

Technical Resource Guide - Operational Implementation: State Medicaid/CHIP Agencies Accepting Federally-facilitated Marketplace (FFM)* Eligibility Decisions

Last updated October 2022

**This resource is intended only for states that use the Federal Marketplace platform, including State-based Marketplaces using the Federal platform (SBM-FPs). Throughout, these states are referred to as Federally-Facilitated Marketplace (FFM) states.*

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- Purpose
- Background: Account Transfer (AT)
- State Models for Handling FFM Eligibility Decisions
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Purpose

Provide State Medicaid and Children's Health Insurance Program (CHIP) Agency (SMA) policy and technical staff an implementation guide for accepting FFM Medicaid and CHIP program eligibility decisions as assessments or as final determinations (either temporarily or by formally delegating eligibility determination authority to the FFM).

For an explanation of the considerations in deciding which approach to select, please see the "Overview: State Medicaid/CHIP Agencies Accepting Federally-facilitated Marketplace Eligibility Decisions" document.

Background: Account Transfer (AT)

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Contents

- Background
- Key Terminology: AT Operations
- High-level Overview of AT
- Outbound (OB) AT
- Outbound Response (OBR) AT
- Inbound (IB) AT

Purpose

- This section is intended to provide an overview of the AT process, the flow of information from the FFM to the SMA and the SMA to the FFM, and the three types of AT transactions between the FFM and the SMA.

Audience

- State policy and technical staff

Background

What is an AT?

- An AT is the sending of a consumer's account, as required under 42 CFR § 435.1200, 42 CFR § 457.348, 45 CFR § 155.345, including information used to evaluate eligibility for an insurance affordability program, via a secure electronic file between the FFM and SMAs, to facilitate a single, streamlined application (SSApp) or coverage transition process for consumers, regardless of the initial point of application.
- The FFM has three AT types
 - Outbound (OB) AT¹: FFM to state
 - Outbound Response (OBR) AT: Deferred² response from state to FFM, to communicate state's final eligibility determination for a consumer initially referred via OB AT
 - Inbound (IB) AT: State to FFM

1. There is an additional transaction referred to as an acknowledgment; this is an immediate (synchronous) payload from SMA to FFM to indicate that the SMA received an Outbound AT

2. The OBR AT is not an immediate acknowledgement of/response to an OB AT; it occurs only after the state has made a final eligibility determination

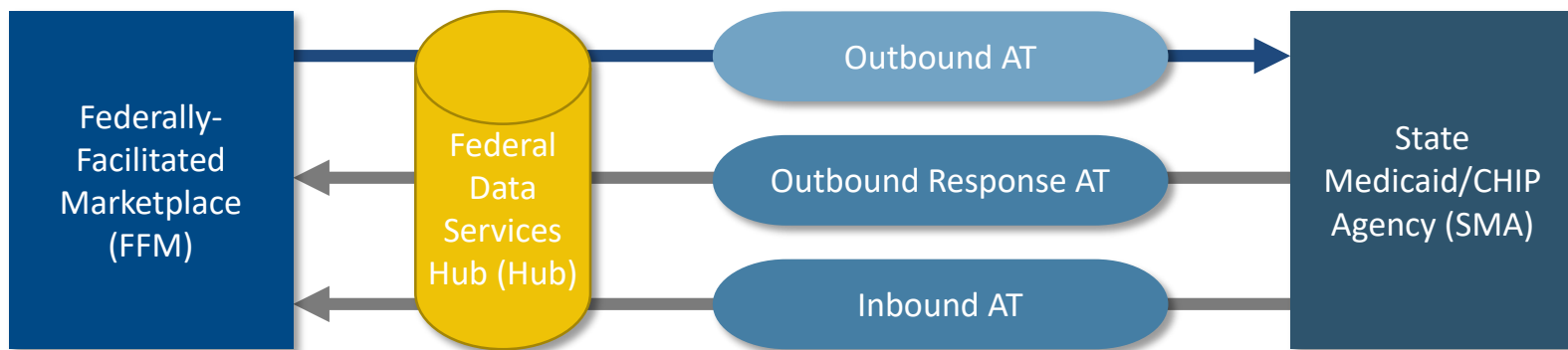
Key Terminology: AT Operations

Terminology	Definition
Non-MAGI Medicaid Referral	<p>Accounts are automatically sent from the FFM to the state via OB AT for a non-Modified Adjusted Gross Income (MAGI) Medicaid determination if a consumer meets at least <u>one</u> of the following criteria:</p> <ul style="list-style-type: none"> ○ Answers “yes” to specific screening questions ○ Is at least 65 years old ○ Receives Title II income related to having a disability <p>All FFM states must make eligibility determinations for all non-MAGI referrals</p>
Full Determination	<p>An applicant whom the FFM evaluates as ineligible for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the state, can request to be sent to the state for a full determination.</p> <p>In assessment (FFM-A) and temporary determination (FFM-Temp D) states, the state must evaluate the applicant on all bases (MAGI and non-MAGI). In determination (FFM-D) states, the state must evaluate the consumer on a non-MAGI basis only. Required in accordance with 45 CFR § 155.345(b) and (c)</p>
Referred	<p>A consumer on a transferred account that is sent from the FFM to the state for Medicaid/CHIP eligibility; can have a status of fully-verified, pend, and/or inconsistent (regardless of FFM-A, FFM-Temp D, or FFM-D state)</p>
Verified	<p>All factors of eligibility for Medicaid/CHIP have been verified by the FFM, including immigration status or U.S. citizenship, income, and residency; no further verification of the information needed by the state unless the state’s hierarchy has a verification data source other than what FFM uses to verify</p>

Key Terminology: AT Operations (con't.)

Terminology	Definition
Pend	A verification issue that occurs when income, residency, and/or Social Security Number (SSN) are unverified or data sources are not aligned with consumers' attestation.
Inconsistency	A verification issue that occurs when an applicant's U.S. citizenship or immigration status is unverified.

High-level Overview of AT



Outbound (OB) AT (from FFM to SMA)

- Initial transfer of consumer account information from FFM to SMA via the Hub
- Occurs when a consumer applies at the FFM and at least one applicant:
 - Is assessed/determined by the FFM to be MAGI-based Medicaid/CHIP-eligible, Emergency Medicaid-eligible, or CHIP Unborn Child-eligible;
 - Requests a full determination; and/or
 - Needs to be evaluated for Medicaid on a non-MAGI basis *or* for CHIP waiting period exceptions

Outbound Response (OBR) AT (from SMA to FFM)

- *Deferred* response from SMA to FFM via the Hub, regarding SMA eligibility determination for a consumer sent via OB AT
- SMAs should send OBR ATs for consumers they determine Medicaid/CHIP eligible *and* ineligible
 - For consumers found by SMA to be ineligible for Medicaid/CHIP: Upon receipt of the OBR AT, the FFM generates a notice¹ to the consumer that they have been denied Medicaid/CHIP by the SMA and to update and resubmit their FFM application to see if they are eligible for a qualified health plan (QHP) with or without financial assistance
 - For consumers found by SMA to be eligible for Medicaid/CHIP: Upon receipt of the OBR AT, the FFM does not generate a notice to the consumer

1. Sample FFM OBR AT notice: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/outbound-account-transfer.pdf>

Inbound (IB) AT (from SMA to FFM)

- Sent from SMA to FFM via the Hub when a consumer's application for Medicaid/CHIP is denied, they are terminated at renewal, they have a change in circumstances which makes them Medicaid/CHIP-ineligible, or they lose Medicaid/CHIP for reasons other than a procedural denial or termination¹
- Upon receipt of the IB AT, the FFM generates a notice² to the consumer that they have been denied Medicaid/CHIP by the SMA, and tells them to create and submit a new FFM application to see if they are eligible for a QHP with or without financial assistance
- Presence of the IB AT can also help the consumer avoid needing to send in documentation proving their eligibility for a Medicaid/CHIP Denial or Loss of Minimum Essential Coverage (MEC) special enrollment period (SEP), when outside of Open Enrollment (OE)

1. There are some exceptions to states responsibilities to send Inbound ATs to the FFM. For details see: <https://www.hhs.gov/guidance/document/coordination-eligibility-and-enrollment-between-medicaid-chip-and-federally-facilitated>

2. Sample FFM IB AT notice: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/inbound-account-transfer.pdf>

State Models for Handling FFM Eligibility Decisions

State Models for Handling FFM Eligibility Decisions

Contents

- Types of Accounts Sent by the FFM
- Overview of State Models
 - Assessment (FFM-A) States
 - Temporary Determination (FFM-Temp D) States
 - Determination (FFM-D) States
- Non-MAGI Referrals
- Full Determination Requests
- Payment Error Rate Measurement (PERM) Audits
- FFM-D State Appeals Delegation
- Summary: State Actions by Model

Purpose

- This section is intended to provide an overview of the models that states can choose to ensure coordinated eligibility and enrollment among insurance affordability programs, specifically between the FFM and SMAs in making MAGI-based Medicaid/CHIP eligibility as outlined in 42 CFR § 435.1200 and 45 CFR § 155.345. Accompanying each model's description is a summary of the state responsibilities; responsibilities that apply to all states regardless of model are also included.

Audience

- State policy and technical staff

Types of Accounts Sent by the FFM

- The FFM securely sends consumer information via Outbound AT through the Hub to the SMA, with applicants tagged for SMA action. The electronic account transfer includes information collected and generated by the FFM or the state regarding each individual's Medicaid/CHIP eligibility and enrollment.
- Regardless of the state model, states may receive the following types of accounts from the FFM:
 - Consumers assessed or determined as potentially eligible for MAGI-based Medicaid/CHIP
 - Consumers who attested to income within the Medicaid/CHIP range but whose information has not been fully-verified (i.e., have a pend/inconsistency)
 - Consumers who meet any criteria for a non-MAGI Medicaid referral
 - Consumers whom the FFM evaluates as ineligible for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the state, but who requested a full Medicaid/CHIP determination

Overview of State Models

States have the flexibility to decide whether the FFM or the state will make the final MAGI-based Medicaid and/or CHIP eligibility determination for consumers who apply for coverage at the FFM. There are three possible models:

- 1. FFM-A states:** The FFM makes a preliminary assessment of eligibility for MAGI-based Medicaid and/or CHIP, and the state Medicaid/CHIP agency makes a final eligibility determination
- 2. FFM-Temp D states:** The state temporarily accepts fully-verified FFM MAGI-based assessments of eligibility for Medicaid and/or CHIP as final determinations
- 3. FFM-D states:** The state formally delegates to the FFM the authority to make final eligibility determinations for MAGI-based Medicaid and/or CHIP, when the application information is fully-verified

IMPORTANT: Regardless of a state's model, the FFM will send them Outbound ATs for all referred applicants, including those with outstanding eligibility verification issues. The state needs to resolve outstanding verification issues, reach a final determination, and enroll applicants, as appropriate

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

Assessment (FFM-A) States

- FFM-A states use the FFM's preliminary assessment of MAGI-based Medicaid and/or CHIP eligibility to make a final determination of eligibility.
- For **MAGI-based** eligibility referrals, the SMA must:
 - Complete any necessary verifications (i.e., resolve inconsistencies and pends) for all accounts
 - Conduct a final Medicaid/CHIP eligibility determination
- For **non-MAGI referrals** and **requests for full determinations**, the SMA must conduct determinations
- If consumers are determined eligible, the SMA must timely enroll them in the appropriate eligibility group, as applicable
- The SMA must send an OBR AT for all OB ATs received, once final eligibility determination is complete

FFM-A States: State Responsibilities

- Work with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state data to support state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable
- Notify the FFM of receipt of the OB AT (acknowledgement)
- Promptly conduct a final MAGI and non-MAGI based eligibility determination, as applicable (for FFM MAGI-based referrals, non-MAGI referrals, and full determination requests – on all bases)
 - Do not require the consumer to start a new application
 - Do not request information from the consumer that is already included in the AT
 - Accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the SMA
 - Collect additional information to resolve any outstanding FFM Medicaid/CHIP verification issues
 - For pends, the state must attempt to resolve income and residency verification issues in accordance with requirements at 42 CFR § 435.948 and § 435.956(c)
 - For citizenship or immigration status inconsistencies, as required by 42 CFR § 435.956(b), the state must provide a reasonable opportunity period (ROP) to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals. The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP¹
- Notify the consumer of their final eligibility determination
- Begin providing coverage, as applicable
- Notify the FFM (via Outbound Response AT – SMA to FFM) of the SMA's final determination of the consumer's eligibility²

1. 45 CFR 155.305(c) and (d), 42 CFR 431.10(c)(1)(i)(3), and 42 CFR 457.348(b); ROP regulation at 42 CFR 435.956 for Medicaid and 42 CFR 457.380 for CHIP

2. See slide 39 for details on when Outbound Response ATs are needed

FFM-Temp D States: Temporarily accepting FFM MAGI-based Medicaid/CHIP assessments as determinations

- FFM-A states can elect to temporarily accept fully-verified FFM MAGI-based Medicaid and/or CHIP assessments as determinations (become an FFM-Temp D state). States do not need any additional or express authority from CMS to implement this option. However, states should seek concurrence from CMS when implementing this temporary policy to ensure proper implementation, provide documentation of the change for PERM/MEQC and other audits, and establish the timeframe for the use of this option¹
- For **MAGI-based** eligibility referrals, the SMA must:
 - Promptly enroll consumers for whom the FFM was able to fully verify their eligibility information
 - Complete verifications and conduct final eligibility determinations for consumers for whom the FFM was not able to verify their eligibility information
- For **non-MAGI** Medicaid referrals and **requests for full determinations**, the SMA must conduct determinations
- The SMA must enroll consumers as appropriate
- The SMA must send an OBR AT for all OB ATs received, once final eligibility determination is complete

1. FFM-Temp D is intended to only be used on a temporary basis. As part of the concurrence process, CMS will ask states to identify the timeframe for which they will use FFM-Temp D approach. States that wish to accept FFM eligibility results as determinations indefinitely should formally transition to an FFM-D by formally delegating to the FFM the authority to make MAGI-based eligibility determinations

FFM-Temp D States: State Responsibilities

- The state works with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state data to support state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable
- Notify the FFM of receipt of the OB AT (acknowledgement)
- Promptly enroll in MAGI-based Medicaid or CHIP referred individuals whose eligibility information has been fully-verified by the FFM
 - The state must accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the state agency
- For individuals with outstanding MAGI-based verification issues:
 - Collect additional information to resolve any outstanding verification issues
 - For pends, the state must attempt to resolve income and residency verification issues in accordance with requirements at 42 CFR § 435.948 and § 435.956(c)
 - For citizenship or immigration status inconsistencies, as required by 42 CFR § 435.956(b), the state must provide an ROP to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals. The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP¹
 - Complete a final determination, and enroll as applicable
- Determine eligibility on a non-MAGI basis, if applicable
- Determine eligibility on a MAGI and non-MAGI basis, for consumers who requested a full determination
- Notify the FFM (via Outbound Response AT – SMA to FFM) of SMA's final determination of the consumer's eligibility²

1. 42 CFR 435.956

2. See slide 39 for details on when Outbound Response ATs are needed

Determination (FFM-D) States

- FFM-D states formally delegate authority to the FFM, through the State Plan, to determine eligibility for MAGI-based Medicaid and/or CHIP, when the FFM can fully verify eligibility information. States can elect to accept fully-verified FFM MAGI-based eligibility determinations for both Medicaid and CHIP, only Medicaid, or only CHIP. The FFM (1) makes the final MAGI-based Medicaid and/or CHIP eligibility determination when no verifications issues are present or refers the account to the SMA in the case of a verifications issue, and (2) securely transmits the consumer's account information to the SMA via an Outbound AT through the Hub
- For **MAGI-based** eligibility referrals, the SMA must:
 - Promptly enroll consumers for whom the FFM was able to fully verify their eligibility information
 - Complete verifications and conduct final eligibility determinations for consumers for whom the FFM was not able to fully verify their eligibility information
- For **non-MAGI** Medicaid referrals and **requests for full determinations (on a non-MAGI basis only)**, the SMA must conduct final determinations
- If consumers are determined eligible, the SMA must timely enroll them in the appropriate eligibility group, as applicable
- The SMA must send an OBR AT for most OB ATs received, once final eligibility determination is complete

FFM-D States: State Responsibilities

- The state works with CMS, via the quarterly FFM Data Collection Tool update process, to ensure that state-specific MAGI-related Medicaid/CHIP eligibility rules are programmed into the FFM eligibility rules logic, as applicable
- Notify the FFM of receipt of the OB AT (acknowledgement)
- Promptly enroll in MAGI-based Medicaid or CHIP referred individuals whose eligibility information has been fully-verified by the FFM
 - The state must accept fully-verified FFM findings related to specific eligibility criteria, without further verification, if such findings were made in accordance with policies and procedures applied by the state agency
- For individuals with outstanding MAGI-based verification issues:
 - Collect additional information to resolve any outstanding verification issues
 - For pends, the state must attempt to resolve income and residency verification issues in accordance with requirements at 42 CFR § 435.948 and § 435.956(c)
 - For citizenship or immigration status inconsistencies, as required by 42 CFR § 435.956(b), the state must provide an ROP to the applicant while the state continues efforts to complete verification of the individual's U.S. citizenship or satisfactory immigration status or request documentation, if necessary. If an ROP is provided, the state agency must begin to furnish benefits to otherwise eligible individuals. The state agency may not delay, deny, reduce, or terminate benefits to otherwise eligible individuals during the ROP¹
 - Complete a final determination, and enroll as applicable
- Determine eligibility on a non-MAGI basis, if applicable (non-MAGI referrals and full determination requests – non-MAGI basis only)
- Notify the FFM (via Outbound Response AT – SMA to FFM) of SMA's final determination of the consumer's eligibility²

1. 42 CFR 435.956

2. See slide 39 for details on when Outbound Response ATs are needed

All FFM States: Non-MAGI Medicaid Referrals

- All FFM states must make eligibility determinations for all non-MAGI referrals
- Accounts are automatically sent via Outbound AT from the FFM to the SMA for a non-MAGI Medicaid determination if a consumer meets at least one of the following criteria:
 - Answers “yes” to specific screening questions (see image at right)
 - Is at least 65 years old
 - Receives Title II income related to having a disability

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[← Back](#) | [1 Set up](#) - **[2 Household](#)** - [3 Coverage & changes](#) - [4 Review & submit](#)

Disabilities & help with activities

Does Baby have a special health care need, physical disability, or mental health condition that limits their ability to work, attend school, or take care of their daily needs?

Optional.

[Learn how to answer and why we're asking.](#)

Yes

No

[Clear your selection](#)

Does Baby need help with daily activities (like dressing or using the bathroom), or live in a medical facility or nursing home?

Optional.

[Learn why we ask about needing help with daily activities.](#)

Yes

No

[Clear your selection](#)

[Save & continue](#)

All FFM States: Full Determination Requests¹

- FFM-A & FFM-Temp D states
 - Consumers in these states who are found ineligible by the FFM for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the SMA can request a **full determination** by the state
 - **The state must determine the consumer's Medicaid/CHIP eligibility on all bases (MAGI and non-MAGI)**
- FFM-D states
 - Consumers in these states who are found ineligible by the FFM for MAGI-based Medicaid, Emergency Medicaid, and who did not attest to a recent Medicaid/CHIP denial by the SMA can request that the state conduct a determination for **non-MAGI Medicaid**
 - **The state must determine the consumer's Medicaid eligibility on a non-MAGI basis only**

1. 45 CFR 155.302(b)(4)(i)(B)

Payment Error Rate Measurement (PERM) Audits

- Because FFM-Temp D and FFM-D states delegate authority to the FFM to determine MAGI-based eligibility when eligibility information is fully verifiable, these fully-verified FFM eligibility decisions may be sampled as part of Payment Error Rate Measurement (PERM)'s review of the accuracy of the FFM's eligibility decisions for MAGI-based Medicaid and CHIP
- Therefore, the FFM (not the state) would be responsible for any identified FFM-Temp D or FFM-D state fully verified eligibility determination errors. However, these states are still responsible for performing all required actions following receipt of the AT from the FFM and will be reviewed accordingly (e.g., placing the beneficiary in the correct category based on the FFM determination, correctly ingesting the AT file into the state eligibility system)
 - No FFM eligibility errors were identified in recent PERM audits of FFM eligibility decisions for fully-verified Medicaid/CHIP applications

FFM-D State Appeals Delegation

- FFM-D states have the option to delegate a subset of fair hearings for Medicaid and/or CHIP to the Federal Marketplace Appeals Entity
 - FFM-D states can opt to delegate fair hearings for consumers whose income eligibility is determined by the FFM based on MAGI¹
 - Individuals who are dissatisfied with the eligibility determination made by the FFM reserve the right to have their fair hearing conducted by either the state Medicaid or CHIP agency or the Federal Marketplace Appeals Entity
 - States must complete a Memorandum of Agreement (MOA) between the state agency and Federal Marketplace Appeals Entity²

1. States must continue to process fair hearings for all eligibility denials in which income is not determined based on MAGI and for all MAGI-based determinations made by the state

2. A template MOA between the State Medicaid Agency and CMS for appeals delegation is available from CMS upon request. The agreement specifies the responsibilities of the Federal Marketplace Appeals Entity and the Medicaid/CHIP agency and outlines the conditions under which the state delegates authority to the Federal Marketplace Appeals Entity to conduct fair hearings for denials of eligibility

Summary: State Actions by Model

	State Actions		
FFM Eligibility	FFM-A	FFM-Temp D	FFM-D
MAGI			
MAGI Medicaid or CHIP eligible <u>NO verification issues</u>	State processes AT, and makes final determination, and enrolls consumer as applicable	State enrolls applicant based on FFM's determination	
MAGI Medicaid or CHIP eligible <u>WITH outstanding verification issues related to residency and income</u> ("verification pend")	State processes AT, attempts to resolve verification pend, makes final determination, and enrolls consumer as applicable		
MAGI Medicaid or CHIP eligible <u>WITH verification issue related to citizenship or immigration</u> ("verification inconsistency" with NO pend)	State processes AT, provides ROP, attempts to resolve verification inconsistency, makes final determination, and enrolls consumer as applicable		
Other			
Non-MAGI Referrals	State processes AT, makes non-MAGI eligibility determination, and enrolls consumer as applicable		
Requests for Full Determinations	State processes AT, makes eligibility determination on all bases (MAGI and non-MAGI), and enrolls consumer as applicable	State processes AT, makes non-MAGI eligibility determination, and enrolls consumer as applicable	

NOTE: Refer to slide 44 for definitions of pends and inconsistencies

Deep Dive: Outbound AT

Deep Dive: Outbound AT

Contents

- Business Flow of OB and OBR ATs
- Data Flow
- Error Processing
- Payload FAQs

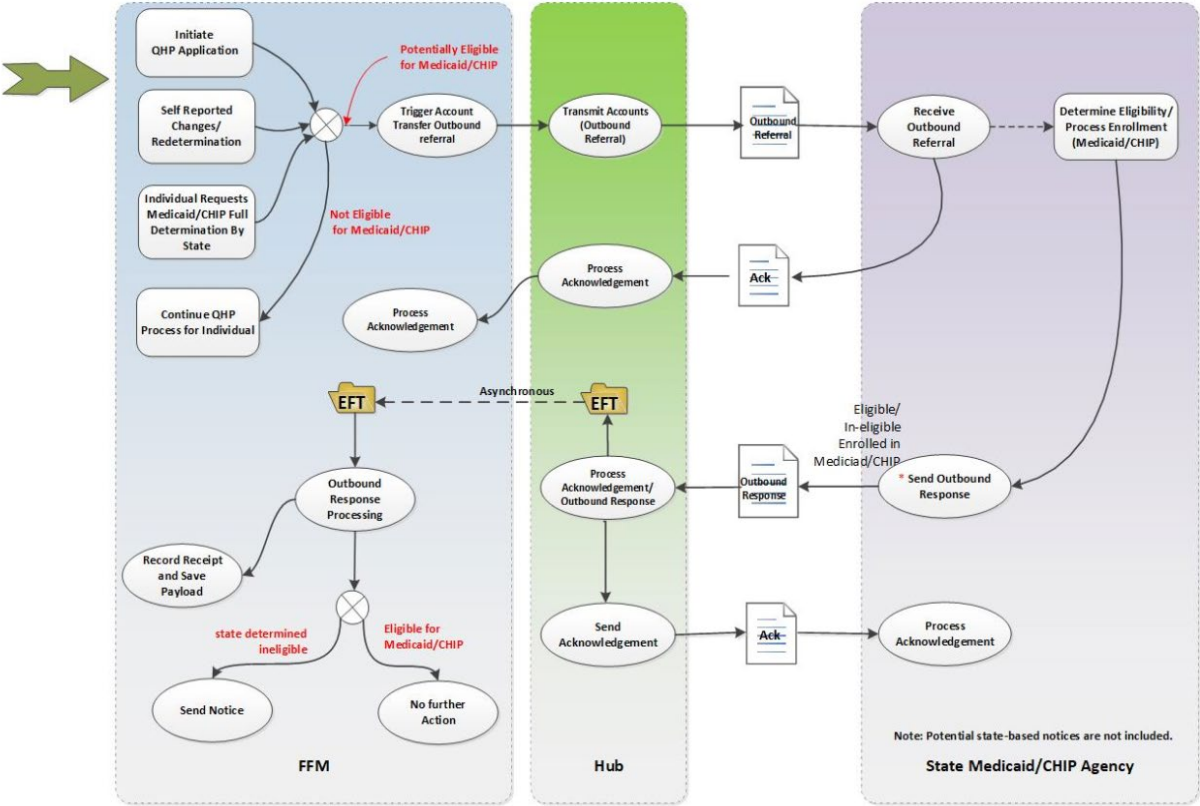
Purpose

- This section provides technical details on the data flow from the FFM to the SMA. It also addresses how to read specific indicators in the AT payload.

Audience

- State technical staff and business owners

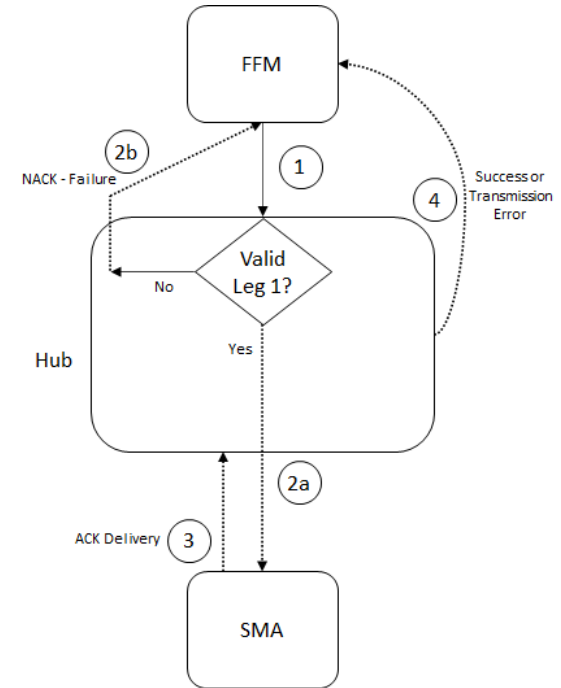
High-Level Business Flow: Outbound & Outbound Response AT with FFM



Outbound AT (FFM to SMA): High-Level Data Flow

Outbound ATs are processed through the Hub using the following steps:

1. Outbound AT originates at FFM
2. Hub validates the AT payload and either:
 - 2a. Sends it to SMA in real-time, if payload is valid
 - or*
 - 2b. Sends failure message (“NACK – Failure”) to FFM, if payload is not valid
3. SMA sends an *immediate* (synchronous) **acknowledgement** indicating, “We got it” (payload consisting of `exch:AccountTransferResponse`). SMAs should not process payload before sending acknowledgement; FFM recommends storing payloads in temporary queue
4. Hub sends SMA’s response code (Success or Transmission Error) to FFM



Outbound AT: Error Processing

- When an Outbound AT fails at the Hub, and the maximum number of retries (5) are not successful, the FFM data warehouse (MIDAS) transfers the AT payload to the SMA via Enterprise File Transfer (EFT), in a file referred to as the **Unsent File Record (UFR)**
- The UFR is sent to SMAs on a monthly basis
- All FFM states must review the UFR in a timely manner and proceed with processing the referrals¹

1. 42 CFR 435.1200

Outbound AT Payload: FAQs

Q: How can I distinguish an Initial Referral vs. Subsequent Referrals?

A: The application ID remains the same, while the transfer ID and the referral ID will change for each transfer

- *Reference:* Application ID shown on [Slide 58: “2a: Application Identification”](#)

Q: How do I distinguish referrals for state programs from FFM eligibility?

A: The OB payload includes all application members with at least one applicant referred for state program eligibility; there may also be applicants eligible for coverage at the FFM

- The ReferralActivityEligibilityReasonReference ref number points to the eligibility program the applicant is referred for. In the Medicaid scenario, it is “e26529.”
 - *Reference:* Applicant Referred for State Program shown on [Slide 62, 4th: Referral Activity – One per Applicant](#) and eligibility program is shown on [Slide 59, 3rd: Eligibility - note ID e26529](#)
- An applicant who is eligible for FFM coverage will not have a referral activity. Their FFM eligibility will be shown in the FFM Eligibility section of the payload
 - *Reference:* Applicant Eligible for FFM shown on [Slide 60: 3a: Exchange Eligibility](#)

Outbound AT Payload: FAQs (con't.)

Q: *How are the verifications sent in the AT payload?*¹

A: There is a section of the AT payload labeled VerificationMetadata which contains all verifications specific to each person listed on the application

- *Reference: SSN Verification shown on [Slide 69, 9th: Verification Metadata Segments \(0 to many\)](#)*

Q: *Where can I find the overall status indicator of the payload?**

A: The ReferralActivityStatusCode indicates the overall status of the payload located within the ReferralActivityStatus node of the payload

- *Reference: Status of “Initiated” shown on [Slide 62, 4th: Referral Activity – One per Applicant](#)*

1. See the following CMS resources for more detail:
 - a) Outbound Account Transfer (AT): Identifying Eligibility Referral Reason and Verification Status
 - b) Outbound Account Transfer Scenarios for States (Overview & Sample Payloads)

Deep Dive: Outbound Response AT

Deep Dive: Outbound Response AT

Contents

- Overview
- Data Flow
- When to send OBR to the FFM
- Sending OBR

Purpose

- This section provides details on the OBR AT and describes the data flow from the SMA to FFM. It also outlines when states should send OBR AT and instructions.

Audience

- State technical staff and business owners

Outbound Response AT (SMA to FFM): Overview

SMA sends this *deferred* response to the FFM to communicate SMA's final eligibility determination for a consumer initially referred via Outbound AT.

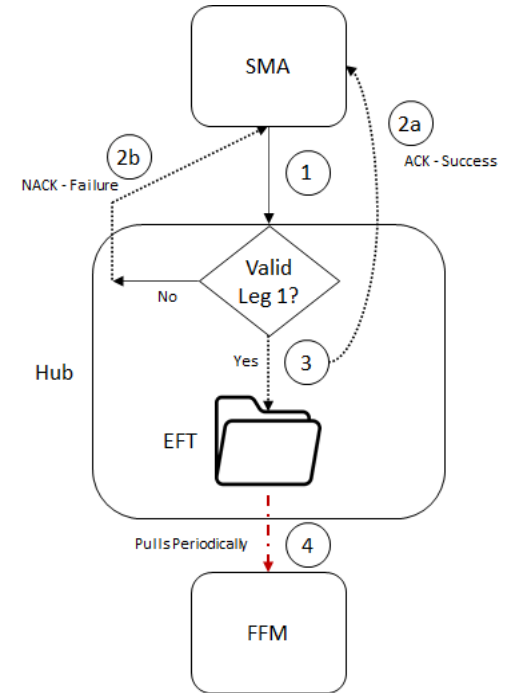
- Flow is the same as for Inbound AT, since both AT types are SMA to FFM.
- Generally, SMA should send OBR ATs for consumers they determine Medicaid/CHIP-eligible **or** ineligible.
- FFM does not update applications with information from the OBR AT payload.
- Upon receipt of OBR AT for consumers found by the SMA to be Medicaid/CHIP *ineligible*, FFM generates a notice informing the consumer they have been found ineligible for Medicaid/CHIP by the SMA and requesting they update and resubmit an FFM application for coverage and financial assistance.¹
- Upon receipt of OBR AT for consumers found by the SMA to be Medicaid/CHIP-eligible, FFM does not generate a notice to the consumer.

1. Sample FFM Outbound Response AT notice: <https://marketplace.cms.gov/technical-assistance-resources/training-materials/outbound-account-transfer.pdf>

Outbound Response AT: High-Level Data Flow

OBR ATs are processed through the Hub using the following steps as shown in the flow:

1. OBR AT originates at SMA
2. Hub validates the AT and sends one of the following to SMA:
 - 2a. “ACK - Success” if payload is valid
 - or*
 - 2b. “NACK – Failure” if payload is not valid
3. Hub places valid payload (“ACK - Success”) in EFT folder for FFM
4. FFM fetches payload from EFT folder; there may be a time delay, as processing is not real-time



NOTE: The OBR AT Business Flow is on slide 30

When to Send Outbound Response ATs

States must notify the FFM via OBR AT of the state's final eligibility determination (eligible *or* ineligible) for the following ATs sent by the FFM:

- **FFM-D states**

- For OB ATs received for CHIP waiting period exceptions, full determination requests, *or* non-MAGI referrals
- For OB ATs received with a verification issue (pend or inconsistency) for Medicaid, CHIP, and/or Unborn Child

FFM-D states do not need to send OBR ATs for Emergency Medicaid (for individuals who meet all the eligibility requirements for Medicaid, except for U.S. citizenship or satisfactory immigration status) referrals

- **FFM-A and FFM-Temp D states**

- For all OB ATs received from the FFM¹

1. 42 CFR 435.1200(d)(5)

Sending Outbound Response ATs

- The SMA should associate the OBR AT to the original OB AT by using the TransferActivity identifier (ID) from the original OB AT in the response. This ID always begins with “FFM”.
- In preparing OBR AT payloads, SMAs should alter these elements from original OB AT to ensure correct transmission:
 - TransferActivity/RecipientTransferActivityCode
 - TransferActivity/RecipientTransferActivityStateCode [not applicable in OBR]
 - Sender/InformationExchangeSystemCategoryCode
 - Sender/InformationExchangeSystemStateCode [*only* in OBR]
 - Receiver/InformationExchangeSystemCategoryCode
 - Receiver/InformationExchangeSystemStateCode [not applicable in OBR]

Reference: [Slide 55: “1a: Transfer Header Outbound AT”](#) and [Slide 56: “1b: Transfer Header Outbound Response AT”](#)

Appendix

Appendix

Contents

- [Verification FAQs \(Slides 43- 46\)](#)
- [Essential FFM AT Artifacts \(Slide 47\)](#)
- [Obtaining FFM AT Documents and Test Payloads \(Slide 48\)](#)
- [Key CMS/Affiliated Stakeholders and Contacts \(Slide 49\)](#)
- [Key Terminology \(Slides 50 - 51\)](#)
- [Outbound & Outbound Response AT Payload \(Slides 52 - 74\)](#)

Audience

- State technical staff and business owners

Verification: FAQs

Q: *What is an FFM Medicaid/CHIP verification issue, and when does it occur?*

A: An FFM Medicaid/CHIP verification issue is the broad term used when there is variation between the data that a consumer submits on their FFM application and the information available from the FFM's trusted data sources or consumer information cannot be otherwise verified by the FFM. Medicaid or CHIP verification issues occur when an applicant at the FFM indicates that they want help paying for coverage and appears potentially eligible for Medicaid/CHIP, but through the course of their application and the FFM's related checks of trusted data sources, either:

- The FFM doesn't have or can't find data to verify a consumer's attestation

OR

- The data provided by the consumer doesn't match the data found by the FFM when it checks trusted data sources, and is not found to be "reasonably compatible"

Note: The FFM has a separate process for resolving verification issues related to coverage offered through the FFM and the help related to paying for such coverage (APTC, CSR)

Verification: FAQs (con't.)

Q: *What is the difference between a Medicaid/CHIP pend and a Medicaid/CHIP inconsistency?*

A: While Medicaid/CHIP agencies typically refer to all outstanding verification issues as “inconsistencies,” the FFM separates outstanding Medicaid/CHIP eligibility verification issues into two types:

- **PEND:** When income, residency, and/or Social Security Number (SSN) are unverified or data sources are not aligned with consumers' attestation. *Only once these eligibility factors are verified can an applicant receive a final determination of Medicaid/CHIP eligibility and be enrolled, if eligible*
- **INCONSISTENCY:** When U.S. citizenship or immigration status is unverified. As long as there is no other factor of eligibility that is unverified and the consumer is otherwise Medicaid/CHIP-eligible, *the consumer is furnished benefits and is provided an ROP to verify their U.S. citizenship or satisfactory immigration status*

Verification: FAQs (con't.)

Q: *What happens if the FFM finds a consumer (potentially) eligible for Medicaid/CHIP coverage, with one or more verification issues?*

A: If the FFM finds a consumer (potentially) eligible for Medicaid/CHIP with one or more verification issues, the FFM sends that consumer's information to the SMA via Outbound AT. As noted previously, the SMA—*regardless of whether an FFM-A, FFM-Temp D, or FFM-D state*—must identify the verification issue(s) in the AT payload, follow its verification plan to resolve the outstanding issue(s), make a final Medicaid/CHIP eligibility determination, and enroll the consumer as applicable. A consumer in this scenario will see language on their HealthCare.gov application eligibility results page and in their FFM eligibility determination notice (EDN) stating that they may be eligible for Medicaid/CHIP but may need to send more information to their SMA, which will make the final Medicaid/CHIP eligibility determination. The EDN also notes that the SMA will reach out to the consumer with any next steps to resolve the outstanding verification issue(s), such as any additional information the consumer needs to submit so the SMA can make a final determination of Medicaid/CHIP eligibility, and enroll the consumer in coverage, as applicable

Verification: FAQs (con't.)

- Q:** *Who is responsible for resolving verification issues related to Medicaid/CHIP eligibility for consumers who apply for coverage at the FFM?*
- A:** In all FFM states (regardless of model), the SMA is responsible for resolving outstanding eligibility verification issues in the Outbound AT sent by the FFM
- Q:** *Are consumers who are referred to the state Medicaid/CHIP agency with outstanding verification issues eligible for FFM coverage with financial assistance while the verification issues are being resolved?*
- A:** Consumers with Medicaid/CHIP verification issues who are referred by the FFM to the SMA are not eligible for FFM coverage with financial assistance while the SMA is resolving those verifications issues. If a consumer in this scenario wants to enroll in FFM coverage, they'll have to pay full cost for their share of the FFM plan and covered services

Essential FFM AT Artifacts

Important AT artifacts include the AT Business Service Definition (BSD) and AT Release Notes*

- [Hub AT BSD](#) (Latest version is v2.4 dated May 2016). The BSD provides business and technical specifications and has several attachments:
 - Referral Activity Scenarios spreadsheet (App. B); ties in with many AT payload samples
 - [Data Architecture artifacts zip](#) (Section 6) which includes:
 - Mapping spreadsheet – detailed requirements for 500+ data elements
 - Schematron – constraints and business rules
 - XML Schemas – data model
 - Code lists – valid values
 - Sample payloads – associated with Referral Activity Scenarios in the BSD (App. B)
 - 3 Technical Papers
 - *Understanding Artifacts – key!*
 - Eligibility Data Structure
 - References, Roles, and Metadata
- [Hub Release 18 AT Service Release Notes](#) – This document presents a summary of all changes made to the AT Service architecture artifacts with the Hub R18 which is the last release

* States should review communications from CMS, zONE materials, and other CMS resources for changes/information about the most updated AT functionality/operations

Obtaining FFM AT Documents and Test Payloads

AT v2.4 documents, including the following, are available in zONE:*

- BSD
- XML Schemas
- Schematron
- Code lists
- Mapping spreadsheet
- Additional sample payloads
- AT Release Notes

* For help accessing zONE, please contact your state IT PM

Key CMS/Affiliated Stakeholders/Contacts

- CMCS: Contact your state leads and DSG Project Officers
- ISAVE State Testing Team: ISAVE_STATE_Team@tistatech.com
- CMS State Testing Team: state.testing@cms.hhs.gov
- Regional Technical Support (RTS): Hubsupport@sparksoftcorp.com
- Exchange Operations Support Center (XOSC) Helpdesk: CMS_FEPS@cms.hhs.gov

Key Terminology: AT Payload

Terminology	Definition
AccountTransferRequest (large)	All Outbound AT, Inbound AT, and Outbound Response (OBR) AT
AccountTransferResponse	<i>Acknowledgement</i> response sent by receiver immediately upon receiving a payload in any direction
Conditional	Refers to data elements within AT Payload. See Hub AT Mapping Spreadsheet , Column D. When a data element is "Conditional", it is required only under certain circumstances (e.g., RecipientTransferActivityStateCode is required if RecipientTransferActivityCode is not "Exchange")
Constraints	Any limit imposed on a data value (i.e., length, valid characters, valid choices, pattern, value range, etc.).
EFT	Enterprise File Transfer; CMS data zone where Inbound ATs and OBR ATs are temporarily stored prior to retrieval by FFE
FTI	Federal Tax Information; IRS regulated; only available to a few states. See Column I in the Mapping Spreadsheet , for data elements that are considered FTI.
Maximum payload	One that includes all optional and repeatable data elements
Minimum payload	Includes the required elements only
Namespaces	Prefix to element name to denote schema source (collection of element types); separated from element name by a colon (':') <ul style="list-style-type: none"> ext:, exch:, hix-core:, hix-ee:, nc:, etc.

Key Terminology: AT Payload (con't.)

Terminology	Definition
NIEM	National Information Exchange Model; used by many federal, state and local governments for XML information exchange; reference model that facilitates reuse; has <i>domains</i> such as Immigration, Justice, Human Services, etc. <ul style="list-style-type: none"> • ACA extended NIEM with health insurance exchange (hix) constructs • Exchange (exch:) vs. extension (ext:) schema – include other schemas • Constraint schemas – applies limits to data elements
Nillable	Refers to data elements within AT Payload. State may omit <i>required</i> elements if they are marked nillable. See Hub AT Mapping Spreadsheet , Column J <ul style="list-style-type: none"> • e.g., PersonMedicaidIdentification is nillable for Inbound AT and OBR (but not for Outbound) • <hix-core:PersonMedicaidIdentification xsi:nil="true"/>
Optional	Refers to data elements with AT Payload. "Optional" elements are not essential; if sender has no data, exclude these (but do not send empty elements). See Hub AT Mapping Spreadsheet , Column D.
Required	Refers to data elements with AT Payload. See Hub AT Mapping Spreadsheet , Column D. When a data element is "Required", it must be included (unless nillable)
Schematron	Detailed business rules and most AT data constraints; enforces conditionals
UFR	Unsent File Record; CMS file used to send AT payloads to the SMA via EFT, when an Outbound AT fails at the Hub, and the maximum number of retries are not successful
XML Schema	Overall message structure, data types, code lists, optional vs. required, whether or not element is repeatable
XPath	Used to navigate through elements in an XML message; see Mapping Spreadsheet, Column N; for example: <ul style="list-style-type: none"> • exch:AccountTransferRequest/ext:TransferHeader/ext:TransferActivity/ext:RecipientTransferActivityStateCode

Outbound & Outbound Response AT Payload: Samples

Note: Unless otherwise noted, the following payload samples apply to both Outbound and Outbound Response AT

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

High Level Collapsed View: Scenario 1_Medicaid MAGI Outbound AT Payload

This shows a high-level collapsed view of an Outbound AT payload. S:ID values are used to link to related elements elsewhere in the payload. Line numbers give a sense of how many lines have been collapsed (that is, how big the collapsed segment is). The order of elements does not dictate the order in which elements are processed due to the linkage of IDs and Refs throughout the payload.

```
1  <?xml version="1.0" encoding="UTF-8"?>
2  <exch:AccountTransferRequest ext:atVersionText="2.4"
3    xmlns:exch="http://at.dsh.cms.gov/exchange/1.0"
4    xmlns:ext="http://at.dsh.cms.gov/extension/1.0"
5    xmlns:hix-core="http://hix.cms.gov/0.1/hix-core"
6    xmlns:hix-ee="http://hix.cms.gov/0.1/hix-ee"
7    xmlns:niem-core="http://niem.gov/niem/niem-core/2.0"
8    xmlns:s="http://niem.gov/niem/structures/2.0">
9    <ext:TransferHeader>
10   <hix-core:Sender s:id="Sender">
11   <hix-core:Receiver s:id="medicaidReceiver">
12   <hix-ee:InsuranceApplication>
13   <hix-ee:MedicaidHousehold s:id="mh7769">
14   <hix-ee:MedicaidHousehold s:id="mh6580">
15   <hix-core:Person s:id="pe6003">
16   <hix-core:Person s:id="pe2013">
17   <hix-ee:TaxReturn>
18   <hix-core:VerificationMetadata s:id="vm14007">
19   <hix-core:VerificationMetadata s:id="vm15297">
20   <hix-core:VerificationMetadata s:id="vm16609">
21   <hix-core:VerificationMetadata s:id="vm17841">
22   <hix-core:VerificationMetadata s:id="vm19039">
23   <ext:PhysicalHousehold>
24   </exch:AccountTransferRequest>
```

Any ID can be referenced (pointed to) from *anywhere* in the payload.

1st: Outbound Transfer Header, Sender, Receiver

```
<ext:TransferHeader>
  <ext:TransferActivity>
    <niem-core:ActivityIdentification>
      <niem-core:IdentificationID>PFM00000000000008676</niem-core:IdentificationID>
    </niem-core:ActivityIdentification>
    <niem-core:ActivityDate>
      <niem-core:DateTime>2018-08-23T11:45:15.980-04:00</niem-core:DateTime>
    </niem-core:ActivityDate>
    <ext:TransferActivityReferralQuantity>2</ext:TransferActivityReferralQuantity>
    <ext:RecipientTransferActivityCode>MedicaidCHIP</ext:RecipientTransferActivityCode>
    <ext:RecipientTransferActivityStateCode>NJ</ext:RecipientTransferActivityStateCode>
  </ext:TransferActivity>
</ext:TransferHeader>
<hix-core:Sender s:id="Sender">
  <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:InformationExchangeSystemCategoryCode>
</hix-core:Sender>
<hix-core:Receiver s:id="medicaidReceiver">
  <hix-core:InformationExchangeSystemCategoryCode>MedicaidAgency</hix-core:InformationExchangeSystemCategoryCode>
  <hix-core:InformationExchangeSystemStateCode>NJ</hix-core:InformationExchangeSystemStateCode>
</hix-core:Receiver>
```

This shows the Transfer Header, Sender and Receiver nodes. Transfer Header contains payload metadata. Reference: For a comparison of these nodes between Outbound AT and Outbound Response AT payloads, see slides [Slide 55 “1a: Transfer Header Outbound AT”](#) and [Slide 56: “1b: Transfer Header Outbound Response AT”](#).

1a: Transfer Header

Outbound AT – FFE Sender; State Receiver

```
1  <ext:TransferHeader>
2  <ext:TransferActivity>
3      <nc:ActivityIdentification>
4          <nc:IdentificationID>FFM00000000000900015</nc:IdentificationID>
5      </nc:ActivityIdentification>
6      <nc:ActivityDate>
7          <nc:DateTime>2018-10-01T18:13:51.0Z</nc:DateTime>
8      </nc:ActivityDate>
9      <ext:TransferActivityReferralQuantity>1</ext:TransferActivityReferralQuantity>
10     <ext:RecipientTransferActivityCode>MedicaidCHIP</ext:RecipientTransferActivityCode>
11     <ext:RecipientTransferActivityStateCode>NY</ext:RecipientTransferActivityStateCode>
12 </ext:TransferActivity>
13 </ext:TransferHeader>
14 <hix-core:Sender s:id="ffeSender">
15     <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:InformationExchangeSystemCategoryCode>
16 </hix-core:Sender>
17 <hix-core:Receiver s:id="mcReceiver">
18     <hix-core:InformationExchangeSystemCategoryCode>MedicaidAgency</hix-core:InformationExchangeSystemCategoryCode>
19     <hix-core:InformationExchangeSystemStateCode>NY</hix-core:InformationExchangeSystemStateCode>
20     <hix-core:InformationExchangeSystemCountyName>Onondaga</hix-core:InformationExchangeSystemCountyName>
21 </hix-core:Receiver>
22
```

In this example, the FFM is sending an Outbound AT payload to the NY SMA.

1b: Transfer Header Outbound Response AT – State Sender; FFE Receiver

```
26 <ext:TransferHeader>
27   <ext:TransferActivity>
28     <nc:ActivityIdentification>
29       <nc:IdentificationID>FFM0000000000900015</nc:IdentificationID>
30     </nc:ActivityIdentification>
31     <nc:ActivityDate>
32       <nc:DateTime>2018-10-01T18:13:51.0Z</nc:DateTime>
33     </nc:ActivityDate>
34     <ext:TransferActivityReferralQuantity>1</ext:TransferActivityReferralQuantity>
35     <ext:RecipientTransferActivityCode>Exchange</ext:RecipientTransferActivityCode>
36   </ext:TransferActivity>
37 </ext:TransferHeader>
38 <hix-core:Sender s:id="mcSender">
39   <hix-core:InformationExchangeSystemCategoryCode>MedicaidAgency</hix-core:InformationExchangeSystemCategoryCode>
40   <hix-core:InformationExchangeSystemStateCode>NY</hix-core:InformationExchangeSystemStateCode>
41   <hix-core:InformationExchangeSystemCountyName>Onondaga</hix-core:InformationExchangeSystemCountyName>
42 </hix-core:Sender>
43 <hix-core:Receiver s:id="ffeReceiver">
44   <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:InformationExchangeSystemCategoryCode>
45 </hix-core:Receiver>
```

In this example, the NY SMA is sending an OBR payload to the FFM.

2nd: Application with Applicants

```
32 <hix-ee:InsuranceApplication>
33   <hix-core:ApplicationCreation>
38   <hix-core:ApplicationSubmission>
43   <hix-core:ApplicationUpdate>
48   <hix-core:ApplicationIdentification>
52   <hix-ee:InsuranceApplicant>
53     <hix-core:RoleOfPersonReference s:ref="pe6003"/>
54     <hix-ee:InsuranceApplicantAbsentParentOrSpouseCode>No</hix-ee:InsuranceApplicantAbsentParentOrSpouseCode>
55     <hix-ee:InsuranceApplicantBlindnessOrDisabilityIndicator>false</hix-ee:InsuranceApplicantBlindnessOrDisabilityIndicator>
56     <hix-ee:InsuranceApplicantCoverageDuringPreviousSixMonthsIndicator>false</hix-ee:InsuranceApplicantCoverageDuringPreviousSixMonthsIndicator>
57     <hix-ee:InsuranceApplicantEligibleITUServicesIndicator>false</hix-ee:InsuranceApplicantEligibleITUServicesIndicator>
58     <hix-ee:InsuranceApplicantFixedAddressIndicator>true</hix-ee:InsuranceApplicantFixedAddressIndicator>
59     <hix-ee:InsuranceApplicantIncarceration s:metadata="vm14007">
60       <hix-core:IncarcerationIndicator s:metadata="vm14007">false</hix-core:IncarcerationIndicator>
61     </hix-ee:InsuranceApplicantIncarceration>
62     <hix-ee:InsuranceApplicantLawfulPresenceStatus>
63       <hix-ee:LawfulPresenceStatusArrivedBefore1996Indicator>false</hix-ee:LawfulPresenceStatusArrivedBefore1996Indicator>
64       <hix-ee:LawfulPresenceStatusEligibility>
65         <hix-ee:EligibilityIndicator>true</hix-ee:EligibilityIndicator>
66       </hix-ee:LawfulPresenceStatusEligibility>
67       <hix-ee:LawfulPresenceStatusEligibility>
68         <hix-ee:EligibilityIndicator s:metadata="vm19039">true</hix-ee:EligibilityIndicator>
69       </hix-ee:LawfulPresenceStatusEligibility>
70     </hix-ee:InsuranceApplicantLawfulPresenceStatus>
71     <hix-ee:InsuranceApplicantLongTermCareIndicator>false</hix-ee:InsuranceApplicantLongTermCareIndicator>
72     <hix-ee:InsuranceApplicantNonESICoverageIndicator>false</hix-ee:InsuranceApplicantNonESICoverageIndicator>
73     <hix-ee:InsuranceApplicantParentCaretakerIndicator>true</hix-ee:InsuranceApplicantParentCaretakerIndicator>
74     <hix-ee:InsuranceApplicantReceivedITUServicesIndicator>false</hix-ee:InsuranceApplicantReceivedITUServicesIndicator>
75     <hix-ee:InsuranceApplicantRecentMedicalBillsIndicator>false</hix-ee:InsuranceApplicantRecentMedicalBillsIndicator>
76     <hix-ee:InsuranceApplicantStateBenefitsThroughPublicEmployeeIndicator>false</hix-ee:InsuranceApplicantStateBenefitsThroughPublicEmployeeIndicator>
77     <hix-ee:InsuranceApplicantStudentIndicator>false</hix-ee:InsuranceApplicantStudentIndicator>
78     <hix-ee:CSREligibility s:id="e25472">
79     <hix-ee:MedicaidMAGIEligibility s:id="e26529">
```

Node indicating Marketplace coverage

The InsuranceApplicant Node contains details of each applicant's attestations and eligibilities.

2a: Application Identification

```
9 <ext:TransferHeader>
10 <ext:TransferActivity>
11 <niem-core:ActivityIdentification>
12 <niem-core:IdentificationID>FFM00000000000008676</niem-core:IdentificationID>
13 </niem-core:ActivityIdentification>
14 <niem-core:ActivityDate>
15 <niem-core:DateTime>2018-08-23T11:45:15.980-04:00</niem-core:DateTime>
16 </niem-core:ActivityDate>
17 <ext:TransferActivityReferralQuantity>2</ext:TransferActivityReferralQuantity>
18 <ext:RecipientTransferActivityCode>MedicaidCHIP</ext:RecipientTransferActivityCode>
19 <ext:RecipientTransferActivityStateCode>NJ</ext:RecipientTransferActivityStateCode>
20 </ext:TransferActivity>
21 </ext:TransferHeader>
```

The transfer ID changes for initial vs subsequent referrals

```
29 <hix-ee:InsuranceApplication>
30 <hix-core:ApplicationCreation>
35 <hix-core:ApplicationSubmission>
40 <hix-core:ApplicationUpdate>
45 <hix-core:ApplicationIdentification>
46 <niem-core:IdentificationID>02153131</niem-core:IdentificationID>
47 <niem-core:IdentificationCategoryText>Exchange</niem-core:IdentificationCategoryText>
48 </hix-core:ApplicationIdentification>
```

The application identification remains constant through all transfers

```
276 <hix-ee:ReferralActivity>
277 <niem-core:ActivityIdentification>
278 <niem-core:IdentificationID>FFM00000000000010138</niem-core:IdentificationID>
279 </niem-core:ActivityIdentification>
280 <niem-core:ActivityDate>
283 <hix-ee:ReferralActivitySenderReference s:ref="Sender"/>
284 <hix-ee:ReferralActivityReceiverReference s:ref="medicaidReceiver"/>
285 <hix-ee:ReferralActivityStatus>
289 <hix-ee:ReferralActivityEligibilityReasonReference s:ref="e26529"/>
290 </hix-ee:ReferralActivity>
```

The referral ID changes for initial vs subsequent referrals

3rd: Eligibility - note ID e26529

```
76 <hix-ee:InsuranceApplicantStateBenefitsThroughPublicEmployeeIndicator>false</hix-ee:InsuranceApplicantStateBenefit
77 <hix-ee:InsuranceApplicantStudentIndicator>false</hix-ee:InsuranceApplicantStudentIndicator>
78 <hix-ee:CSREligibility s:id="e25472">
89 <hix-ee:MedicaidMAGIEligibility s:id="e26529">
90 <hix-ee:EligibilityDateRange>
95 <hix-ee:EligibilityDetermination>
100 <hix-ee:EligibilityReasonText>999</hix-ee:EligibilityReasonText>
101 <hix-ee:EligibilityIndicator>true</hix-ee:EligibilityIndicator>
102 <hix-ee:EligibilityEstablishingSystem>
105 <hix-ee:MedicaidHouseholdReference s:ref="mh6580"/>
106 <hix-ee:MedicaidMAGIIncomeEligibilityBasis>
126 <hix-ee:MedicaidMAGIResidencyEligibilityBasis>
137 <hix-ee:MedicaidMAGIParentCaretakerCategoryEligibilityBasis>
146 <hix-ee:MedicaidMAGIPregnancyCategoryEligibilityBasis>
156 <hix-ee:MedicaidMAGIChildCategoryEligibilityBasis>
166 <hix-ee:MedicaidMAGIAdultGroupCategoryEligibilityBasis>
175 <hix-ee:MedicaidMAGIAdultGroupXXCategoryEligibilityBasis>
183 <hix-ee:MedicaidMAGIOptionalTargetedLowIncomeChildEligibilityBasis>
191 <hix-ee:MedicaidMAGICitizenOrImmigrantEligibilityBasis>
200 <hix-ee:MedicaidMAGI-CHIPRA214EligibilityBasis>
208 <hix-ee:MedicaidMAGISevenYearLimitEligibilityBasis>
216 <hix-ee:MedicaidMAGIFormerFosterCareCategoryEligibilityBasis>
226 <hix-ee:MedicaidMAGIDependentChildCoverageEligibilityBasis>
235 <hix-ee:MedicaidMAGIFiveYearBarEligibilityBasis>
243 <hix-ee:MedicaidMAGISSNVerificationEligibilityBasis>
252 </hix-ee:MedicaidMAGIEligibility>
253 <hix-ee:MedicaidNonMAGIEligibility s:id="e24021">
275 <hix-ee:InsuranceApplicantTemporarilyLivesOutsideApplicationStateIndicator>false</hix-ee:InsuranceApplicantTempora
276 <hix-ee:InsuranceApplicantHadMedicaidDuringFosterCareIndicator>false</hix-ee:InsuranceApplicantHadMedicaidDuringFo
277 <hix-ee:InsuranceApplicantLivesWithMinorAgeDependentIndicator>false</hix-ee:InsuranceApplicantLivesWithMinorAgeDep
278 <hix-ee:InsuranceApplicantHouseholdExceptionIndicator>false</hix-ee:InsuranceApplicantHouseholdExceptionIndicator>
```

This node shows an applicant's eligibility for state Medicaid program. The s:id "e26529" identifies this eligibility program.

3a: Exchange Eligibility

```
<hix-ee:ExchangeEligibility xmlns:z="http://niem.gov/niem/structures/2.0" sid="e710095">
  <hix-ee:EligibilityDateRange>
    <niem-core:StartDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
      <niem-core:Date>2020-04-01</niem-core:Date>
    </niem-core:StartDate>
    <niem-core:EndDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
      <niem-core:Date>2020-12-31</niem-core:Date>
    </niem-core:EndDate>
    <hix-ee:EligibilityDateRange>
      <hix-ee:EligibilityDetermination>
        <niem-core:ActivityDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
          <niem-core:DateTime>2020-02-18T15:07:34.023-05:00</niem-core:DateTime>
        </niem-core:ActivityDate>
        </hix-ee:EligibilityDetermination>
      <hix-ee:EligibilityReasonText>999</hix-ee:EligibilityReasonText>
      <hix-ee:EligibilityIndicator>true</hix-ee:EligibilityIndicator>
      <hix-ee:EligibilityEstablishingSystem>
        <hix-core:InformationExchangeSystemCategoryCode xmlns:hix-core="http://hix.cms.gov/0.1/hix-core">Exchange</hix-core:InformationExchangeSystemCategoryCode>
      </hix-ee:EligibilityEstablishingSystem>
      <hix-ee:ExchangeOIPResidencyEligibilityBasis>
        <hix-core:StatusIndicator xmlns:hix-core="http://hix.cms.gov/0.1/hix-core">true</hix-core:StatusIndicator>
        <hix-ee:EligibilityBasisStatusCode>Complete</hix-ee:EligibilityBasisStatusCode>
        <hix-ee:EligibilityBasisDetermination>
          <niem-core:ActivityDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
            <niem-core:DateTime>2020-02-18T15:07:34.023-05:00</niem-core:DateTime>
          </niem-core:ActivityDate>
          </hix-ee:EligibilityBasisDetermination>
        <hix-ee:MedicaidResidencyEligibilityBasisCorrectStateIndicator>false</hix-ee:MedicaidResidencyEligibilityBasisCorrectStateIndicator>
      </hix-ee:ExchangeOIPResidencyEligibilityBasis>
      <hix-ee:ExchangeVerifiedCitizenshipOrLawfulPresenceEligibilityBasis>
        <hix-core:StatusIndicator xmlns:hix-core="http://hix.cms.gov/0.1/hix-core">true</hix-core:StatusIndicator>
        <hix-ee:EligibilityBasisStatusCode>Complete</hix-ee:EligibilityBasisStatusCode>
        <hix-ee:EligibilityBasisDetermination>
          <niem-core:ActivityDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
            <niem-core:DateTime>2020-02-18T15:07:34.023-05:00</niem-core:DateTime>
          </niem-core:ActivityDate>
          </hix-ee:EligibilityBasisDetermination>
        </hix-ee:ExchangeVerifiedCitizenshipOrLawfulPresenceEligibilityBasis>
      <hix-ee:ExchangeIncarcerationEligibilityBasis>
        <hix-core:StatusIndicator xmlns:hix-core="http://hix.cms.gov/0.1/hix-core">true</hix-core:StatusIndicator>
        <hix-ee:EligibilityBasisStatusCode>Complete</hix-ee:EligibilityBasisStatusCode>
        <hix-ee:EligibilityBasisDetermination>
          <niem-core:ActivityDate xmlns:niem-core="http://niem.gov/niem/niem-core/2.0">
            <niem-core:DateTime>2020-02-18T15:07:34.023-05:00</niem-core:DateTime>
          </niem-core:ActivityDate>
          </hix-ee:EligibilityBasisDetermination>
        </hix-ee:ExchangeIncarcerationEligibilityBasis>
      </hix-ee:ExchangeEligibility>

```

This node shows applicant eligibility for coverage at the FFM

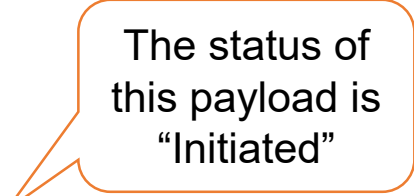
3b: CHIP Eligibility – pointed to from ReferralActivityEligibilityReasonReference (not shown)

```
49 <hix-ee:InsuranceApplicant>
50 <hix-core:RoleOfPersonReference s:ref="pe22560"/>
51 <hix-ee:InsuranceApplicantAbsentParentOrSpouseCode>No</hix-ee:InsuranceApplicantAbsentParentOrSpouseCode>
52 <hix-ee:InsuranceApplicantBlindnessOrDisabilityIndicator>false</hix-ee:InsuranceApplicantBlindnessOrDisabilityIndicator>
53 <hix-ee:InsuranceApplicantCoverageDuringPreviousSixMonthsIndicator>false</hix-ee:InsuranceApplicantCoverageDuringPreviousSixMonthsIndicator>
54 <hix-ee:InsuranceApplicantEligibleITUServicesIndicator>false</hix-ee:InsuranceApplicantEligibleITUServicesIndicator>
55 <hix-ee:InsuranceApplicantFixedAddressIndicator>true</hix-ee:InsuranceApplicantFixedAddressIndicator>
56 <hix-ee:InsuranceApplicantIncarceration s:metadata="vm37159">
57 <hix-ee:InsuranceApplicantLawfulPresenceStatus>
58 <hix-ee:InsuranceApplicantLongTermCareIndicator>false</hix-ee:InsuranceApplicantLongTermCareIndicator>
59 <hix-ee:InsuranceApplicantNonESICoverageIndicator>false</hix-ee:InsuranceApplicantNonESICoverageIndicator>
60 <hix-ee:InsuranceApplicantParentCaretakerIndicator>true</hix-ee:InsuranceApplicantParentCaretakerIndicator>
61 <hix-ee:InsuranceApplicantReceivedITUServicesIndicator>false</hix-ee:InsuranceApplicantReceivedITUServicesIndicator>
62 <hix-ee:InsuranceApplicantRecentMedicalBillsIndicator>false</hix-ee:InsuranceApplicantRecentMedicalBillsIndicator>
63 <hix-ee:InsuranceApplicantStateBenefitsThroughPublicEmployeeIndicator>false</hix-ee:InsuranceApplicantStateBenefitsThroughPublicEmployeeIndicator>
64 <hix-ee:InsuranceApplicantStudentIndicator>false</hix-ee:InsuranceApplicantStudentIndicator>
65 <hix-ee:CHIPEligibility s:id="e92781">
66 <hix-ee:EligibilityDateRange>
67 <niem-core:StartDate>
68 <niem-core:Date>2018-01-01</niem-core:Date>
69 </niem-core:StartDate>
70 </hix-ee:EligibilityDateRange>
71 <hix-ee:EligibilityDetermination>
72 <niem-core:ActivityDate>
73 <niem-core:DateTime>2018-08-23T12:53:09.606-04:00</niem-core:DateTime>
74 </niem-core:ActivityDate>
75 </hix-ee:EligibilityDetermination>
76 <hix-ee:EligibilityReasonText>999</hix-ee:EligibilityReasonText>
77 <hix-ee:EligibilityIndicator>true</hix-ee:EligibilityIndicator>
78 <hix-ee:EligibilityEstablishingSystem>
79 <hix-ee:CHIPIncomeEligibilityBasis>
80 <hix-ee:CHIPMedicaidResidencyEligibilityBasis>
81 <hix-ee:CHIPIncarcerationEligibilityBasis>
82 <hix-ee:CHIPPregnancyCategoryEligibilityBasis>
83 <hix-ee:CHIPTargetedLowIncomeChildEligibilityBasis>
84 <hix-ee:CHIPUnbornChildCategoryEligibilityBasis>
85 <hix-ee:CHIPStateHealthBenefitsEligibilityBasis>
```

This shows part of the InsuranceApplicant node with the program sub-node showing CHIP eligibility.

4th: Referral Activity – One per Applicant

```
279 <hix-ee:ReferralActivity>
280   <niem-core:ActivityIdentification>
281     <niem-core:IdentificationID>FFM00000000000010138</niem-core:IdentificationID>
282   </niem-core:ActivityIdentification>
283   <niem-core:ActivityDate>
284     <niem-core:DateTime>2018-08-23T11:45:15.980-04:00</niem-core:DateTime>
285   </niem-core:ActivityDate>
286   <hix-ee:ReferralActivitySenderReference s:ref="Sender"/>
287   <hix-ee:ReferralActivityReceiverReference s:ref="medicaidReceiver"/>
288   <hix-ee:ReferralActivityStatus>
289     <hix-ee:ReferralActivityStatusCode>Initiated</hix-ee:ReferralActivityStatusCode>
290   <hix-ee:ReferralActivityOverallVerificationStatusCode>Y</hix-ee:ReferralActivityOverallVerificationStatusCode>
291   </hix-ee:ReferralActivityStatus>
292   <hix-ee:ReferralActivityEligibilityReasonReference s:ref="e26529"/>
293 </hix-ee:ReferralActivity>
294 <hix-ee:InsuranceApplicantFosterCareIndicator>false</hix-ee:InsuranceApplicantFosterCareIndicator>
295 </hix-ee:InsuranceApplicant>
296 <hix-ee:InsuranceApplicant>
297   <hix-core:RoleOfPersonReference s:ref="pe2013"/>
```



Each applicant eligible for a state program is referred in “ReferralActivity” node. The ReferralActivityEligibilityReasonReference s:ref value points to the s:id of the eligibility program node - “e26529” in this example.

4a: ReferralActivityReasonCode: Full Determination

```
271 <hix-ee:ReferralActivity>
272   <niem-core:ActivityIdentification>
273     <niem-core:IdentificationID>FFM0000000000006006</niem-core:IdentificationID>
274   </niem-core:ActivityIdentification>
275   <niem-core:ActivityDate>
276     <niem-core:DateTime>2018-08-22T17:29:25.428-04:00</niem-core:DateTime>
277   </niem-core:ActivityDate>
278   <hix-ee:ReferralActivitySenderReference s:ref="Sender"/>
279   <hix-ee:ReferralActivityReceiverReference s:ref="medicaidReceiver"/>
280   <hix-ee:ReferralActivityStatus>
281     <hix-ee:ReferralActivityStatusCode>Initiated</hix-ee:ReferralActivityStatusCode>
282   </hix-ee:ReferralActivityStatus>
283   <hix-ee:ReferralActivityReasonCode>FullDetermination</hix-ee:ReferralActivityReasonCode>
284 </hix-ee:ReferralActivity>
285 <hix-ee:InsuranceApplicantFosterCareIndicator>false</hix-ee:InsuranceApplicantFosterCareIn
286 </hix-ee:InsuranceApplicant>
```

This sub-node under InsuranceApplicant identifies the reason this consumer was referred. In this example, the consumer is referred for a full determination. The IdentificationID is a referred person-level unique id and is not present for consumers who are not being referred.

5th: Application Signer and Primary Contact

```
52 <hix-ee:InsuranceApplicant>
296 <hix-ee:InsuranceApplicant>
527 <hix-ee:InsuranceApplicationRequestingFinancialAssistanceIndicator>true</hix-ee:InsuranceApplicationRequestingFir
528 <hix-ee:InsuranceApplicationCoverageRenewalYearQuantity>4</hix-ee:InsuranceApplicationCoverageRenewalYearQuantity>
529 <hix-ee:SSFSigner>
530 <hix-core:RoleOfPersonReference s:ref="pe6003"/>
531 <hix-ee:Signature>
532 <hix-core:SignatureName>
533 <niem-core:PersonFullName>asfdsd</niem-core:PersonFullName>
534 </hix-core:SignatureName>
535 <hix-core:SignatureDate>
536 <niem-core:Date>2018-08-23</niem-core:Date>
537 </hix-core:SignatureDate>
538 </hix-ee:Signature>
539 <hix-ee:SSFAttestation>
540 <hix-ee:SSFAttestationCollectionsAgreementIndicator>true</hix-ee:SSFAttestationCollectionsAgreementIndicator>
541 <hix-ee:SSFAttestationMedicaidObligationsIndicator>true</hix-ee:SSFAttestationMedicaidObligationsIndicator>
542 <hix-ee:SSFAttestationNonPerjuryIndicator>true</hix-ee:SSFAttestationNonPerjuryIndicator>
543 <hix-ee:SSFAttestationNotIncarceratedIndicator>true</hix-ee:SSFAttestationNotIncarceratedIndicator>
544 <hix-ee:SSFAttestationNotIncarceratedIndicator s:metadata="vml4007">true</hix-ee:SSFAttestationNotIncarcerat
545 <hix-ee:SSFAttestationPrivacyAgreementIndicator>true</hix-ee:SSFAttestationPrivacyAgreementIndicator>
546 <hix-ee:SSFAttestationPendingChargesIndicator>false</hix-ee:SSFAttestationPendingChargesIndicator>
547 <hix-ee:SSFAttestationInformationChangesIndicator>true</hix-ee:SSFAttestationInformationChangesIndicator>
548 <hix-ee:SSFAttestationApplicationTermsIndicator>true</hix-ee:SSFAttestationApplicationTermsIndicator>
549 </hix-ee:SSFAttestation>
550 </hix-ee:SSFSigner>
551 <hix-ee:InsuranceApplicationRequestingMedicaidIndicator>false</hix-ee:InsuranceApplicationRequestingMedicaidIndi
552 <hix-ee:SSFPrimaryContact>
553 <hix-core:RoleOfPersonReference s:ref="pe6003"/>
554 <hix-ee:SSFPrimaryContactPreferenceCode>Email</hix-ee:SSFPrimaryContactPreferenceCode>
555 </hix-ee:SSFPrimaryContact>
556 <hix-ee:InsuranceApplicationTaxReturnAccessIndicator>true</hix-ee:InsuranceApplicationTaxReturnAccessIndicator>
557 </hix-ee:InsuranceApplication>
```

The RoleOfPersonReference s:ref points to person s:id - pe6003 (defined elsewhere in the payload). In this example, the Primary Contact and the signer is the same person.

6th: Medicaid Household(s)

```
557 </hix-ee:InsuranceApplication>
558 <hix-ee:MedicaidHousehold s:id="mh7769">
559   <hix-ee:HouseholdIncome>
560     <hix-core:IncomeFrequency>
561       <hix-core:FrequencyCode>Annually</hix-core:FrequencyCode>
562     </hix-core:IncomeFrequency>
563     <hix-core:IncomeAmount>11880</hix-core:IncomeAmount>
564     <hix-core:IncomeCategoryCode>Wages</hix-core:IncomeCategoryCode>
565     <hix-core:IncomeSubjectToFederalRestrictionsIndicator>false</hix-core:IncomeSubject
566   </hix-ee:HouseholdIncome>
567   <hix-ee:HouseholdIncome>
568     <hix-core:IncomeFrequency>
569       <hix-core:FrequencyCode>Monthly</hix-core:FrequencyCode>
570     </hix-core:IncomeFrequency>
571     <hix-core:IncomeAmount>990.00</hix-core:IncomeAmount>
572   </hix-ee:HouseholdIncome>
573   <hix-ee:HouseholdIncome>
574     <hix-core:IncomeFrequency>
575       <hix-core:FrequencyCode>Annually</hix-core:FrequencyCode>
576     </hix-core:IncomeFrequency>
577     <hix-core:IncomeAmount>11880.00</hix-core:IncomeAmount>
578   </hix-ee:HouseholdIncome>
579   <hix-ee:HouseholdSizeQuantity>2</hix-ee:HouseholdSizeQuantity>
580   <hix-ee:HouseholdMemberReference s:ref="pe6003"/>
581   <hix-ee:HouseholdMemberReference s:ref="pe2013"/>
582   <hix-ee:MedicaidHouseholdEffectivePersonQuantity>2</hix-ee:MedicaidHouseholdEffective
583   <hix-ee:MedicaidHouseholdIncomeAboveHighestApplicableMAGIStandardIndicator>true</hix-
584 </hix-ee:MedicaidHousehold>
```

This node shows Medicaid Household size and income details.

7th: Person Details – note ID pe6003

```
552 | <hix-ee:SSFFPrimaryContact>
553 |   <hix-core:RoleOfPersonReference s:ref="pe6003"/>
554 |   <hix-ee:SSFFPrimaryContactPreferenceCode>Email</hix-ee:SSFFPrimaryContactPreferenceCode>
555 | </hix-ee:SSFFPrimaryContact>
556 | <hix-ee:InsuranceApplicationTaxReturnAccessIndicator>true</hix-ee:InsuranceApplicationTaxReturnAccessIndicator>
557 | </hix-ee:InsuranceApplication>
558 | <hix-ee:MedicaidHousehold s:id="mh7769">
559 | <hix-ee:MedicaidHousehold s:id="mh6580">
612 | <hix-core:Person s:id="pe6003">
613 |   <niem-core:PersonAgeMeasure>
614 |     <niem-core:MeasurePointValue>38</niem-core:MeasurePointValue>
615 |   </niem-core:PersonAgeMeasure>
616 |   <niem-core:PersonBirthDate>
617 |     <niem-core:Date>1980-01-01</niem-core:Date>
618 |   </niem-core:PersonBirthDate>
619 |   <niem-core:PersonLivingIndicator>true</niem-core:PersonLivingIndicator>
620 |   <niem-core:PersonName>
621 |     <niem-core:PersonGivenName>Parent</niem-core:PersonGivenName>
622 |     <niem-core:PersonSurName>Griffith</niem-core:PersonSurName>
623 |   </niem-core:PersonName>
624 |   <niem-core:PersonSexText>Female</niem-core:PersonSexText>
625 |   <niem-core:PersonSSNIdentification s:metadata="vml6609">
626 |     <niem-core:IdentificationID>348703094</niem-core:IdentificationID>
627 |     <niem-core:IdentificationCategoryText>SSN</niem-core:IdentificationCategoryText>
628 |   </niem-core:PersonSSNIdentification>
629 |   <niem-core:PersonUSCitizenIndicator s:metadata="vml7841">true</niem-core:PersonUSCitizenIndicator>
630 |   <hix-core:TribalAugmentation>
631 |     <hix-core:PersonRecognizedTribeIndicator>false</hix-core:PersonRecognizedTribeIndicator>
632 |     <hix-core:PersonAmericanIndianOrAlaskaNativeIndicator>false</hix-core:PersonAmericanIndianOrAlaskaNativeIndicator>
633 |   </hix-core:TribalAugmentation>
634 |   <hix-core:PersonAugmentation>
635 |     <hix-core:PersonAssociation>
636 |       <niem-core:PersonReference s:ref="pe2013"/>
637 |       <hix-core:FamilyRelationshipCode>19</hix-core:FamilyRelationshipCode>
638 |       <hix-core:PersonCaretakerDependentCode>No</hix-core:PersonCaretakerDependentCode>
639 |     </hix-core:PersonAssociation>
640 |     <hix-core:PersonContactInformationAssociation>
641 |       <niem-core:AssociationBeginDate>
642 |         <niem-core:Date>2018-08-23</niem-core:Date>
```

Each application member is defined once in a single “Person” node and is referenced by the value of its s:id attribute. This node includes member demographic information.

7a: Additional Person Details

```
634 <hix-core:FamilyRelationshipCode>19</hix-core:FamilyRelationshipCode>
635 <hix-core:PersonCaretakerDependentCode>No</hix-core:PersonCaretakerDependentCode>
636 </hix-core:PersonAssociation>
637 <hix-core:PersonContactInformationAssociation>
657 <hix-core:PersonContactInformationAssociation>
677 <hix-core:PersonContactInformationAssociation>
678 <niem-core:AssociationBeginDate>
679 <niem-core:Date>2018-08-23</niem-core:Date>
680 </niem-core:AssociationBeginDate>
681 <niem-core:ContactInformationIsPrimaryIndicator>true</niem-core:ContactInformationIsPrimaryIndica
682 <hix-core:ContactInformation>
683 <niem-core:ContactMailingAddress>
684 <niem-core:StructuredAddress>
685 <niem-core:LocationStreet>
686 <niem-core:StreetFullText>123 Street</niem-core:StreetFullText>
687 </niem-core:LocationStreet>
688 <niem-core:LocationCityName>City</niem-core:LocationCityName>
689 <niem-core:LocationCountyName>Essex</niem-core:LocationCountyName>
690 <niem-core:LocationCountyCode>013</niem-core:LocationCountyCode>
691 <niem-core:LocationStateUSPostalServiceCode>NJ</niem-core:LocationStateUSPostalServiceCode>
692 <niem-core:LocationPostalCode>07009</niem-core:LocationPostalCode>
693 </niem-core:StructuredAddress>
694 </niem-core:ContactMailingAddress>
695 <niem-core:ContactTelephoneNumber>
696 <niem-core:FullTelephoneNumber>
697 <niem-core:TelephoneNumberFullID>222-222-2222</niem-core:TelephoneNumberFullID>
698 </niem-core:FullTelephoneNumber>
699 </niem-core:ContactTelephoneNumber>
700 </hix-core:ContactInformation>
701 <hix-core:ContactInformationCategoryCode>Residency</hix-core:ContactInformationCategoryCode>
702 </hix-core:PersonContactInformationAssociation>
703 <hix-core:PersonContactInformationAssociation>
704 <hix-core:ContactInformation>
705 <niem-core:ContactEmailID>ulapittutt-8022@yopmail.com</niem-core:ContactEmailID>
706 </hix-core:ContactInformation>
707 </hix-core:PersonContactInformationAssociation>
708 <hix-core:PersonEmploymentAssociation>
```

This node contains member contact information details.

8th: Tax Return Details

```
767 <hix-core:Person s:id="pe2013">
844 <hix-ee:TaxReturn>
845 <hix-ee:TaxHousehold>
846 <hix-ee:HouseholdIncome>
847 <hix-core:IncomeFrequency>
848 <hix-core:FrequencyCode>Annually</hix-core:FrequencyCode>
849 </hix-core:IncomeFrequency>
850 <hix-core:IncomeAmount>11880</hix-core:IncomeAmount>
851 <hix-core:IncomeDate>
852 <niem-core:Year>2018</niem-core:Year>
853 </hix-core:IncomeDate>
854 <hix-core:IncomeFederalPovertyLevelPercent>73.</hix-core:IncomeFederalPovertyLevelPercent>
855 <hix-core:IncomeVariableIndicator>>false</hix-core:IncomeVariableIndicator>
856 </hix-ee:HouseholdIncome>
857 <hix-ee:HouseholdSizeQuantity>2</hix-ee:HouseholdSizeQuantity>
858 <hix-ee:PrimaryTaxFiler>
859 <hix-core:RoleOfPersonReference s:ref="pe6003"/>
860 </hix-ee:PrimaryTaxFiler>
861 <hix-ee:TaxDependent>
862 <hix-core:RoleOfPersonReference s:ref="pe2013"/>
863 </hix-ee:TaxDependent>
864 </hix-ee:TaxHousehold>
865 <hix-ee:TaxReturnIncludesDependentIndicator>>true</hix-ee:TaxReturnIncludesDependentIndicator>
866 </hix-ee:TaxReturn>
```

This node contains attested tax household income and related information.

9th: Verification Metadata Segments (0 to many)

```
883 <hix-core:VerificationMetadata s:id="vmlb297">
884 <hix-core:FFEVerificationCode>P</hix-core:FFEVerificationCode>
885 <hix-core:VerificationAuthorityTDS-FEPS-AlphaCode>SSA</hix-core:VerificationAuthorityTDS-FEPS-AlphaCode>
886 <hix-core:VerificationDate>
887 <niem-core:DateTime>2018-08-23T10:10:35.496-04:00</niem-core:DateTime>
888 </hix-core:VerificationDate>
889 <hix-core:VerificationRequestingSystem>
890 <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:InformationExchangeSystemCategoryCode>
891 </hix-core:VerificationRequestingSystem>
892 <hix-core:VerificationIndicator>false</hix-core:VerificationIndicator>
893 <hix-core:VerificationDescriptionText>Title IIMonthlyIncome</hix-core:VerificationDescriptionText>
894 <hix-core:VerificationStatus>
895 <hix-core:VerificationStatusCode>1</hix-core:VerificationStatusCode>
896 </hix-core:VerificationStatus>
897 <hix-core:VerificationCategoryCode>CurrentIncome</hix-core:VerificationCategoryCode>
898 </hix-core:VerificationMetadata>
899 <hix-core:VerificationMetadata s:id="vml6609">
900 <hix-core:FFEVerificationCode>Y</hix-core:FFEVerificationCode>
901 <hix-core:VerificationAuthorityTDS-FEPS-AlphaCode>SSA</hix-core:VerificationAuthorityTDS-FEPS-AlphaCode>
902 <hix-core:VerificationDate>
903 <niem-core:DateTime>2018-08-23T10:07:30.594-04:00</niem-core:DateTime>
904 </hix-core:VerificationDate>
905 <hix-core:VerificationRequestingSystem>
906 <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:InformationExchangeSystemCategoryCode>
907 </hix-core:VerificationRequestingSystem>
908 <hix-core:VerificationIndicator>true</hix-core:VerificationIndicator>
909 <hix-core:VerificationDescriptionText>SSN</hix-core:VerificationDescriptionText>
910 <hix-core:VerificationStatus>
911 <hix-core:VerificationStatusCode>5</hix-core:VerificationStatusCode>
912 </hix-core:VerificationStatus>
913 <hix-core:VerificationCategoryCode>SSN</hix-core:VerificationCategoryCode>
914 <hix-core:ResponseCode>A</hix-core:ResponseCode>
915 </hix-core:VerificationMetadata>
```

The VerificationMetadata segments contain verifications specific to each person listed on the application. SSA verification metadata segments for Title II monthly income and SSN are shown here.

10th: Physical Household – refs to members

```
915 </hix-core:VerificationMetadata>
916 <hix-core:VerificationMetadata s:id="vm17841">
933 <hix-core:VerificationMetadata s:id="vm19039">
950 <ext:PhysicalHousehold>
951   <hix-ee:HouseholdMemberReference s:ref="pe6003"/>
952   <hix-ee:HouseholdMemberReference s:ref="pe2013"/>
953 </ext:PhysicalHousehold>
954 </exch:AccountTransferRequest>
```

The PhysicalHousehold node refers to all the members on an application via the s:ref attribute pointing to each member's Person s:id.

11th: Various References to Person pe6003

```
Line 53:      <hix-core:RoleOfPersonReference      s:ref="pe6003"/>
Line 530:    <hix-core:RoleOfPersonReference      s:ref="pe6003"/>
Line 553:    <hix-core:RoleOfPersonReference      s:ref="pe6003"/>
Line 580:    <hix-ee:HouseholdMemberReference  s:ref="pe6003"/>
Line 607:    <hix-ee:HouseholdMemberReference  s:ref="pe6003"/>
Line 612:    <hix-core:Person      s:id="pe6003">
Line 787:    <niem-core:PersonReference  s:ref="pe6003"/>
Line 859:    <hix-core:RoleOfPersonReference  s:ref="pe6003"/>
Line 951:    <hix-ee:HouseholdMemberReference  s:ref="pe6003"/>
```

Person s:id (unique to each application member) is used to refer to a particular person using the PersonReference elements at different places within the payload.

11a: Person pe6003 Details – appears only once

```
612 <hix-core:Person s:id="pe6003">
613   <niem-core:PersonAgeMeasure>
614     <niem-core:MeasurePointValue>38</niem-core:MeasurePointValue>
615   </niem-core:PersonAgeMeasure>
616   <niem-core:PersonBirthDate>
617     <niem-core:Date>1980-01-01</niem-core:Date>
618   </niem-core:PersonBirthDate>
619   <niem-core:PersonLivingIndicator>true</niem-core:PersonLivingIndicator>
620   <niem-core:PersonName>
621     <niem-core:PersonGivenName>Parent</niem-core:PersonGivenName>
622     <niem-core:PersonSurName>Griffith</niem-core:PersonSurName>
623   </niem-core:PersonName>
624   <niem-core:PersonSexText>Female</niem-core:PersonSexText>
625   <niem-core:PersonSSNIdentification s:metadata="vm16609">
626     <niem-core:IdentificationID>348703094</niem-core:IdentificationID>
627     <niem-core:IdentificationCategoryText>SSN</niem-core:IdentificationCategoryText>
628   </niem-core:PersonSSNIdentification>
629   <niem-core:PersonUSCitizenIndicator s:metadata="vm17841">true</niem-core:PersonU:
630   <hix-core:TribalAugmentation>
634   <hix-core:PersonAugmentation>
766 </hix-core:Person>
767 <hix-core:Person s:id="pe2013">
```

Each application member is defined once in a single “Person” node and is referenced by the value of its s:id attribute.

12th: SSN is Linked to Verification Metadata

```
Line 625:    <niem-core:PersonSSNIdentification    s:metadata="vm16609">  
Line 899:    <hix-core:VerificationMetadata    s:id="vm16609">
```

There is a linkage from the data being verified to the VerificationMetadata element. In this example, member SSN is linked to the VerificationMetadata s:id using the s:metadata attribute. This means that the SSN has been verified.

12a: Verification Metadata vm16609 for SSN

```
899 <hix-core:VerificationMetadata s:id="vm16609">
900   <hix-core:FFEVerificationCode>Y</hix-core:FFEVerificationCode>
901   <hix-core:VerificationAuthorityTDS-FEPS-AlphaCode>SSA</hix-core:VerificationAuth
902   <hix-core:VerificationDate>
903     <niem-core:DateTime>2018-08-23T10:07:30.594-04:00</niem-core:DateTime>
904   </hix-core:VerificationDate>
905   <hix-core:VerificationRequestingSystem>
906     <hix-core:InformationExchangeSystemCategoryCode>Exchange</hix-core:Informatior
907   </hix-core:VerificationRequestingSystem>
908   <hix-core:VerificationIndicator>true</hix-core:VerificationIndicator>
909   <hix-core:VerificationDescriptionText>SSN</hix-core:VerificationDescriptionText>
910   <hix-core:VerificationStatus>
911     <hix-core:VerificationStatusCode>5</hix-core:VerificationStatusCode>
912   </hix-core:VerificationStatus>
913   <hix-core:VerificationCategoryCode>SSN</hix-core:VerificationCategoryCode>
914   <hix-core:ResponseCode>A</hix-core:ResponseCode>
915 </hix-core:VerificationMetadata>
```

This is the expanded VerificationMetadata node from the previous slide.