Medicaid and Children's Health Insurance Program Eligibility Processing Data Report Specifications

Updated June 2026

Version 5

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I. Introduction

A. What's new?

This version of the Medicaid and Children's Health Insurance Program Eligibility Processing Data Report Specifications includes the following updates:

1. Updates Section II, Data Specifications: Monthly Report, and Section III, Reporting the Outcomes of Previously Pending Renewals, to account for new renewal outcome metrics related to Medicaid community engagement requirements.
2. Makes non-substantive updates throughout the document to replace the word "terminations" with "disenrollments."
3. Makes non-substantive updates to dates in examples so the entire document is refreshed with the timing of these updates.

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

B. About the submission

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

States submit monthly reports to CMS. The monthly report, as specified in section II, is due by the 8th calendar day of each month. The updates to previously pending renewals, as specified in section III, is due by the 15th calendar day of each month. Should the 8th or 15th calendar day fall on a weekend or holiday, states may submit by the next business day.

2. How will the data be submitted?

These reports are submitted to CMS using the same portal in which states enter their Performance Indicator (PI) data (https://sdis.medicaid.gov/user/login). This portal is set up to accept submissions from those with PI submission credentials.

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

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

States should report on renewals initiated (metric 4) and each renewal disposition (metric 5 and its submetrics and metrics 9, 10, 11, 12, and 13) as of the last day of the reporting period. For example, the data included in the June 2027 report should only include renewals initiated in June 2027 and renewal outcomes as of June 30, 2027 for those renewals due in June 2027. States should not make corrections to reflect work completed after the last day of the month of the reporting period except as noted in section III.

4. How can questions about data be answered?

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

- States can access help at any time by emailing CMSEligEnrollSupport@cms.hhs.gov.

II. Data Specifications: Monthly Report

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

Table 1: Summary of Monthly Period Reporting Specifications

What is the monthly report?	The monthly report contains data on pending and completed applications and renewals and pending fair hearings. States report Medicaid and CHIP data in this report.[1] Data will **not** be reported separately by program.
How do I submit it?	States log on to https://sdis.medicaid.gov/user/login.
When is it due?	By the 8th calendar day of the month following the reporting period. Should the 8th calendar day fall on a weekend or holiday, states may submit by the next business day.
What if, after submission, I need to change or update data previously reported?	States update the monthly report at the same link, https://sdis.medicaid.gov/user/login, if they later discover they made a mistake, or if they did not have all of the data they needed to complete the form when it was initially submitted.
What if I have questions not answered in these instructions?	If the state has questions while completing the monthly report, please email the technical assistance help desk at **C**MSEligEnrollSupport@cms.hhs.gov**.**

A. Monthly Report Metric Specifications

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

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

1. Monthly Report Metrics 1-3: Application Processing

States report Monthly Report Metrics 1-3 and submetrics only until all pending applications that were received between March 1, 2020, and the end of the month prior to the state's unwinding period are processed. Once a state has completed and reported the processing of all pending applications as 0 to CMS, the fields may be left blank in future submissions.

Additionally, in the monthly reports, states will report on number of applications completed and those that remain pending as of the last day in the reporting period covered by the report. Tables 2-4 provide instructions for how to report these metrics.

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

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

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

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

Table 3: Monthly Metrics 2, 2a, and 2b

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

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

Table 4: Monthly Metrics 3, 3a, and 3b

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

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

2. Monthly Report Metric 4: Renewals Initiated

States report on the number of renewals initiated in the monthly reports. Table 5 provides instructions for how to report this metric.

Table 5: Monthly Metric 4

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

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

States report on the number of beneficiaries due for renewal and the final disposition of renewals in the monthly reports. Tables 6-8 provide instructions for how to report these metrics.

Table 6: Monthly Metrics 5, 5a, 5a(1), 5a(2), 5b, 5c, and 5d

Metric 5: Total beneficiaries due for a renewal in the reporting period	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, with a renewal due, or scheduled for completion, in the reporting period. A renewal is considered due in the month that aligns with the last day of coverage for a cohort (regardless of when the renewal is initiated), **not** the first date that bulk disenrollments are effective. – For example, a beneficiary who is determined ineligible and whose last day of coverage is June 30, 2024, is considered to have a renewal due in the June reporting period. • **This metric is not cumulative** and should only include data on renewals due in the reporting period, representing beneficiaries whose renewal processes were initiated in a prior month, based on the state's renewal policy. In this context, which renewals are "due" relate to the state's timeline for the renewal process. For example, if a state initiated a batch of renewals on March 15th and has a timeline of 75 days for the renewal process, CMS considers that batch of renewals "due" at the end of May. • Note: When a state has no renewals due in a reporting period, the state may report "0" and include a data note. • This metric is the sum of metrics 5a, 5b, 5c, and 5d. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	Renewals that have been initiated but are not due in the reporting period and renewals that have not been initiated.
What do states include in the Metric 5 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.
Metric 5a: Of the beneficiaries included in Metric 5, the number renewed and retained in Medicaid or CHIP (those who remained enrolled)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP at the end of the reporting period. • **This metric is not cumulative** and should only include those beneficiaries renewed and retained in the reporting period. • This metric is a subset of metric 5. • This metric is the sum of metrics 5a(1) and 5a(2). • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary whose renewal was due in the reporting period but their eligibility was not retained in Medicaid or CHIP at the end of the reporting period.
What do states include in the Metric 5a Notes free text field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format for metrics 5a, 5a(1), or 5a(2).
Metric 5a(1): Number of beneficiaries renewed on an *ex parte*[2] basis	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period on an *ex parte* basis, meaning eligibility was redetermined based on information available to the agency without requiring additional information from the individual. • **This metric is not cumulative;** states only report on those beneficiaries that were renewed on an *ex parte* basis in the reporting period. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary not renewed through *ex parte* processes whose renewal was due in the reporting period.

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

Metric 5a(2): Number of beneficiaries renewed using a renewal form	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period who were renewed and retained in Medicaid or CHIP in the reporting period using a renewal form. • Some states have an approved mitigation to check and use data sources to renew coverage if they are able to do so after a beneficiary was sent a renewal form, regardless of whether the form was returned. This is referred to as a "back-end *ex parte* renewal." States include any individuals who were renewed with this mitigation strategy in this metric. • **This metric is not cumulative**; states only report on those beneficiaries that were renewed using a renewal form in the reporting period. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary not renewed through use of a form in the reporting period.
Metric 5b: Of the beneficiaries included in Metric 5, the number determined ineligible for Medicaid or CHIP	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period and who were determined ineligible for Medicaid or CHIP. This includes all individuals for whom the state has sufficient information to make a determination of ineligibility. • **This metric is not cumulative** and only includes data on beneficiaries determined ineligible for Medicaid or CHIP in the reporting period. • Individuals who request voluntary disenrollment or closure *after* their renewal is initiated should be counted in this metric. Individuals the state verifies as being deceased or no longer a state resident during the renewal process are also counted in this metric. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary who remained eligible for Medicaid or CHIP coverage, any beneficiary the state redetermines as ineligible based on a change in circumstances in between regular renewals, and any beneficiary who requested voluntary closure prior to the initiation of their renewal.
What do states include in the Metric 5b Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.
Metric 5c: Of the beneficiaries included in Metric 5, the number disenrolled for procedural reasons (i.e., failure to respond)	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewal was due in the reporting period and whose coverage ended because the state has insufficient information to complete an eligibility determination, also known as procedural reasons. • Procedural reasons include instances where a beneficiary fails to return the renewal form or other information necessary to complete a Medicaid or CHIP renewal. • **This metric is not cumulative** and only includes data on beneficiaries whose renewal is due and were disenrolled from Medicaid or CHIP for procedural reasons in the reporting period. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• All exclusions listed in metric 5. • Any beneficiary who was not disenrolled for procedural reasons in the reporting period, which includes: – (1) any beneficiary who the state determined ineligible, or verified at renewal as deceased or no longer a state resident; – (2) any beneficiary who was disenrolled for failure to respond to a request for information related to a change in circumstances in between regular renewals; and – (3) any beneficiary the state would have disenrolled for a procedural reason, except the disenrollment was not effectuated because of a state's mitigation plan or adoption of strategies that allow the state to hold procedural disenrollments.

What do states include in the Metric 5c Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.
Metric 5d: Of the beneficiaries included in Metric 5, the number whose renewal was not completed	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, whose renewals were due in the reporting period but were not completed by the end of the reporting period. In other words, a final eligibility determination had not been made as of the end of the reporting period. • This metric is also known as "pending renewals." • If the state is holding procedural disenrollments in a particular month(s), the state should include the beneficiaries whose renewal was due but who are not being procedurally terminated during the reporting period in this metric. • Individuals who were sent advance notice of disenrollment for failure to return their renewal form but return their renewal form before their coverage ends should also be reported in this metric. • **This metric is not cumulative** and only includes data on incomplete renewals, including those for whom procedural disenrollments were held, that were due in the reporting period. • This metric is a subset of metric 5. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Any beneficiary whose renewal was completed. • Any beneficiary the state has not initiated a renewal regardless of the month the individual's renewal is due.
What do states include in the Metric 5d Notes?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • If the state is holding procedural disenrollments, please include a note for the relevant month and, if possible, include the number of affected individuals.

Table 7: Monthly Metric 6

Metric 6: Month in which renewals due in the reporting period were initiated	
How is the metric defined?	States expand a drop-down menu and select the month in which the renewals that were due in the reporting period covered by the report were initiated; this should be based on the state's timeline for the renewal process.
What do states include in the Metric 6 Notes?	• If a state initiates a cohort due in a particular month across multiple months, please include those months in the notes. The portal only permits states to select a single month via the drop-down, however, states can add additional months in the notes. • If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 8: Monthly Metric 7

Metric 7: Number of beneficiaries initiated and due for a renewal whose renewal has not yet been completed	
How is the metric defined?	• This is defined as the total number of beneficiaries, including those receiving full or limited benefits, due for renewal whose renewal has been initiated but not been fully processed. This is commonly referred to as the "renewal backlog," representing all renewals that have been initiated and scheduled for completion, but are not complete as of the end of the reporting period. • States that are holding procedural disenrollments should report the beneficiaries whose renewal was due but for whom the state is holding the procedural disenrollment in this metric until these renewals reach a final disposition. • **This metric is cumulative;** it counts all renewals that have been initiated to date **and** were due prior to or as of the last day of the reporting period covered by this report (per the state's timeline for the renewal process), but whose renewals were not fully processed as of the last day in the reporting period. • States should be cautious of simply adding the numbers previously reported in 5d, as doing so would not reflect renewals that may have been completed after the month in which it was due. • This metric must be reported at the individual level, not household.

What is excluded from this metric?	All renewals that have been completed, and any renewals the state has not initiated, regardless of when the renewal is due.
What do states include in the Metric 7 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. • If the state is holding procedural disenrollments, please include a note for the relevant month and if possible, include the number of affected individuals.

4. Monthly Report Metric 8: Medicaid Fair Hearings

States must report Medicaid fair hearings that have been pending more than 90 days at the end of the reporting period. Table 9 provides instructions for how to report this metric.

Table 9: Monthly Metric 8

Metric 8: Total number of Medicaid fair hearings pending more than 90 days at the end of the reporting period	
How is the metric defined?	• This metric includes: – All pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 431.224(a), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 431.221(a)(1) as of the end of the reporting period. – All pending fair hearings for which the state has not taken action within 90 days from the date the enrollee filed a managed care organization (MCO), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) appeal, not including the number of days the enrollee took to subsequently file for a State fair hearing. – This includes Medicaid fair hearing requests received both before and after the end of the continuous enrollment condition. – All pending Medicaid fair hearings governed by the rules at 42 CFR part 431 subpart E, not just fair hearings related to eligibility determinations. – For states utilizing Medicaid expansion CHIP, all pending fair hearings, including those meeting the criteria for an expedited resolution in accordance with 42 C.F.R. § 457.1160(a) or 42 C.F.R. § 457.1260(f), for which the state has not taken final administrative action within 90 days of the date the agency received a request for a fair hearing in accordance with 42 C.F.R. § 457.1130(a) as of the end of the reporting period.
What is excluded from this metric?	• Fair hearings for which a final fair hearing decision was issued and a state has taken final administrative action in accordance with 42 CFR 431.244(f). A final fair hearing decision may include a dismissal of the fair hearing request. • Appeals still pending with the managed care plan which have not yet proceeded to a State fair hearing governed by the rules at 42 CFR part 431 subpart E. • Separate CHIP review data.
What do states include in the Metric 8 Notes field?	• If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format. For example, please specify if the state is not able to report solely Medicaid fair hearings data and has included separate CHIP reviews in the reported information. • If data are available, states may include in the Metric 8 Notes field the number of fair hearings reported in the total that are pending more than 90 days because the appellant requested a delay or failed to take a required action (see 42 CFR 431.244(f)(4)(i)(A)). • This field should be left blank if the state has nothing additional to report.

5. Monthly Report Metrics 9-13: Renewals and Outcomes (Community Engagement)

Any state and the District of Columbia that elects to provide coverage to 1) the adult group described in 42 § C.F.R. 435.119 under the state plan or 2) to certain individuals generally described at § 435.119 who are enrolled in a section 1115 demonstration that provides minimum essential coverage (MEC) to such population ("applicable 1115 waiver") must apply community engagement requirements described in section 1902(xx) of the Social Security Act (the Act) as a condition of eligibility for applicants and beneficiaries. In accordance with § 435.562, these states must report data in the monthly reports about the final disposition of renewals for beneficiaries who were specified excluded individuals described in § 435.554 or applicable individuals in § 435.554 at renewal. CMS collects this data through metrics 9, 10, 11, 12, and 13 of the monthly report. States begin reporting metrics 9 through 13 for the reporting month the community engagement requirement under section 1902(xx) of the Act is effective in the state. CMS recognizes that when a state first implements community engagement that it will report "0" for renewal outcomes in metrics 9 through 13 until the monthly report in which the first cohort of renewals that include beneficiaries subject to community engagement is due in the reporting period. Tables 10-14 provide instructions for how to report metrics 9 through 13.

States that do not provide Medicaid to applicable individuals described in section 1902(xx) of the Act do not need to report Metrics 9 through 13 to CMS.

Table 10: Monthly Metric 9

Metric 9: Of the beneficiaries included in metric 5a, the number renewed who are determined to be a specified excluded individual	
How is the metric defined?	• This is defined as the total number of beneficiaries who: – Were due for renewal in the reporting period; – Were renewed in the Medicaid adult group described in § 435.119 or an applicable 1115 waiver; and – Were determined to be a specified excluded individual at renewal. • **This metric is not cumulative**; states only report on those beneficiaries that were renewed in the reporting period who were a specified excluded individual. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Renewals for specified excluded individuals that have been initiated but are not due in the reporting period and renewals that have not been initiated. • Any beneficiary renewed in the adult group described in § 435.119 or applicable 1115 waiver who was determined to be an applicable individual at renewal. • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver whose renewal remained pending at the end of the reporting period and does not have a determination of eligibility. • Any Medicaid or CHIP beneficiary who was renewed in a group other than the adult group described in § 435.119 or applicable 1115 waiver. • Any beneficiary whose renewal was due in the reporting period, but their eligibility was not retained in Medicaid or CHIP at the end of the reporting period.
What do states include in the Metric 9 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 11: Monthly Metric 10

Metric 10: Of the beneficiaries included in metric 5a, the number renewed who are applicable individuals and either demonstrated community engagement or were deemed to have demonstrated community engagement by meeting a mandatory exception	
How is the metric defined?	• This is defined as the total number of beneficiaries who: – Were due for renewal in the reporting period; – Were determined to be an applicable individual described in § 435.551 at renewal; and – Were renewed in the Medicaid adult group described in § 435.119 or an applicable 1115 waiver and demonstrated community engagement or were deemed to have demonstrated community engagement based on a mandatory exception. • **This metric is not cumulative**; states only report on those beneficiaries that were renewed in the reporting period who were an applicable individual and demonstrated community engagement or were deemed to have demonstrated community engagement at renewal based on a mandatory exception. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Renewals for applicable individuals that have been initiated but are not due in the reporting period and renewals that have not been initiated. • Any beneficiary renewed in the adult group described in § 435.119 or applicable 1115 waiver who was determined to be a specified excluded individual at renewal. • Any beneficiary renewed who was determined to be an applicable individual and who was deemed to have demonstrated community engagement for one or more months at renewal due to a short-term hardship exception. • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver whose renewal was due and remained pending at the end of the reporting period. • Any Medicaid or CHIP beneficiary who was renewed in a group other than the adult group described in § 435.119 or applicable 1115 waiver. • Any beneficiary whose renewal was due in the reporting period, but their eligibility was not retained in Medicaid or CHIP at the end of the reporting period.
What do states include in the Metric 10 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 12: Monthly Metric 11

Metric 11: Of the beneficiaries included in metric 5a, the number renewed who are applicable individuals and were deemed to have demonstrated community engagement by meeting a short-term hardship exception	
How is the metric defined?	• This is defined as the total number of beneficiaries who: – Were due for renewal in the reporting period; – Were determined to be an applicable individual at renewal; and – Were renewed in the Medicaid adult group described in § 435.119 or an applicable 1115 waiver and were deemed to have demonstrated community engagement for one or more months based on a short-term hardship exception described in § 435.555. • **This metric is not cumulative**; states only report on those beneficiaries that were renewed in the reporting period who were an applicable individual and were deemed to have demonstrated community engagement for one or more months at renewal based on a short-term hardship exception. • This metric is a subset of metric 5a. • This metric must be reported at the individual level, not household. • States that do not elect to offer short-term hardships for applicable individuals in the state plan may select that this metric is not applicable rather than report a value of “0”.

What is excluded from this metric?	• Renewals for applicable individuals that have been initiated but are not due in the reporting period and renewals that have not been initiated. • Any beneficiary renewed in the adult group described in § 435.119 or applicable 1115 waiver who was determined to be a specified excluded individual at renewal. • Any beneficiary renewed who was determined to be an applicable individual and who demonstrated community engagement or was deemed to have demonstrated community engagement due to a mandatory exception for all months selected by the state for individuals to demonstrate community engagement at renewal. • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver whose renewal was due and remained pending at the end of the reporting period. • Any Medicaid or CHIP beneficiary who was renewed in a group other than the adult group described in § 435.119 or applicable 1115 waiver. • Any beneficiary whose renewal was due in the reporting period, but their eligibility was not retained in Medicaid or CHIP at the end of the reporting period.
What do states include in the Metric 11 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 13: Monthly Metric 12

Metric 12: Of the beneficiaries included in metric 5b, the number determined ineligible due to not meeting the community engagement requirement after being provided a notice of noncompliance	
How is the metric defined?	• This is defined as the total number of beneficiaries who: – Were due for renewal in the reporting month; – Met all eligibility criteria in the adult group described in § 435.119 or applicable 1115 waiver except community engagement; and – Were determined ineligible for Medicaid due to not meeting the community engagement requirement after being provided a notice of noncompliance; and • Individuals who did not meet the Medicaid community engagement requirement are those for whom the state had sufficient information to determine that the individual was not a specified excluded individual or was an applicable individual who did not demonstrate or was deemed to have demonstrated community engagement. • **This metric is not cumulative**; states only report on those beneficiaries that were determined ineligible in the reporting period for not meeting the community engagement requirement. • This metric is a subset of metric 5b. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Renewals that have been initiated but are not due in the reporting period and renewals that have not been initiated. • Any beneficiary who remained eligible for Medicaid or CHIP coverage during the reporting period. • Any beneficiary the state redetermines as ineligible based on a change in circumstances in between regular renewals, and any beneficiary who requested voluntary closure prior to the initiation of their renewal. • Individuals who were determined ineligible for not meeting other program eligibility criteria (for example, ineligible based on income or state residency). • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver who did not return their renewal form or requested information needed to renew eligibility. • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver whose renewal was due and remained pending at the end of the reporting period.
What do states include in the Metric 12 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

Table 14: Monthly Metric 13

Metric 13: Of the beneficiaries included in metric 5c, the number disenrolled for procedural reasons after being provided a notice of noncompliance with community engagement	
How is the metric defined?	• This is defined as the total number of beneficiaries: – Whose renewal was due in the reporting period, and – Who otherwise met program eligibility criteria (for example, income and residency) but did not provide sufficient information necessary for the state to determine if the individual was a specified excluded individual or was an applicable individual who demonstrated or was deemed to have demonstrated community engagement after providing a notice of noncompliance with community engagement. • **This metric is not cumulative** and only includes data on beneficiaries whose renewal is due and were disenrolled from Medicaid for procedural reasons in the reporting period after being provided a notice of noncompliance with community engagement. • This metric must be reported at the individual level, not household.
What is excluded from this metric?	• Renewals that have been initiated but are not due in the reporting period and renewals that have not been initiated. • Any beneficiary who remained eligible for Medicaid or CHIP coverage during the reporting period. • Individuals who were determined ineligible due to not meeting the community engagement requirement after being provided a notice of noncompliance (i.e., state has sufficient information related to community engagement) or for not meeting other eligibility criteria (for example, ineligible based on income or state residency). • Individuals enrolled in the adult group described in § 435.119 or applicable 1115 waiver disenrolled for procedural reasons for failing to return their renewal form or requested information needed to verify other eligibility criteria (for example, insufficient information to verify income or state residency). • Any beneficiary enrolled in the adult group described in § 435.119 or applicable 1115 waiver whose renewal was due and remained pending at the end of the reporting period.
What do states include in the Metric 13 Notes field?	If a state has any additional context that impacts the data that they feel CMS should be aware of, they should use the free text field to report that information in narrative format.

III. Reporting Outcomes of Previously Pending Renewals

A. Introduction

States may not always complete renewals by the renewal due date. These renewals are considered "pending" renewals and are reported in submetric 5d of the monthly renewal report described in Section II. To understand the disposition of renewals that are initially reported as pending, CMS issued revised specifications to collect these data. Subsections B and C outline the key details of this reporting.

B. Reporting Schedule

States report the updated monthly report with the outcomes of previously pending renewals by the 15th of the month in accordance with the sample schedule in Table 10 below.

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

States submit an updated monthly report consistent with the example timeframes outlined in Table 10.

Table 15: Sample Timeline for Updating and Submitting Monthly Reports with Outcomes of Previously Pending Renewals

Column 1	Column 2	Column 3	Column 4
Monthly report	**Original data report due date**	**Updated data report "as of date" for previously pending renewals**	**Updated data report due to CMS**
June (2027)	July 8	September 30	October 15, 2027
July (2027)	August 8	October 31	November 15, 2027
August (2027)	September 8	November 30	December 15, 2027

C. Specifications for Reporting Outcomes of Previously Pending Renewals

1. What data are updated?

For each monthly report, states update the monthly metric 5 and its submetrics (monthly metrics 5a, 5a(1), 5a(2), 5b, 5c, and 5d), and metrics 9, 10, 11, 12, and 13, as needed, to reflect the outcomes of renewals previously reported as pending (monthly metric 5d of the original monthly report). As a reminder, metric 5 represents the total number of beneficiaries due for renewal in the reporting period, and the submetrics (5a, 5a(1), 5a(2), 5b, 5c, and 5d) represent the dispositions of those renewals. The submetrics are as follows:

- 5a, total beneficiaries renewed and retained in Medicaid and CHIP
- 5a(1), total beneficiaries renewed on an *ex parte* basis
- 5a(2), total beneficiaries renewed using a renewal form
- 5b, total beneficiaries determined ineligible for Medicaid or CHIP

- 5c, total beneficiaries who were disenrolled for procedural reasons
- 5d, total beneficiaries whose renewal was not completed ("pending renewals")

Metrics 9, 10, 11, 12, and 13 represent the dispositions of renewals for beneficiaries who were determined to be specified excluded individuals or applicable individuals at renewal as described in section 1902(xx) of the Act in the monthly reports. The metrics are as follows:

- 9, total beneficiaries renewed who were a specified excluded individual
- 10, total beneficiaries renewed who were applicable individuals and demonstrated community engagement or who were deemed to have demonstrated community engagement due to a mandatory exception
- 11, total beneficiaries renewed who were applicable individuals and were deemed to have demonstrated community engagement due to a short-term hardship exception
- 12, total beneficiaries determined ineligible due to not meeting the community engagement requirement
- 13, total beneficiaries disenrolled for procedural reasons after being provided a notice of noncompliance with community engagement

In updating the monthly metrics, states report the dispositions of pending renewals as of the last day of the third month after the original reporting period. For example, when states update the July 2027 monthly report, states report the status or disposition of previously pending renewals as of October 31, 2027. When states update the August 2027 monthly report, states report the status of previously pending renewals as of November 30, 2027.

Table 16 below presents an illustrative example of how CMS expects states to update prior monthly reports to incorporate the outcomes of previously pending renewals for metric 5 and its submetrics.

- **Column 2** represents the original monthly report, reflecting outcomes as of the end of the reporting period (March in this example) and showing 200 pending renewals.[3]
- **Column 3** reflects the information states need to collect – the disposition of the 200 renewals reported as pending in Column 2, as of June 30, the last day of the third month after the March reporting period. **States do not report the values shown in Column 3 to CMS.**

Column 4 reflects the values states will input into the data collection portal

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

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

Column 1	Column 2	Column 3	Column 4
Metric	**Original March 2027 Monthly Report, as submitted to CMS by April 8, 2027**	**Outcomes of 200 previously pending renewals as of June 30, 2027**	**Updated July Monthly Report, as submitted to CMS by July 15, 2027**
5. Renewals due	1000		1000
5a. Number renewed and retained in Medicaid or CHIP	550	+100	650
5a(1). Number renewed on *ex parte* basis	300	+0	300
5a(2). Number renewed using a renewal form	250	+100	350
5b. Number determined ineligible for Medicaid or CHIP using a renewal form	200	+50	250
5c. Number disenrolled for procedural reasons	50	+50	100
5d. Number whose renewal was not completed ("pending renewals")	200	-200	0

2. What do the updated data include and exclude?

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

States also make corresponding updates about the final disposition of renewals for beneficiaries who were specified excluded individuals or applicable individuals at renewal as described in section 1902(xx) of the Act. Outcomes of pending renewals for those renewed in the adult group or an applicable 1115 waiver are added to the appropriate outcome based on how they were adjudicated: renewed who were a specified excluded individual (9), renewed who demonstrated community engagement or who met a mandatory exception (10), renewed who met a short-term hardship exception (11), determined ineligible due to not meeting the community engagement requirement (12), disenrolled for procedural reasons after being provided with a notice of noncompliance with community engagement (13). These updates are a subset of the updates to metric 5 and its submetrics. States do not need to separately subtract data reported in pending renewals submetric (5d) to report updates for metrics 9 through 13.

These updates do *not* include a revised outcome for a renewal that reached a final disposition (i.e., reported in monthly metric 5a (including 5a(1) and 5a(2)), 5b, 5c, 9, 10, 11, 12, or 13)) as of the end of

the original reporting period because the individual experienced a change in circumstances following the renewal. States do not include outcomes of renewals when an individual returns a form during the reconsideration period.

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

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

D. Frequently Asked Questions

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

1. What is the difference between an "update" and a "correction"?
   - CMS is using "update" in this context to refer to changes made to a monthly report to reflect the outcomes of previously pending renewals three months after the original monthly report submission.
   - CMS is using "correction" to refer to changes made to a monthly report to revise previously reported data. Such corrections reflect the status of outcomes as of the end of the original reporting period and may include changes such as fixing typos, correcting data reported for the wrong submetric, or other inaccuracies identified.
2. Which metrics are updated?
   - States update the outcome metrics: 5a, 5a(1), 5a(2), 5b, 5c, 5d, 9, 10, 11, 12, and 13. CMS would not generally expect changes to metric 5, renewals due in the reporting period, unless the state is also reporting corrections (see question 3 below).
3. What, if anything, do states include in the notes field for corrections?
   - If the state makes corrections, please add to the notes for relevant metrics: "The data also reflect corrections not previously reported."
4. The state identified an issue and reinstated coverage for beneficiaries who were reported as procedurally disenrolled. How should these reinstatements be reflected as a correction or an update?
   - Reinstatements of coverage following a disenrollment are not included as a correction nor an update.
5. How can the state reflect the status of individuals who were procedurally terminated, but returned their renewal form during the reconsideration period?
   - The reporting detailed in Section III collects the outcomes for individuals whose renewals were previously reported as pending. Individuals who returned their renewal form during the reconsideration period would have already been terminated for procedural reasons, and thus are not included as part of this update.

- If the state is tracking the number of individuals that return renewal forms during the reconsideration period and their outcomes, and would like to share this information with CMS, please feel free to include it in the *notes field* for metric 5c.

6. Do states include the status of individuals who completed a renewal, but later experienced a change in circumstance in the updated reports?
   - No. The purpose of metrics 5 (and its submetrics), 6, 7, 9, 10, 11, 12, and 13 of the data report is to collect the outcomes for individuals' renewals. As such, the state does not update the status of outcomes for individuals for whom the state previously determined eligible to reflect the result of a redetermination based on a change in circumstances that occurs after the renewal.
7. What if my state is unable to report the dispositions of previously pending renewals as described in Section III of this document?
   - If a state is unable to report these data, please notify CMS by sending an email to CMSEligEnrollSupport@cms.hhs.gov as soon as possible for technical assistance.

IV. Change Log

Table 17: Change Log

No.	Change	Date
1	Updated baseline report submission due date, consistent with COVID-19 Unwinding FAQs released by CMS in October 2022	12/2022
2	Added additional reporting guidance when submission date falls on holiday or weekend	12/2022
3	Added guidance that states should note in the free-text field if they are reporting application processing metrics at the household level	12/2022
4	Added definition of disability-related application, consistent with COVID-19 Unwinding FAQs released by CMS in October 2022	12/2022
5	Added context related to the Consolidated Appropriations Act, 2023	10/2023
6	Removed guidance around selecting “unable to report” for all metrics	10/2023
7	Added guidance around Medicaid fair hearings that should be included and excluded in the unwinding metric reports	10/2023
8	Clarified expectations around reporting metrics at the household vs. individual level	10/2023
9	Clarified guidance for metric 5b (beneficiaries determined ineligible for Medicaid or CHIP) to remove language around transfers to the Marketplace	10/2023
10	Removed “annual” from specifications for reporting Medicaid renewals initiated and outcomes	10/2023
11	Removed “prepopulated” from specifications for reporting metric 5a(2) (beneficiaries renewed using a renewal form)	10/2023
12	Added guidance for state reporting related to mitigation strategies	10/2023
13	Added Chapter IV with guidance for reporting pending renewals	10/2023
14	Removed Chapter II reporting guidance pertaining to the Unwinding Baseline Report	7/2024
15	Made minor edits to guidance for metrics 4, 5, 5a, 5a(1), 5a(2), 5b, 5c, 5d, 6, 7, and 8	7/2024
16	Updated Chapter III, Reporting the Outcomes of Previously Pending Renewals, to account for ongoing data reporting	7/2024
17	Updated technical assistance mailbox to CMSEligEnrollSupport@cms.hhs.gov	11/2025
18	Made non-substantial revisions to replace all instances of “procedural termination” and “procedurally terminated” to “procedural disenrollment” and “procedurally disenrolled” and update the year in the examples to align with timing of this update	6/2026
19	Updated Chapter II and Chapter III to account for reporting renewal outcomes related to Medicaid community engagement requirements	6/2026