIS only includes 10 call center fields for states to report. If the state has more than 10 call centers that receive Medicaid/CHIP related calls, it should consolidate the call centers into "main" call centers, if appropriate. For example, if MCO X has three total call centers, then the state should combine these call centers into one "MCO X" call center and report combined data from the three call centers. The state should contact CMS with any questions or concerns.

~~Indicator 4: Number of Applications Received in Previous Week~~

Indicator 4 is no longer applicable.

Indicator 5: Number of Applications Received

1. ***For "number of applications received" (Indicator 5), are you only looking for people who are applying through the Medicaid agency, or for all individuals applying through other agencies or the Marketplace?***

   States should report applications received by any agency in the state (all doorways), including both MAGI and non-MAGI applications, and not just applications received directly by the Medicaid agency. Coverage through the Marketplace is a separate program from Medicaid and CHIP, therefore, any transition from the Marketplace (qualified health plans (QHPs), etc.) to Medicaid or CHIP eligibility is a new application for Medicaid/CHIP coverage, regardless of whether the applicant took action to initiate this change. The number of applications received by each agency (Medicaid, separate CHIP agency, and/or state-based marketplace) should be reported separately in sub-indicators 5b, 5h, and 5n. The top-line sub-indicator 5a (total applications received) should include all applications received through any door.

2. ***Within the applications indicator, which applications should be included? Should even those applications for disability-related coverage be included?***

   States should include any application submitted by an applicant that will require a Medicaid or CHIP determination in Indicator 5 (number of applications received). If the state uses a combined application for some or all Medicaid applicants that also screens individuals for other social service programs (such as SNAP), these applications should be included when Medicaid or CHIP is among the programs the person is being evaluated for. If the state has separate applications for different Medicaid populations (e.g., a family Medicaid application and an ABD application), all applications should be included in the applications indicator.

3. ***Our state has a new joint Eligibility & Enrollment system for CHIP and Medicaid that happens to sit in the CHIP agency. Did I hear correctly that all of these applications should be reported as Medicaid?***

   Yes, please report these together in sub-indicator 5b (applications received by Medicaid agency) and add a note of explanation in the free-text data limitations field. Only states with a separate CHIP agency, separate CHIP application process, and separate CHIP eligibility & enrollment system are approved to report sub-indicator 5h (applications received by CHIP Agency). All other states using a single/streamlined Medicaid and CHIP application and eligibility & enrollment system should report the applications received by the state agency in the "applications received by Medicaid agency" sub-indicators (5b–5g).

4. ***Should account transfers received from the FFM be included in the number of applications received (Indicator 5)? If so, what channel should these transfers be reported under?***

   States should not include transfers in the number of applications received for Indicator 5, as these should be separately captured in Indicator 6 (number of electronic accounts transferred).

5. ****Please clarify how FFM transfers are captured in the indicators for number of applications?***

   Transfers from the federally-facilitated marketplace (FFM) to states should not be included in Indicator 5. This is the same regardless of whether the state is an assessment state (where the FFM only assesses Medicaid/CHIP eligibility before transferring to the state for a final eligibility determination) or a determination state (where the FFM makes a final determination of Medicaid/CHIP eligibility and transfers accounts to the state for enrollment). Instead, these transfers should be counted in Indicator 6 (number of electronic accounts transferred).

6. ****How should we report on individuals whose eligibility information is transferred administratively (for example, SSI recipients who are auto-enrolled, or enrollments via Express Lane Eligibility [ELE] programs)? Should these individuals be counted in the applications indicator and/or the determinations indicator?***

   Individuals who enter a state's eligibility determination system via an administrative data transfer rather than by submitting an application should not be counted in Indicator 5 (total applications received). This would be the case for SSI recipients who are auto-enrolled into Medicaid; ELE determinations; and transfers from an existing 1115 demonstration.

   These individuals should, however, be counted in the determinations reported in sub-indicator 9a (total Medicaid eligible). They should also be reported in sub-indicator 9i (Medicaid eligible via other method), and not in sub-indicator 9h (Medicaid eligible via administrative determination). When states report individuals in sub-indicator 9i (Medicaid eligible via other method), a description of how these individuals were determined eligible (e.g. through ELE processes) should be included in the data limitations field.

   The only determinations that should be included in sub-indicator 9h (Medicaid eligible via administrative determination) are those made through the targeted enrollment strategies outlined in the May 17th SHO letter. However, as of 2025, no states have an active approval to use a targeted enrollment strategy and therefore should not be reporting sub-indicator 9h (Medicaid eligible via administrative determination).

7. ***In our new eligibility system, applicants in the state-based marketplace (SBM) check a box requesting that the system determine whether they are eligible for subsidized coverage, which would include both Advanced Premium Tax Credits (APTC) and Medicaid eligibility. Given that the applicant is not***

distinguishing a request for APTC from an application for Medicaid, how should we capture this activity?

Please capture this activity as an application in Indicator 5 (number of applications received). In all SBM states the process of applying for and receiving an eligibility determination for subsidies, Medicaid, and CHIP is integrated, so all applications to the SBM requesting a screening for financial assistance should receive a Medicaid or CHIP determination. Given this, when an individual submits an application to the SBM for financial assistance, this application should be counted in sub-indicator 5a (total applications received). The state should report the "door" through which these applications were received in sub-indicator 5n (applications received by SBM). An individual who applies for coverage via the SBM but does not request financial assistance should not be counted in these indicators, as those applications will not undergo an assessment or determination of Medicaid/CHIP eligibility.

8. ***Our state has an eligibility system that is integrated with our SBM and has an online application for all subsidized insurance requests. When should we count applications as submitted to the Marketplace as opposed to submitted to the Medicaid agency?***

   All applications for financial assistance received by the SBM should appear in sub-indicator 5n (applications received by the SBM); this includes online applications and applications received by the SBM via other channels. Sub-indicator 5b (applications received by Medicaid agency) would include any applications that came to the state Medicaid agency via any other channel—but would not include those applications that came to the online portal shared with the SBM.

9. ****If an individual is disenrolled from Medicaid due to failure to respond to a renewal notice and subsequently provides their renewal information after disenrollment, should this be counted as a new application or a renewal?***

   Renewal information submitted at any time after the individual is disenrolled from Medicaid or CHIP should be counted as a new application. Therefore, these individuals should be included in Indicator 5 (number of applications received) and Indicator 12 (processing time for determinations at application).

10. ****If a household application has three members in total, but two of them are enrolled in Medicaid and the third is a new applicant (currently in a QHP, APTC or Essential Plan (EP), etc.) being determined for eligibility, how should the new applicant be captured in Indictors 5 and 12?***

    The individual not currently enrolled in Medicaid or CHIP is considered a new applicant. Because coverage through the Marketplace is a separate program from Medicaid and CHIP, CMS would consider any transition from the Marketplace (QHPs, etc.) to Medicaid or CHIP eligibility to be an application for Medicaid/CHIP coverage, regardless of whether the applicant took action to initiate this change. Therefore, in this scenario, the state should include this individual in indicator 5 (number of applications received) and Indicator 12 (processing time for determinations at application).

Indicator 6: Number of Electronic Accounts Transferred

1. ***We are an FFM state. If we have not started to receive account transfers from the FFM, what should we report in the "electronic accounts transferred" indicator?***

   A state should leave sub-indicators 6a (total transfer accounts received from the FFM) and 6e through 6h (determined account transfers received, assessed account transfers received, request for full determination transfers received, and transfers of unknown type received) blank for any month in which the state is not yet receiving account transfers from the FFM. This may be the case for a state that transitions from an SBM to using the FFM. Please explain in the data limitations text field the systems issues that prevent your state from receiving electronic account transfers.

2. ***Please clarify how SBM transfers are captured in Indicator 6?***

   Because all SBMs are integrated with Medicaid and CHIP, SBM states should report no transfer activity reported in Indicator 6 (number of electronic accounts transferred).

3. ***My state is changing the eligibility limit in our 1115 demonstration and some individuals will now be transferred to the Marketplace. How should that be reported?***

   In FFM states, individuals who are transferred electronically to the Marketplace should be reported in sub-indicators 6j (total transfer accounts sent to FFM). As noted above, SBM states should report no transfer activity, as SBM and Medicaid/CHIP eligibility systems are integrated.

Indicator 7: Number of Renewals

1. ***Does the renewals indicator include all individuals who are due for renewal, or only those who have been determined? Should it include those who receive a redetermination outside of the annual renewal cycle?***

   The renewals indicator should include those individuals who came up for annual renewal within the month, including individuals with limited benefit packages and individuals with comprehensive benefit packages, regardless of whether those individuals received a completed eligibility determination within the month.

   For example, if a state sent renewal forms to 15,000 individuals in October 2025, and 12,000 of those individuals responded to the request for verification information, with 10,000 determined eligible, 1,000 determined ineligible, and 1,000 still pending determination as of October 31st, all 15,000 individuals who came up for annual renewal should be counted in sub-indicator 7a reported in the October 2025 data. Those individuals should also be counted in either sub-indicator 7b (Medicaid MAGI renewals), 7c (Medicaid non-MAGI renewals), or 7d (CHIP renewals).

   The outcome of the annual renewal process should be captured in other indicators. In the example above, we would expect that:

   - The 10,000 individuals determined eligible would be reported in Indicator 9 (total number of individuals determined eligible)
   - The 1,000 who were determined ineligible and the 3,000 whose accounts were closed due to lack of response would be reported in Indicator 10 (total number of individuals determined ineligible)
   - The 1,000 whose redetermination was still pending as of the last day of October would be reported in Indicator 11 (number of pending applications or redeterminations)

Indicator 8: Total Enrollment

1. ***What is the difference between the "individuals determined eligible" and "total enrollment" indicators? Aren't these measuring the same thing?***

   Indicator 9 (total number of individuals determined eligible) is counting the number of people for whom your agency made a determination action. For individuals determined Medicaid eligible under MAGI rules or determined CHIP eligible, they will be counted in only one reporting period in Indicator 9—for example, a person who applied in October 2025 and was determined eligible in November 2025 would be counted in November 2025 only. The next time this person would be counted in this metric would be when they were re-determined as part of the annual renewal process (for example, in November 2026) or due to a change in circumstances, or if they disenrolled and re-applied at a later date. The exception to this rule is for individuals who receive an initial determination under MAGI rules and a subsequent determination under non-MAGI rules. For example, if an individual, who applied in October 2025, was determined Medicaid eligible in November 2025 under MAGI rules and was then determined Medicaid eligible under non-MAGI rules in December 2025, that individual would be counted in both November and December 2025.

   Indicator 8 (total enrollment) is a point-in-time count of the total number of individuals enrolled in Medicaid or CHIP, receiving comprehensive benefits that meet the minimum essential coverage (MEC) requirements, as of the last day of the month. It should not be restricted to only those who newly enrolled in Medicaid/CHIP during the month. For example, a person who applied, was determined eligible, and enrolled in November 2025 and remained enrolled through October 31, 2026 would be counted in Indicator 8 during the November 2025 reporting period through the October 2026 reporting period.

2. ***Within the enrollment indicator, should the number reported for "Total Medicaid enrollees" (sub-indicator 8a) contain the sum total of CHIP enrollees and traditional Medicaid enrollees, while "Total CHIP enrollment" (8h) contains only CHIP enrollees?***

   No. Sub-indicator 8a (total Medicaid enrollees) should contain only those funded under Title XIX of the Social Security Act. Total number of CHIP enrollees (i.e. individuals funded under Title XXI of the Social Security Act, including through MCHIP programs) should be reported separately in sub-indicator 8h. The sum of these two fields should equal the total number of unduplicated Medicaid and CHIP enrollees, receiving comprehensive benefits that meet MEC requirements, in the state.

3. ***If an individual is determined to be eligible in October, but that eligibility will not begin until January, how should that individual be reported in the "enrollment" and "determined eligible" indicators?***

   All individuals should be included in the Indicator 9 (total number of individuals determined eligible) only for the reporting period in which the determination was made. Individuals should be included in Indicator 8 (total enrollment) for each reporting period during which they are enrolled. In your example, the individual

should be included in Indicator 9 (total number of individuals determined eligible) for the month of October. However, the individual would not be included in the Indicator 8 (total enrollment) until January, when he or she actually became a Medicaid enrollee. That individual should then be included in Indicator 8 for every reporting period thereafter until he or she disenrolls.

4. ***When you talk about total enrollment, do you want an unduplicated number? So if someone is in multiple programs, we will report them as only one person?***

   Yes, Indicator 8 (total enrollment) should be reported as an unduplicated number of individuals enrolled in Medicaid or CHIP as of the last day of the reporting period. If systems limitations prevent a state from unduplicating this data, we ask that you note that in the data limitations text field.

5. ***Should the enrollment indicator include spend-down enrollees and/or emergency Medicaid enrollees, who may transition on and off the program from month to month?***

   States should report only those individuals receiving comprehensive Medicaid benefits that meet MEC requirements. For example, individuals eligible for only a limited benefit package (i.e., individuals only eligible for emergency Medicaid, family planning services, etc.) should not be included. If individuals eligible for spend-down programs receive comprehensive benefits and services that are funded through a combination of state and federal funds they should be included in the enrollment indicator.

6. ***Are individuals with a share of cost reported in total enrollment?***

   Individuals who become eligible for Medicaid through share of cost (or the medically needy program) should be counted in Indicator 8 (total enrollment) if they qualify for comprehensive benefits funded through a combination of state and federal funds that meet MEC requirements.

7. ***Should we report enrollees of our state's 1115 waiver program in the "total enrollees" count?***

   If individuals in your state's 1115 waiver program are eligible for a comprehensive medical benefits package that meets MEC requirements, then they should be included in Indicator 8 (total enrollment). If the 1115 waiver provides only limited benefits (for example, covering only basic primary care visits), then these individuals should not be included in Indicator 8. If you would like to discuss the specifics of your state's 1115 waiver program to determine whether to include it in the total enrollment indicator, please contact CMS.

   Additionally, individuals enrolled under section 1115 demonstrations that are not statewide and/or offer very limited provider networks should be excluded from the total Medicaid enrollment indicator.

8. ***Should individuals with limited benefits be excluded from any counts other than total enrollment?***

   No; please exclude individuals eligible for limited benefits from Indicator 8 (total enrollment) only, and not from other indicators. As discussed below, the enrollment and determined eligible numbers will not be directly comparable.

9. ****Are states required to update enrollment counts retroactively for greater accuracy? For example, a data pull later in the month will have a higher enrollment count for the prior month than a data pull right after the close of the month because additional beneficiaries will have been made retroactively eligible during that time.***

   Yes, states must report updated enrollment counts in the prior month's updated report when they submit the next month's preliminary report. For example, when submitting the November 2025 preliminary report (on December 8th, 2025), the state should also report in its October 2025 updated report enrollment data to show any retroactive enrollments. When submitting its December 2025 preliminary report, the state need not update any enrollment data from October 2025, but it must report in its November 2025 updated report enrollment data to show any retroactive enrollments.

   For all other indicators, changes between the preliminary and updated reports are considered corrections, and these corrections should also be implemented in the preliminary report (at the time of completing the updated report).

10. ***Should we include pregnant women who receive full benefits in Indicator 8?***

    If the pregnant women receive a comprehensive medical benefits package, they should be included in the enrollment counts.

11. ****How should states report on MAGI and non-MAGI enrollment (sub-indicators 8b–8g)?***

    Sub-indicator 8b (total MAGI enrollees) should include all individuals enrolled in a Medicaid eligibility group that is subject to the MAGI determination rules. Sub-indicator 8e (total non-MAGI enrollees) should include all individuals enrolled in a Medicaid eligibility group that is not subject to MAGI determination rules. If your state is reporting on these indicators using a different method, please describe the method in the data limitations.

Indicators 9 and 10: Total Number of Individuals Determined Eligible or Ineligible

1. ***Is the eligibility indicator intended to include those who were determined eligible in the prior month?***

   No, Indicator 9 (total number of individuals determined eligible) should be counted in the reporting period in which the determination occurred. For example, a person who applied in October 2025 and was determined eligible in November 2025 would be counted in November 2025 only.

2. ***What is the difference between the "individuals determined eligible" and "total enrollment" indicators? Aren't these measuring the same thing?***

   Indicator 9 (total number of individuals determined eligible) is counting the number of people for whom your agency made a determination action. For individuals determined Medicaid eligible under MAGI rules or determined CHIP eligible, they will be counted in only one reporting period in Indicator 9—for example, a person who applied in October 2025 and was determined eligible in November 2025 would be counted in November 2025 only. The next time this person would be counted in this metric would be when they were re-determined as part of the annual renewal process (for example, in November 2026) or due to a change in circumstances, or if they disenrolled and re-applied at a later date. The exception to this rule is for individuals who receive an initial determination under MAGI rules and a subsequent determination under non-MAGI rules. For example, if an individual, who applied in October 2025, was determined Medicaid eligible in November 2025 under MAGI rules and was then determined Medicaid eligible under non-MAGI rules in December 2025, that individual would be counted in both November and December 2025.

   Indicator 8 (total enrollment) is a point-in-time estimate of the total number of individuals enrolled in Medicaid or CHIP, receiving comprehensive benefits that meet MEC requirements, as of the last day of the month). It should not be restricted to only those who newly enrolled in Medicaid/CHIP during the month. For example, a person who applied, was determined eligible, and enrolled in November 2025 and remained enrolled through October 31, 2026, would be counted in Indicator 8 during the November 2025 reporting period through the October 2026 reporting period.

3. ***Should states include individuals denied for procedural reasons, in addition to individuals who did not meet program eligibility requirements, in Indicator 10?***

   Yes, states should include in Indicator 10 those individuals determined ineligible due to not meeting program eligibility requirements as well as those for whom the agency was not able to obtain enough information to make an eligibility determination (procedural denials). However, states should break out these two groups in the "by determination reason" breakouts for those determined Medicaid ineligible (sub-indicators 10b–10b) and CHIP ineligible (sub-indicators 10h–10i), respectively.

4. ***Should the sum of total number of individuals determined eligible (Indicator 9) and total number of individuals determined ineligible (Indicator 10) equal the total number of applications received (Indicator 5) each month?***

   No, we would not expect these numbers to match, for the following three reasons:

   - The unit of measure in Indicator 5 (number of applications received) is "applications," which in many cases will contain more than one person who will receive a determination. The unit of measure in Indicators 9 and 10 (total number of individuals determined eligible and ineligible) is "individuals" (which can also be thought of as determination actions). Even if every application received in a given reporting period was processed and received a final determination in the same period, we would not expect the indicators to match because of the differences in the units being counted.
   - Applications should be counted in the reporting period in which they are received, while determinations should be counted in the reporting period during which they occurred. It is likely that some applications received toward the end of the reporting period will not be processed and receive final determinations until subsequent reporting periods.
   - The top-line number of individuals determined eligible and ineligible for Medicaid or CHIP (sub-indicators 9a, 9j, 10a, and 10h) should include all determinations and redeterminations made during the reporting period, and not only those that are linked to an initial application for benefits. Specifically, individuals who receive a redetermination because they came up for annual renewal should be included in Indicators 9 and 10 (total number of individuals determined eligible and ineligible) but not in Indicator 5 (number of applications received). Similarly, individuals receiving a redetermination due to a change in circumstance outside the annual renewal process should be counted in Indicators 9 and 10, but would not be counted in Indicator 5.

5. ***If an individual has been eligible in the past and just completed a redetermination under which they were determined to still be eligible, should they be counted in the "determined eligible" indicator?***

   Yes. Individuals should be counted in Indicator 9 (total number of individuals determined eligible) or 10 (total number of individuals determined ineligible) each time that a final determination is made, regardless of their previous enrollment status. In this case, the individual should be counted in either sub-indicator 9a (total Medicaid eligible) or 9j (total CHIP eligible), as well as in either sub-indicator 9g (Medicaid eligibility determined at annual renewal) or 9l (determined CHIP eligible at annual renewal).

   In general, we would expect an individual to be counted either in Indicator 9 or 10 at each of the following events: (1) when determined eligible or ineligible at initial application; (2) when determined eligible or ineligible at annual renewal; (3) when determined eligible or ineligible at an unscheduled redetermination due to a change in circumstance; and (4) if they re-apply after leaving the program and receive a new determination of eligible or ineligible.

If an individual has their eligibility re-run outside of their annual renewal period that does not trigger a change to their annual renewal period and the individual is determined still eligible, then that individual should be counted in sub-indicator 9i (Medicaid eligible via other method) or sub-indicator 9m (all others determined CHIP eligible). However, if the individual is determined ineligible, then they should be counted in sub-indicator 10f (Medicaid determination – ineligible via other application type) or 10l (CHIP determination – ineligible via other application type).

6. ***Our state accepted new applications for MAGI-based Medicaid starting in October 2025, but we didn't enroll this new population until January 1, 2026. How should this be reported in the number of eligibility determinations (Indicators 9 and 10) and in total enrollment (Indicator 8)?***

   Determinations should be reported in the month that the agency made the determination, even if that is not the same month in which the person was able to enroll in the program. For example, if an individual was determined eligible for Medicaid under MAGI rules in November 2025, but was not enrolled in Medicaid until January 1, 2026, the state should report this individual in sub-indicator 9a (total Medicaid eligible) in the November 2025 reporting period and in sub-indicator 8a (total Medicaid enrollees) starting in the January 2026 reporting period. Note that the individual would be included in sub-indicator 8a in every month during which they were enrolled, not just the first month.

7. ****Please clarify how FFM transfers are captured in the eligibility determinations indicators?***

   In determination states, the FFM will make (and report on) the final determination, so these states should not report these individuals in Indicator 9 (total number of individuals determined eligible) or Indicator 10 (total number of individuals determined ineligible).

   In assessment states, the state makes the final eligibility determination, so the state should count transfers from the FFM in Indicator 9 (total number of individuals determined eligible) or 10 (total number of individuals determined ineligible), as appropriate, in the month in which the state makes the final eligibility determination (which may differ from the month in which the transfer was received). When reporting determinations by reason for determination, these transfers should be reported as determinations made at application (sub-indicators 9d or 10d for Medicaid determinations, and sub-indicators 9k or 10j for CHIP determinations).

   In both determination and assessment states, individuals determined eligible should be included in Indicator 8 (total enrollment) once the individual's coverage begins.

8. ****Can you explain why individuals who receive a final eligibility determination from the FFM should not be included in the "determined eligible/ineligible" indicators?***

   This is to avoid double-counting. Since CMS will already be tracking and reporting the FFM eligibility determinations, these determinations should not be duplicated in the data that states are reporting to us.

9. ***If an individual is determined to be eligible in October, but that eligibility will not begin until January, how should that individual be reported in the "enrollment" and "determined eligible" indicators?***

   All individuals should be included in Indicator 9 (total number of individuals determined eligible) during the month in which the determination was made. Individuals should be included in Indicator 8 (total enrollment) for each reporting period during which they are enrolled. In your example, the individual should be included in Indicator 9 for the month of October. However, the individual would not be included in Indicator 8 until January, when he or she actually became a Medicaid enrollee. That individual should then be included in the enrollment indicator for every reporting period thereafter until he or she disenrolled.

10. ***For individuals who are first determined eligible under MAGI, but then are determined eligible on a non-MAGI basis within the same reporting period, should we report one determination or two?***

    Both determinations should be counted in sub-indicator 9a (total Medicaid eligible). This means that it is possible (if both the non-MAGI determination and the MAGI determination are completed within the same reporting period) that one individual could have two eligibility determinations in the same reporting period.

11. ****How should we report on individuals whose eligibility information is transferred administratively (for example, SSI recipients who are auto-enrolled, or enrollments via Express Lane Eligibility [ELE] programs)? Should these individuals be counted in the applications indicator and/or the determinations indicator?***

    Individuals who enter a state's eligibility determination system via an administrative data transfer rather than by submitting an application should not be counted in Indicator 5 (total applications received). This would be the case for SSI recipients who are auto-enrolled into Medicaid; ELE determinations; and transfers from an existing 1115 demonstration.

    These individuals should, however, be counted in the determinations reported in sub-indicator 9a (total Medicaid eligible). They should also be reported in sub-indicator 9i (Medicaid eligible via other method), and not in sub-indicator 9h (Medicaid eligible via administrative determination). When states report individuals in sub-indicator 9i (Medicaid eligible via other method), a description of how these individuals were determined eligible (e.g., through ELE processes) should be included in the data limitations field.

    The only determinations that should be included in sub-indicator 9h (Medicaid eligible via administrative determination) are those made through the targeted enrollment strategies outlined in the May 17, 2013 SHO letter. However, as of 2025, no states have an active approval to use a targeted enrollment strategy and therefore should not be reporting sub-indicator 9h (Medicaid eligible via administrative determination).

12. ***My state is changing the eligibility limit in our 1115 demonstration and some individuals will now be transferred to the Marketplace. How should that be reported?***

    If your state is ending coverage, consistent with your 1115 demonstration transition plan, your state should do a determination to ensure that individuals are not eligible for any other categories of coverage. These determinations should be counted in Indicator 9 (total number of individuals determined eligible) or Indicator 10 (total number of individuals determined ineligible), as appropriate. If these individuals are over income for the new standard, your state should report them in sub-indicator 10b (Medicaid determination – ineligibility established) and sub-indicator 10f (Medicaid determination – ineligible via other application type).

    In FFM states, individuals who are transferred electronically to the Marketplace should be reported in sub-indicators 6j (total transfer accounts sent to FFM). In SBM states, no transfer activity should be reported.

13. ***My state is moving a group of people from an existing 1115 demonstration into the new adult group in Medicaid. How, when, and where should these individuals be reported in the Performance Indicators?***

    In the month the state makes a determination regarding eligibility for the new adult group for these individuals, they should be reported in Indicator 9 (total number of individuals determined eligible) or Indicator 10 (total number of individuals determined ineligible). Within the 'by reason for determination' break-out, these individuals should be reported in sub-indicator 9i (Medicaid eligible via other method) and not in sub-indicator 9h (Medicaid eligible via administrative determination). A description of how these individuals were determined eligible (e.g., transfer of a group formerly covered under a demonstration) should be included in the data limitations field. In any month in which the individuals are enrolled in comprehensive coverage that meets MEC requirements (whether that is through the 1115 demonstration or through the new adult group) they should also be reported in Indicator 8 (total enrollment).

14. ***How should we categorize presumptively eligible individuals in the Performance Indicators?***

    Those individuals determined presumptively eligible should not be included in Indicator 9 (total number of individuals determined eligible). Only those individuals receiving a "final determination" are included in this count. These individuals should also be excluded from Indicator 12 (processing time for determinations at application). Individuals who are presumptively eligible should be included in the total enrollment count under Indicator 8.

15. ***Should we include the number of individuals who were determined ineligible for Medicaid or CHIP but were determined for a QHP? If the answer is "yes", then would we include both: (a) those determined eligible for a QHP with an APTC subsidy, and (b) those determined eligible for a QHP without an APTC subsidy?***

    Yes, Indicator 10 captures those individuals who are determined ineligible for Medicaid and ineligible for CHIP. Please include all individuals that are determined

ineligible regardless of whether they qualify for a QHP with or without a subsidy. Please note, the Medicaid and CHIP performance indicators only capture data on individuals eligible or ineligible for Medicaid or CHIP, and do not ask states to report on individuals' eligibility for a QHP.

16. ***If an individual is a child and is determined not to be eligible for either CHIP or for Medicaid through either an application or a renewal, should that ineligibility be counted twice, once for each program, since they were not determined eligible for either program?***

    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.

17. ****Indicator 8 regarding total Medicaid and CHIP enrollment should only count people found eligible for comprehensive benefits (excluding those with a limited benefit package such as emergency Medicaid or limited benefit dual eligibles). For Indicator 10, should individuals found eligible for only emergency Medicaid or limited benefit Medicare buy-in benefits be counted as "ineligible" for Medicaid?***

    Individuals found eligible for any Medicaid program (including a limited benefit program) should be counted as "eligible" for Medicaid in Indicator 9 (total number of individuals determined eligible). Only individuals found ineligible for all Medicaid programs (including a limited benefit program) should be counted as "ineligible" of Medicaid in Indicator 10 (total number of individuals determined ineligible). Please exclude individuals eligible for limited benefits from Indicator 8 (total enrollment) only, and not from other indicators. Enrollment data and data regarding individuals determined eligible or ineligible will not be directly comparable.

Indicator 11: Number of Pending Applications or Redeterminations

1. ***Should the "pending" indicator include those in the queue to be worked, or only those cases where processing has begun but cannot be completed until additional information is received?***

   Indicator 11 (number of pending applications or redeterminations) should include all those in the queue as of the last day of the reporting period. That is, it should include all applications and redeterminations that have been received and not completed, including those that are in process but not complete for any reason, whether that is due to outstanding verification items on the part of the applicant or merely the normal processing time needed by the Medicaid or CHIP agency to make a determination.

2. ***Does the pending applications or redeterminations indicator include all accounts that are still undetermined, or only those that are failing to meet the timeliness standard? Should this indicator include online applications that are initiated but not yet submitted?***

   Indicator 11 (number of pending applications or redeterminations) should include all applications that are received by the agency but have not yet been determined within the reporting period. It is a point-in-time count on the last day of the month. This indicator should include only those applications that have been formally submitted to the Medicaid program, but not online applications that have been initiated and not yet submitted to the agency.

Indicator 12: Processing Time for Determinations at Application

1. ***For processing time for determinations at application, how should we handle delays because of outstanding verification items on the part of the applicant? Should that be included in the lag time?***

   Yes, Indicator 12 should include the number of days between the date the Medicaid agency received the application to the date the determination was made. Delays caused by the applicant due to outstanding verification items should be included in the processing time.

2. ***How does the processing time indicator apply to account transfers received from the FFM?***

   The state should count the number of days that elapse between the date the Medicaid agency received the electronic account transfer from the FFM, and the date the final determination is made by the state agency. If the final determination is made by the FFM, that account transfer should be excluded from this indicator.

3. ***For individuals who are first determined under MAGI rules, but then also request a non-MAGI determination, how should processing time be measured and reported?***

   Processing time should be measured and reported separately for each determination. Processing time should be calculated from receipt of the application to the first determination (MAGI), and then from the time of the MAGI determination (or the time of the request for a non-MAGI determination if that request was not made on the application) to the time of the non-MAGI determination.

4. ***Should the median processing time be calculated per application or for each individual on the application?***

   Indicator 12 should be calculated based on the individual level, rather than the application level.

5. ****If a household application has three members in total, but two of them are enrolled in Medicaid and the third is a new applicant (currently in a QHP, APTC or Essential Plan (EP), etc.) being determined for eligibility, how should the new applicant be captured in Indictors 5 and 12?***

   The individual not currently enrolled in Medicaid or CHIP is considered a new applicant. Because coverage through the Marketplace is a separate program from Medicaid and CHIP, CMS would consider any transition from the Marketplace (QHPs, etc.) to Medicaid or CHIP eligibility to be an application for Medicaid/CHIP coverage, regardless of whether the applicant took action to initiate this change. Therefore, in this scenario, the state should include this individual in Indicator 5 (number of applications received) and Indicator 12 (processing time for determinations at application).