

**COMPUTER MATCHING AGREEMENT
BETWEEN
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERVICES
AND
THE DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH ADMINISTRATION
FOR
THE VERIFICATION OF ELIGIBILITY FOR
MINIMUM ESSENTIAL COVERAGE
UNDER
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT
THROUGH A VETERANS HEALTH ADMINISTRATION PLAN**

**Centers for Medicare & Medicaid Services No. 2023-06
Department of Health and Human Services No. 2304**

Effective Date – November 2, 2023

Expiration Date – May 1, 2025

I. PURPOSE, LEGAL AUTHORITIES, AND DEFINITIONS

A. Purpose

The purpose of this Computer Matching Agreement is to assist the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) in determining individuals' eligibility for financial assistance in paying for private health insurance coverage. Through this matching program, the Department of Veterans Affairs (VA), Veterans Health Administration (VHA), provides CMS with data verifying whether an individual who is applying for private health insurance coverage under a qualified health plan (QHP) is eligible for coverage under a VHA health plan. CMS, in its capacity as operator of the Federally-facilitated Exchange (FFE) and the Federal enrollment and eligibility platform, will use VHA's information to verify an Applicant's enrollment in Minimum Essential Coverage (MEC) through a VHA Health Care Program for the purpose of making Eligibility Determinations, including Eligibility Determinations for which HHS is responsible under 45 Code of Federal Regulations (CFR) § 155.302.

CMS makes the data provided by VHA available to the FFE and state-based Administering Entities (AEs) through a data services hub (“the Hub”) to use in determining the Applicant’s eligibility for Insurance Affordability Programs (IAPs), including advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSRs), in paying for private health insurance coverage. VHA health plans provide MEC, and eligibility for such plans precludes eligibility for financial assistance.

The Privacy Act of 1974, as amended (in particular, by the Computer Matching and Privacy Protection Act of 1988 (CMPPA) (Public Law 100-503)), requires the Parties participating in a matching program to execute a written agreement specifying the terms and conditions under which the matching program will be conducted. CMS has determined that use of VHA data by CMS and AEs constitute a "computer matching program" as defined in the CMPPA.

VHA is the Source Agency, as defined by the Privacy Act at 5 U.S.C. § 552a(a)(11); it will provide match results to CMS. The VHA component responsible for the disclosure of information is the VHA Privacy Office Manager, Information Access and Privacy Office. VHA acknowledges that AEs, which include State-based Exchanges (SBEs)¹ and Basic Health Programs (BHPs), will use VHA data, accessed through the Hub, to make Eligibility Determinations. The responsible component for CMS is the Center for Consumer Information & Insurance Oversight (CCIIO). CMS is the Recipient Agency, as defined in 5 U.S.C. § 552a(a)(9), and will be responsible for publishing the Federal Register (FR) Notice required by 5 U.S.C. § 552a(e)(12).

By entering into this Agreement, the Parties agree to comply with the terms and conditions set forth herein, as well as applicable law and regulations. The terms and conditions of this Agreement will be carried out by authorized employees and contractors of CMS and VHA. The terms and conditions under which state-based AEs may receive and use VHA data will be set forth in a separate agreement between CMS and the AEs.

¹ Since January 1, 2014, consumers in every state (including the District of Columbia) have had access to health insurance coverage through Health Insurance Marketplaces operated by State-based Exchanges (SBEs) or by the Federal government through the Federally-facilitated Exchange. SBEs have adopted various names for their programs (e.g., Kentucky’s ‘knect’ or California’s ‘Covered California’) but they are still Exchanges as established under sections 1311(b) and 1311(d)(1) or 1321(c)(1) of the PPACA.

B. Legal Authorities

The following statutes and regulations govern or provide legal authority for the uses of data, including disclosures, under this Agreement:

1. This Agreement is executed pursuant to the Privacy Act of 1974, as amended (5 U.S.C. § 552a), and implementing guidance promulgated thereunder, including Office of Management and Budget (OMB) Circular A-108 "Federal Agency Responsibilities for Review, Reporting, and Publication under the Privacy Act" published at 81 FR 94424 (Dec. 23, 2016) and OMB guidelines pertaining to computer matching published at 54 FR 25818 (June 19, 1989).
2. Under the authority of the Patient Protection and Affordable Care Act (Public Law (P. Law) No. 111-148), as amended by the Health Care and Education Reconciliation Act (P. Law No. 111-152) (collectively, the PPACA) and the implementing regulations, certain individuals are eligible for certain financial assistance in paying for private insurance coverage under a QHP when enrollment is through an Exchange. Such assistance includes APTC, under the Internal Revenue Code (IRC) of 1986, as amended, at 26 U.S.C. § 36B and section 1412 of the PPACA, and CSRs under section 1402 of the PPACA.
3. Section 36B(c)(2) of the IRC, as added by section 1401 of the PPACA, provides that an individual is ineligible for APTC if that individual is eligible for other MEC as defined in 26 U.S.C. § 5000A(f), other than MEC described in 26 U.S.C. § 5000A(f)(1)(C), such as the coverage under VHA Health Care Programs. Section 1402(f)(2) of the PPACA provides that an individual is ineligible for CSRs if the individual is not also eligible for the premium tax credit for the relevant month.
4. Section 1331 of the PPACA authorizes the BHP and § 1331(e)(1)(C) requires the states administering BHP to verify whether an individual is eligible for other MEC as defined in 26 U.S.C. § 5000A(f), such as coverage under VHA Health Care Programs (45 CFR § 155.320(d)).
5. Section 1411 of the PPACA requires the Secretary of HHS to establish a program to determine eligibility for an individual to purchase a QHP through an Exchange and to determine eligibility for APTC and CSRs. Under 45 CFR §§ 155.302 and 155.305, the eligibility determinations for APTC and CSRs may be made by an Exchange or HHS. CMS carries out HHS' responsibilities "through" the Exchanges. The system established by HHS under section 1411 of the PPACA to

determine eligibility for APTC and CSRs requires an Exchange to verify whether an individual is eligible for other MEC, such as coverage under a VHA Health Care Program, by sending the individual's identifying information to HHS for HHS to compare to relevant records to rule other MEC in or out.

C. Definitions

For the purposes of this Agreement:

1. "Administering Entity" or "AE" (sometimes referred to as "state-based AE") means an entity administering an IAP;
2. "Advanced Payments of the Premium Tax Credit" or "APTC" means payment of the tax credit specified in section 36B of the IRC of 1986 (as added by section 1401 of the PPACA) that is provided on an advance basis on behalf of an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the PPACA. APTC is not considered Federal Tax Information under 26 U.S.C. § 6103;
3. "Agent" or "Broker" means a person or entity licensed by the State as an agent, broker or insurance producer;
4. "Applicant" means any individual seeking an Eligibility Determination for enrollment in a QHP through an Exchange, an IAP, or a certification of Exemption, including an Enrollee whose eligibility is determined at the time of a renewal or redetermination;
5. "Authorized Representative" means an individual, person or organization acting, in accordance with 45 CFR § 155.227, on behalf of an Applicant or Enrollee in applying for an Eligibility Determination, including a redetermination, and in carrying out other ongoing communications with the Exchange;
6. "Authorized User" means an information system user who is provided with access privileges to any data resulting from this match or to any data created as a result of this match. Authorized Users include Administering Entities;
7. "Benefit Year" means the calendar year for which a health plan purchased through an Exchange provides coverage for health benefits;
8. "Breach" is defined by OMB Memorandum OMB M-17-12 Preparing for and Responding a Breach of Personally Identifiable Information, (January 3, 2017) as the loss of control, compromise, unauthorized disclosure, unauthorized acquisition, or any similar occurrence where (1) a person other than an

authorized user accesses or potentially accesses personally identifiable information (PII); or (2) an authorized user accesses or potentially accesses PII for other than authorized purpose;

9. "CMS" means the Centers for Medicare & Medicaid Services;
10. "Cost-Sharing Reduction" or "CSR" is defined at 45 CFR § 155.20 and means reductions in cost sharing for an eligible individual enrolled in a silver level plan through an Exchange or for an individual who is an Alaskan Native/American Indian enrolled in a QHP through an Exchange, provided in accordance with section 1402 of the PPACA. CSRs are not considered Federal Tax Information under 26 U.S.C. § 6103;
11. "Eligibility Determination" means the determination of eligibility by an AE for enrollment in a QHP through an Exchange, an IAP or for Certifications of Exemption. This refers to initial determinations or redeterminations based on a change in the individual's status, and appeals;
12. "Enrollee" means an individual enrolled in a QHP through an Exchange or enrolled in a BHP;
13. "Exchange" (otherwise known as Marketplace) means a Federally-facilitated Exchange (FFE) or an SBE (including a not-for-profit exchange) established under sections 1311(b) and 1311(d)(1) or 1321(c)(1) of PPACA. For purposes of this Agreement, all references to an Exchange shall refer equally to and include a state agency that is responsible for administering the IAP Program under which individuals and small businesses may enroll in Qualified Health Plans in the state;
14. "Federally-facilitated Exchange" or "FFE" means an Exchange established by HHS and operated by CMS under § 1321(c)(1) of the PPACA;
15. "HHS" means the Department of Health and Human Services;
16. "Hub" or "CMS Data Services Hub" is the CMS managed, single data exchange for AEs to interface with Federal agency partners. Hub services allow for adherence to federal and industry standards for security, data transport, and data safeguards as well as CMS policy for AEs for eligibility determination and enrollment services;

17. "Insurance Affordability Programs" or "IAPs" include (1) a program that makes available coverage in a QHP through an Exchange with APTC; (2) a program that makes available coverage in a QHP through an Exchange with CSRs; (3) the Medicaid program established under Title XIX of the Social Security Act (the Act); (4) the Children's Health Insurance Program (CHIP) established under Title XXI of the Act; and (5) The BHP established under § 1331 of the PPACA;
18. "Minimum Essential Coverage" or "MEC" is defined in IRC § 5000A(f) and includes health insurance coverage offered in the individual market within a state, which includes a QHP offered through an Exchange, an eligible employer sponsored plan, or government-sponsored coverage such as coverage under Medicare Part A, TRICARE, or a VHA Health Care Program;
19. "Navigator" means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in 45 CFR § 155.210;
20. "PPACA" means Patient Protection and Affordable Care Act (Public Law No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law No. 111-152), codified at 42 U.S.C. §§ 18001 et seq. (collectively, the PPACA);
21. "Personally Identifiable Information" or "PII" is defined in OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable Information (January 3, 2017), and means information that can be used to distinguish or trace an individual's identity, either alone or when combined with other information that is linked or linkable to a specific individual;
22. "Qualified Health Plan" or "QHP" means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 of Title 45 of the CFR issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155 of Title 45 of the CFR;
23. "Recipient Agency" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(9) and means any agency, or contractor thereof, receiving records contained in a system of records from a Source Agency for use in a matching program;
24. "Record" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(4) and means any item, collection, or grouping of information about an individual that is

maintained by an agency, including his or her education, financial transactions, medical history, and criminal or employment history and that contains his or her name, or the identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print or a photograph;

25. "Security Incident" means "Incident," which is defined in OMB Memorandum M-17-12 Preparing for and Responding to a Breach of Personally Identifiable information (January 3, 2017) as an occurrence that (1) actually or imminently jeopardizes, without lawful authority, the integrity, confidentiality, or availability of information or an information system; or (2) constitutes a violation or imminent threat of violation of law, security policies, security procedures, or acceptable use policies;
26. "Source Agency," as defined by the Privacy Act at 5 U.S.C. § 552a(a)(11), means any agency that discloses records contained in a system of records to be used in a matching program;
27. "State-based Exchange" means an Exchange established and operated by a state, and approved by HHS under 45 CFR § 105;
28. "System of Records" or "SOR" is defined by the Privacy Act at 5 U.S.C. § 552a(a)(5) and means a group of any records under the control of any agency from which information about an individual is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual; and
29. "VHA Health Care Program" means a health care program under chapter 17 or 18 of Title 38 U.S.C., as determined by the Secretary of Veterans Affairs, in coordination with the Secretary of Health and Human Services and the Secretary of the Treasury, as defined in regulations implementing 26 U.S.C. § 5000A.

II. RESPONSIBILITIES OF THE PARTIES

A. CMS Responsibilities

1. CMS will develop procedures through which an Applicant or Enrollee may request an Eligibility Determination via a single, streamlined application.
2. CMS and AEs will only request data from VHA's records when necessary for CMS or the AE to make an Eligibility Determination.

3. CMS and AEs will provide to VHA the required data elements necessary and agreed upon by both Parties when requesting data from VHA through the Hub, including, but not limited to, first and last name, gender, date of birth and social security number (SSN).
4. CMS and AEs will receive the VHA response data elements through the Hub and will utilize the information provided by VHA in making Eligibility Determinations.
5. CMS has developed and will maintain procedures through which an AE can request and receive information from VHA through the CMS Hub to make Eligibility Determinations.
6. CMS will enter into agreements with AEs that bind those entities to comply with appropriate privacy and security standards and protections for PII, including requirements for these entities and their employees, contractors, and agents to comply with the privacy and security standards that are consistent with section 1411(g) of the PPACA, 45 CFR § 155.260, and the terms and conditions of this Agreement.
7. CMS will provide Congress and the OMB with advance notice of this matching program and, upon completion of OMB's advance review, will publish the required matching notice in the Federal Register.

B. VHA Responsibilities

1. VHA will develop and maintain procedures to respond to verification requests submitted by CMS and AEs, and to transmit information from its relevant system of records for CMS and AEs to use to verify or validate attestations made by Applicants and Enrollees related to enrollment in VHA Health Care Programs.
2. VHA will perform probabilistic data matching logic activity to match the identity of the Applicant or Enrollee's inputs with VHA data records.
3. VHA will provide VHA data to the Hub, including SSN, MEC start dates and MEC end dates, if present, and transaction ID, in order to verify whether the Applicant or Enrollee was enrolled in VHA Health Care Program within the period requested by CMS or an AE through the Hub.

4. VHA will provide a 'coded' response if the person was either not found within the VHA database or the person was not enrolled within VHA given the time period provided by CMS.

III. JUSTIFICATION AND ANTICIPATED RESULTS

A. Cost Benefit Analysis

As required by § 552a(u)(4) of the Privacy Act, a cost benefit analysis (CBA) is included as Attachment 1, covering this and seven other "Marketplace" matching programs which CMS conducts with other Federal agencies. The CBA demonstrates that monetary costs to operate the eight Marketplace matching programs are approximately \$58.9 million, but does not quantify direct governmental monetary benefits sufficient to estimate whether they offset such costs. The CBA, therefore, does not demonstrate that the matching program is likely to be cost effective (i.e., does not show that the program is likely to pay for itself) and does not produce a favorable benefit-to-cost ratio.

However, other supporting justifications and mitigating factors support approval of this CMA, as described below in Section B. OMB guidance provides that the Privacy Act "does not require the showing of a favorable ratio for the match to be continued". The intention is to provide Congress with information to help evaluate the cost-effectiveness of statutory matching requirements with a view to revising or eliminating them where appropriate." See OMB Guidelines, 54 FR 25818 at 25828.

B. Other Supporting Justifications

Although the cost benefit analysis does not demonstrate that the Marketplace matching programs are likely to be cost effective, ample justification exists in the CBA sections III (Benefits) and IV (Other Benefits and Mitigating Factors) to justify DIB approval of the matching programs. Each Party's Data Integrity Board (DIB) therefore is requested to determine, in writing, that the cost benefit analysis is not required, in accordance with 5 U.S.C. § 552a(u)(4)(B), and to approve the agreement based on these other supporting justifications:

1. Certain Marketplace matching programs are required (i.e., are based on a statutory obligation); not discretionary to conduct.

2. The Marketplace matching programs improve the speed and accuracy of consumer eligibility determinations while minimizing administrative burdens and achieving operational efficiencies.
3. The matching programs benefit the public and consumers by accurately determining consumers' eligibility for financial assistance (including APTC and CSRs).
4. The efficient eligibility and enrollment process provided by the Marketplace matching programs contributes to greater numbers of consumers enrolling in Marketplace qualified health plans, resulting in a reduction of the uninsured population and improving overall health care delivery.
5. Continuing to use the current matching program structure, which is less costly than any alternative structure, is expected to increase the public's trust in the participating agencies as stewards of taxpayer dollars.

C. Specific Estimate of Any Savings

There are no cost savings to conducting the Marketplace matching programs, as opposed to not conducting them. However, use of matching programs is effectively mandated by statute and regulation in order to provide for the streamlined application process required by Congress in section 1413 of the PPACA. Therefore, the optimal result is attained by limiting the cost of conducting the matching programs by using a matching program operational structure and technological process that is more efficient than any alternatives.

IV. RECORDS DESCRIPTION

The Privacy Act at 5 U.S.C. § 552a(o)(1)(C) requires that each CMA specify a description of the records that will be matched and exchanged, including each data element that will be used, the approximate number of records that will be matched, and the projected starting and completion dates of the program.

A. Systems of Records

1. The CMS system of records that supports this matching program is "CMS Health Insurance Exchanges System (HIX)", System No. 09-70-0560, last published in full at 78 FR. 63211 (October 23, 2013), and partially amended at 83 FR 6591 (February 14, 2018). Routine use 3 authorizes CMS'

disclosures of identifying information about Applicants to VHA for use in this matching program.

2. The VA system of records that supports this matching program is “Veterans and Beneficiaries Purchased Care Community Health Care Claims, Correspondence, Eligibility, Inquiry and Payment Files—VA,” System No. 54VA10NB3, last fully published at 80 FR 11527 (March 3, 2015). VHA will match identifying information provided by CMS to VHA information as authorized by Routine use 25 in 54VA10NB3.

B. Number of Records Involved

CMS estimates that approximately 57 million records may be transacted through queries to VHA in fiscal year 2023.

C. Specific Data Elements Used in the Match

1. From CMS to VHA. For each Applicant or Enrollee seeking an Eligibility Determination from an AE, and for whom VHA has the authority to release information, CMS or the AE will submit a request through the Hub to VHA that may contain, but is not limited to, the following specified data elements in a fixed record format:
 - a. First Name (required)
 - b. Middle Name/Initial (if provided by Applicant)
 - c. Surname (Applicant's Last Name) (required)
 - d. Date of Birth (required)
 - e. Gender (required)
 - f. SSN (required)
 - g. Requested QHP Coverage Effective Date (required)
 - h. Requested QHP Coverage End Date (required)
 - i. State identification (required)
 - j. Transaction ID (required)
2. From VHA to CMS. For each Applicant or Enrollee seeking an Eligibility Determination from an AE from whom CMS or an AE has secured consent and VHA has the authority to disclose information, VHA will provide a response to the Hub. The response will be in a standard fixed record format and may contain, but is not limited to, the following specified data elements:

- a. SSN (required)
- b. Start/End Date (s) of enrollment period (s) (when match occurs)
- c. A blank date response when a non-match occurs
- d. If CMS transmits request and a match is made, but VHA's record contains a Date of Death, VHA will respond in the same manner as a non-match response, with a blank date
- e. Enrollment period(s) is/are defined as the timeframe during which the person was enrolled in a VHA Health Care Program

D. Frequency of Data Exchanges

The data exchanges under this agreement will begin November 2, 2023 and continue through May 1, 2025, in accordance with schedules set by CMS and VHA. CMS will submit requests electronically in real-time and batch processing on a daily basis throughout each year.

E. Projected Starting and Completion Dates of the Matching Program

Effective Date – November 2, 2023

Expiration Date – May 1, 2025 (May 1, 2026 if renewed for one year).

V. NOTICE PROCEDURES

The matching notice that CMS will publish in the FR as required by the Privacy Act at 5 U.S.C. § 552a(e)(12) will provide constructive notice of the matching program to affected individuals.

At the time of application or change of circumstances, CMS, or an AE administering an IAP, will provide individualized (i.e., actual) notice of the matching program to Applicants for enrollment in a QHP or an IAP under PPACA on the streamlined eligibility application. The agency administering the IAP, including CMS in its capacity as an FFE, will ensure provision of a Redetermination or Renewal notice in accordance with applicable law. These notices will inform Applicants that the information they provide may be verified with information in the records of other Federal agencies.

VI. VERIFICATION PROCEDURES AND OPPORTUNITY TO CONTEST FINDINGS

The Privacy Act at 5 U.S.C. § 552a(p) requires that each matching agreement specify procedures for verifying information produced in the matching program and for providing affected individuals with an opportunity to contest findings.

A. Verification Procedures

Before an AE may take any adverse action based on the information received from the match, the individual will be permitted to provide the necessary information or documentation to verify eligibility information. When an AE determines that an individual is ineligible for an IAP based on the information provided by the match, and that information is inconsistent with information provided on the streamlined eligibility application or otherwise by an Applicant or Enrollee, the AE will comply with applicable law and will notify the Applicant, or Enrollee of the match findings and provide the following information: (1) The AE received information that indicates the individual is ineligible for an IAP; and (2) the Applicant, or Enrollee has a specified number of days from the date of the notice to contest the determination that the Applicant or Enrollee is not eligible for the relevant IAPs. In complying with applicable law, the AE will in no instance take adverse action in fewer than 30 days after Applicant or Enrollee has received notice.

B. Opportunity to Contest Findings

In the event that information attested to by an individual for matching purposes is inconsistent with information received through electronic verifications obtained by the VHA through the Hub, the individual must be provided notice that the information they submitted did not match information received through electronic verifications as follows:

1. If the AE is an Exchange, an individual seeking to resolve inconsistencies between attestations and the results of electronic verification for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 45 CFR §§ 155.315 and 155.320. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.

2. If the AE is an agency administering a Medicaid or CHIP program, an individual seeking to resolve inconsistencies between attestations and the results of electronic for the purposes of completing an Eligibility Determination should be provided the opportunity to follow the procedures outlined in 42 CFR §§ 435.945 through 435.956. The AE will provide the proper contact information and instructions to the individual resolving the inconsistency.
3. Per 42 CFR § 600.345, if the AE is a BHP, it must elect either the Exchange verification procedures set forth in VI.B.1 or the Medicaid verification procedures set forth at VI.B.2.

VII. DISPOSITION OF MATCHED ITEMS

VHA and CMS will retain the electronic files received from the other Party only for the period of time required for any processing related to the matching program and will then destroy the data by electronic purging, unless VHA or CMS are required to retain the information for enrollment, billing, payment, program audit purposes, or legal evidentiary purposes or where they are required by law to retain the information. The CMS FFE and AE will retain data for such purposes and under the same terms. In case of such retention, VHA and CMS will retire the retained data in their SOR in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). VHA and CMS will not create permanent files or separate systems comprised solely of the data provided by the other agency.

VIII. SECURITY PROCEDURES

1. General. CMS and VHA will maintain a level of security that is commensurate with the risk and magnitude of harm that could result from the loss, misuse, disclosure, or modification of the information contained on the system with the highest appropriate sensitivity level.
2. Legal Compliance. CMS and VHA shall comply with the limitations on use, disclosure, storage, transport, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include section 1411(g) of the PPACA; the Privacy Act of 1974; the E-Government Act of 2002, which includes the Federal Information Security Management Act of 2002 (FISMA), 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558; HIPAA; the Computer Fraud and Abuse Act of 1986; the

Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute.

3. CMS and VHA will comply with OMB circulars and memoranda, such as OMB Circular A-130, Managing Information as a Strategic Resource, published at 81 FR 49689 (July 28, 2016); and National Institute of Standards and Technology (NIST) directives and publications; and the Federal Acquisition Regulations. These laws, directives, and regulations include requirements for safeguarding Federal information systems and PII used in Federal agency business processes, as well as related reporting requirements. The Parties recognize and will implement the laws, regulations, NIST standards, and OMB directives including those published subsequent to the effective date of this Agreement.
4. FISMA requirements apply to all Federal contractors, organizations, or entities that possess or use Federal information, or that operate, use, or have access to Federal information systems on behalf of an agency. Both Parties are responsible for oversight and compliance of their contractors and agents.
5. Incident Reporting

CMS and VHA will comply with OMB reporting guidelines in the event of a Security Incident, loss, potential loss, or Breach of PII (see OMB M-17-12, Preparing for and Responding to a Breach of Personally Identifiable Information (Jan. 3, 2017) and OMB M-23-03, "Fiscal Year 2023 Guidance on Federal Information Security and Privacy Management Requirements" (Dec. 2, 2022)) and notify the National Cybersecurity and Communications Integration Center/United States Computer Emergency Readiness Team (NCCIC/US-CERT) within one hour of being identified by the agency's top-level Computer Security Incident Response Team (CSIRT), Security Operations Center (SOC), or information technology department. In addition, within one hour of discovering the incident, the Party experiencing the incident will notify the other agency's System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If CMS is unable to speak with the other Party's System Security Contact within one hour or if for some reason notifying the System Security Contact is not practicable (e.g., outside of normal business hours), CMS will call VA Network and Security Operations Center (NSOC) toll free at 1-800-877-4328 or via email at HACTSTCustomerSupport@va.gov. If VHA is unable to speak with CMS Systems Security Contact within one hour, VHA will contact CMS IT Service Desk at 1-800-562-1963 or via email at CMS_IT_Service_Desk@cms.hhs.gov.

The Party that experienced the loss, potential loss, Security Incident, or Breach will be responsible for following its established procedures, including notifying the proper organizations (e.g., United States Computer Emergency Readiness Team (US-CERT)), conducting a breach and risk analysis, and determining the need for notice and/or remediation to individuals affected by the loss. Parties under this agreement will follow PII breach notification policies and related procedures as required by OMB guidelines and the US-CERT Federal Incident Notification Guidelines. If the Party experiencing the breach determines that the risk of harm requires notification to the affected individuals or other remedies, then that Party will carry out these remedies without cost to the other Party.

6. Administrative Safeguards

CMS and VHA will restrict access to the matched data and to any data created by the match to only those Authorized Users of the Hub, e.g. AEs and their employees, agents, officials, contractors, etc., who need it to perform their official duties in connection with the uses of data authorized in this Agreement. Further, CMS and VHA will advise all personnel who will have access to the data matched and to any data created by the match of the confidential nature of the data, the safeguards required to protect the data, and the civil and criminal sanctions for noncompliance contained in the applicable Federal laws.

7. Physical Safeguards

CMS and VHA will store the data matched and any data created by the match in an area that is physically and technologically secure from access by unauthorized persons at all times. Physical safeguards may include door locks, card keys, biometric identifiers, etc. Only authorized personnel will transport the data matched and any data created by the match. CMS and VHA will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.

8. Technical Safeguards

CMS and VHA will process the data matched and any data created by the match under the immediate supervision and control of authorized personnel to protect the confidentiality of the data in such a way that unauthorized persons cannot retrieve any such data by means of computer, remote terminal, or other means. Systems

personnel must enter personal identification numbers when accessing data on a Party's systems. VHA and CMS will strictly limit authorization to those electronic data areas necessary for the authorized analyst to perform his or her official duties.

9. Application of Policies and Procedures

Each party will adopt policies and procedures to ensure that it uses the information described in this Agreement that is contained in its respective records or obtained from the other solely as provided in this Agreement. CMS and VHA will comply with their respective policies and procedures and any subsequent revisions.

10. Security Assessment

NIST Special Publication 800-37, as revised, encourages agencies to accept each other's security assessments in order to reuse information system resources and/or to accept each other's assessed security posture in order to share information. NIST 800-37 further encourages that this type of reciprocity is best achieved when agencies are transparent and make available sufficient evidence regarding the security state of an information system so that an authorizing official from another organization can use that evidence to make credible, risk-based decisions regarding the operation and use of that system or the information it processes, stores, or transmits. Consistent with that guidance, the Parties agree to make available to each other upon request system security evidence for the purpose of making risk-based decisions. Requests for this information may be made by either Party at any time throughout the duration or any renewal of this CMA.

11. Compliance

CMS must ensure information systems and data exchanged under this matching agreement are maintained compliant with CMS Acceptable Risk Safeguards (ARS) standards. The ARS document can be found at: <https://security.cms.gov/library/cms-acceptable-risk-safeguards-ars>. To the extent, these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version.

IX. RECORDS USAGE, DUPLICATION AND RE-DISCLOSURE RESTRICTIONS

CMS and VHA will comply with the following limitations on use, duplication, and re-disclosure of the electronic files and data provided by the other Party under this Agreement:

- A. CMS and VHA will only use the data for purposes specified by this Agreement or allowed by applicable SORN or Federal law.
- B. CMS and VHA must seek the consent of the other Party to use or disclose the data for any purpose other than the purposes described in this agreement. VHA and CMS will not give such consent, unless the law permits disclosure, or the disclosure is essential to the matching program. For such permission, the agency requesting permission must specify the following in writing; (1) what data will be used or disclosed, (2) to whom will the data be disclosed, (3) the reasons justifying such use or disclosure, and (4) the intended use of the data.
- C. The matching data provided by VHA under this Agreement will remain the property of VHA and will be retained by CMS and AE to be used for audits to verify the accuracy of matches and to adjudicate appeals. VHA matching data will only be destroyed after the matching activity, appeals and audits involving the data have been completed as described under this Matching Agreement.
- D. CMS will restrict access to data solely to officers, employees, and contractors of CMS and AEs. Through the Hub, CMS may disclose the data received under this Agreement to AEs pursuant to separate CMAs that authorize such entities to use the data for Eligibility Determinations regarding APTC, CSRs, and IAPs.
- E. CMS and AE will restrict access to the results of the data match to Applicants or Enrollees, Application Filers, and Authorized Representatives of such persons and to Certified Application Counselors, Navigators, Agents, and Brokers who have been authorized by the Applicant and are obligated by regulation and/or under agreement with CMS or an AE. CMS and AEs shall require the same or more stringent privacy and security standards as a condition of contract or agreement with individuals or entities, such as Navigators, Agents, or Brokers that (1) gain access from CMS or an AE to PII submitted to an Exchange or (2) collect, use, or disclose PII gathered directly from Applicants or Enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange. (See 45 CFR § 155.260; 42 CFR § 431, subpart F, including subsections 431.301, 431.302, 431.303, 431.305; 42 CFR § 435.945; and 42 CFR § 457.1110).
- F. CMS will not duplicate or re-disclose data provided by VHA within or outside of CMS, except where described in this Agreement or authorized by applicable law.

X. RECORDS ACCURACY ASSESSMENTS

The Privacy Act at 5 U.S.C. § 552a(o)(1)(J) requires that a CMA include “information on assessments that have been made” on the accuracy of the records that will be used in the matching program. CMS has not explicitly assessed the accuracy of the identifying information in the HIX systems of records, but Exchange operations are continually subject to rigorous examination and testing as required by Appendix C of OMB Circular A-123 and they are also evaluated through audits conducted by HHS Office of Inspector General and the Government Accountability Office. VHA currently estimates that 99% of the information within the systems covered by the VHA SORN cited in IV.A.2. is accurate for PPACA purposes in cases where (1) an exact Applicant match is returned, (2) the Applicant has an enrollment status of "verified", and (3) their enrollment period coincides with the start/end dates received from the Hub.

XI. COMPTROLLER GENERAL ACCESS

Pursuant to 5 U.S.C. § 552a(o)(1)(K), the Government Accountability Office (Comptroller General) may have access to all CMS and VHA records, as necessary, in order to verify compliance with this Agreement.

XII. REIMBURSEMENT

All work performed by VHA to perform the computer matches in accordance with this Agreement will be performed on a reimbursable basis. The legal authority for the transfer of funds between CMS and VHA is the Economy Act, 31 U.S.C. § 1535. Reimbursement will be transacted by means of a separate reimbursement instrument in accordance with the established procedures that apply to funding reimbursement actions. CMS and VHA will execute and maintain a separate Interagency Agreement on an annual basis to address CMS reimbursement of relevant VHA costs related to systems access covered by this Agreement. CMS agrees not to process requests directly received from any non-profit entity that VHA does not have the legal authority to bill.

XIII. DURATION OF AGREEMENT

A. Effective Date and Duration

The Effective Date of this Agreement will be November 2, 2023, provided that CMS reported the proposal to re-establish this matching program to the Congressional committees of jurisdiction and OMB in accordance with 5 U.S.C. § 552a(o)(2)(A) and (r) and OMB Circular A-108 and, upon completion of OMB’s advance review,

CMS published notice of the matching program in the Federal Register for at least thirty (30) days in accordance with 5 U.S.C. § 552a(e)(12).

This agreement will be in effect for a period of eighteen (18) months.

The HHS and VA DIBs may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed one year if CMS and VHA can certify to their DIBs that:

1. The matching program will be conducted without change; and
2. The Parties have conducted the matching program in compliance with this Agreement.

If either Party does not want to renew this agreement, it must notify the other Party of its intention not to continue at least ninety (90) days before the expiration of the agreement.

B. Modification

The Parties may modify this Agreement at any time by a written modification, mutually agreed to by both Parties, provided that the modification does not include a significant change. A significant change would require a new matching agreement.

C. Termination

This Agreement may be terminated at any time upon the mutual written consent of the Parties. Either Party may unilaterally terminate this agreement upon written notice to the other Party, in which case the termination date shall be effective ninety (90) days after the date of the notice or at a later date specified in the notice, provided this date does not exceed the approved duration for the agreement. A copy of the notification should be submitted to the Secretary, HHS DIB.

XIV. LIABILITY

- A. Each Party to this Agreement shall be liable for acts and omissions of its own employees.

- B. Neither Party shall be liable for any injury to another Party's personnel or damage to another Party's property, unless such injury or damage is compensable under the Federal Tort Claims Act (28 U.S.C. § 1346(b)), or pursuant to other Federal statutory authority.
- C. Neither Party shall be responsible for any financial loss incurred by the other, whether directly or indirectly, through the use of any data furnished pursuant to this Agreement.

XV. INTEGRATION CLAUSE

This Agreement constitutes the entire agreement of the Parties with respect to its subject matter and supersedes all other computer matching agreements between the Parties that pertain to the disclosure of data between VHA and CMS for the purposes described in this Agreement. CMS and VHA have made no representations, warranties, or promises outside of this Agreement. This Agreement takes precedence over any other documents that may be in conflict with it.

XVI. PERSONS TO CONTACT

- A. The VHA contacts are:

Project Coordinator

Stacey Echols
Director, Health Eligibility Center
2957 Clairmont Rd. NE, Suite 200
Atlanta GA 30329
Telephone: 404-828-5303
E-mail: Stacey.Echols@va.gov

Privacy Issues

Andrea Wilson, RHIA, MAM, CIPP-US
VHA Privacy Office Manager
Information Access and Privacy Office
Office of Health Informatics (OHI) 10A7B
810 Vermont Avenue
Washington, D.C. 20420
Telephone: 321-205-4305
E-mail: Andrea.Wilson3@va.gov

Systems and Security Issues

Adrienne Ficchi, MBA, CHPSE, VHA-CM
Director, Health Care Security Requirements
Health Information Governance (HIG)
VHA, Office of Health Informatics (OHI) 10A7 810
Vermont Avenue, N.W.
Washington, D.C. 20420
Telephone: 215-823-5826
E-mail: Adrienne.Ficchi@va.gov

B. The CMS contacts are:

Program Issues

Darla Lipscomb
Acting Director, Marketplace Eligibility and Enrollment Group
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
7501 Wisconsin Avenue
Bethesda, MD 20814
Telephone: (301) 492-4159
Email: Darla.Lipscomb@cms.hhs.gov

Medicaid/CHIP Issues

Brent Weaver
Director, Data and Systems Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Mail Stop: S2-22-27
Location: S2-23-06
Baltimore, MD 21244-1850
Telephone: (410) 786-0070
Email: Brent.Weaver@cms.hhs.gov

Systems and Security

Darrin V. Lyles
Information System Security Officer (ISSO)
Division of Marketplace IT Operations
Marketplace IT Group

Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244
Telephone: (410) 786-4744
Telephone: (443) 979-3169 (Mobile)
Email: Darrin.Lyles@cms.hhs.gov

Privacy and Agreement Issues

Barbara Demopulos
CMS Privacy Act Officer
Division of Security, Privacy Policy and Governance
Information Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Location: N1-14-56
Baltimore, MD 21244-1849
Telephone: (443) 608-2200
Email: Barbara.Demopulos@cms.hhs.gov

XVII. APPROVALS

Electronic Signature Acknowledgement: The signatories may sign this document electronically by using an approved electronic signature process. Each signatory who electronically signs this renewal agrees that his/her electronic signature has the same legal validity and effect as his/her handwritten signature on the document, and that it has the same meaning as his/her handwritten signature.

A. Centers for Medicare & Medicaid Services Program & Approving Officials

The authorized program and approving officials, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit the organization to the terms of this agreement.

Approved by (Signature of Authorized CMS Program Official)

Jeffrey Grant -S Digitally signed by Jeffrey Grant -S
Date: 2023.03.27 09:43:47 -04'00'

Jeffrey D. Grant
Deputy Director for Operations
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services

Date 03/27/2023

B. Centers for Medicare & Medicaid Services Program & Approving Officials

The authorized program official, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organizations to the terms of this agreement.

Approved by (Signature of Authorized CMS Program Official)

Sara M. Vitolo -S Digitally signed by Sara M. Vitolo -
S
Date: 2023.04.03 08:16:02 -04'00'

Sara Vitolo
Acting Deputy Director
Centers for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services

Date **04/03/2023**

C. Centers for Medicare & Medicaid Services Program & Approving Officials

The authorized approving official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirm that no verbal Agreements of any kind shall be binding or recognized, and hereby commits their respective Organization to the terms of this Agreement.

Approved by (Signature of Authorized CMS Approving Official)

Leslie Nettles Digitally signed by Leslie
Nettles -S
-S Date: 2023.04.03
10:25:37 -04'00'

Leslie Nettles, Deputy Director
Division of Security, Privacy Policy and Governance, and
Acting Senior Official for Privacy
Information Security and Privacy Group
Office of Information Technology
Centers for Medicare & Medicaid Services

Date 04/03/2023

D. U. S. Department of Health and Human Services Data Integrity Board Official

The authorized DIB official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this agreement.

Approved by (Signature of Authorized HHS DIB Official)

Cheryl R. Campbell -S Digitally signed by Cheryl R.
Campbell -S
Date: 2023.06.13 16:37:10 -04'00'

Cheryl Campbell
Chairperson
HHS Data Integrity Board
U.S. Department of Health and Human Services

Date _____

E. Veterans Health Administration Approving Officials

The authorized approving officials, whose signatures appear below, accept and expressly agree to the terms and conditions expressed herein, confirm that no verbal agreements of any kind shall be binding or recognized, and hereby commit their respective organization to the terms of this Agreement.

Approved by (Signature of Authorized VHA Program Officials)

STACEY ECHOLS
139116

Digitally signed by STACEY
ECHOLS 139116
Date: 2023.04.03 12:49:15 -04'00'

Stacey Echols

Director, Health Eligibility Center

VHA Member Services, Department of Veterans Affairs

Date 04/03/2023

Alan J. Greilsamer
237842

Digitally signed by Alan J.
Greilsamer 237842
Date: 2023.04.13 08:41:39 -04'00'

Lloyd Thrower

Deputy CIO, Account Manager for Health

Department of Veterans Affairs

Date 04/13/2023

F. U.S Department of Veterans Affairs Data Integrity Board Official

The authorized DIB official, whose signature appears below, accepts and expressly agrees to the terms and conditions expressed herein, confirms that no verbal agreements of any kind shall be binding or recognized, and hereby commits their respective organization to the terms of this agreement.

Approved by (Signature of Authorized VA DIB Official)



2023.04.20

14:57:35 -04'00'

John Oswalt
Chairman, Data Integrity Board
U.S. Department of Veterans Affairs

Date 04/20/2023

Attachment 1

Marketplace Computer Matching Programs:
Cost-Benefit Analysis



MARKETPLACE COMPUTER MATCHING PROGRAMS: COST-BENEFIT ANALYSIS

Prepared by:

Center of Consumer Information and Insurance Oversight (CCIIO), CMS

COST-BENEFIT ANALYSIS FOR MARKETPLACE MATCHING PROGRAMS

UPDATED SEPTEMBER 15, 2022

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Introduction

This cost benefit analysis (CBA) provides information about the costs and benefits of conducting the eight required Marketplace² matching programs, which are conducted under matching agreements between CMS and each federal data source agency and between CMS and state administering entities (AEs). The objective of the Marketplace matching programs is to support the enrollment of eligible individuals in appropriate health coverage programs, thereby reducing the uninsured population and improving overall health care delivery.

The Marketplace matching programs enable AEs to make efficient and accurate eligibility determinations and redeterminations for enrollment in qualified health plans (QHPs), insurance affordability programs, Medicaid and CHIP programs, and Basic Health Programs, and support the issuance of certificates of exemption to individuals who are exempt from the individual mandate to maintain health insurance coverage. The Marketplace matching programs provide for a single streamlined application process as required by the Affordable Care Act, support accurate and real-time eligibility determinations, and ensure that consumers can enroll in the correct program or be properly determined to be exempt from needing coverage.

The matching programs enable AEs to verify individuals' attested application responses with matched data elements from relevant federal data sources based on the type of eligibility determination being performed. These data elements may include citizenship or immigration status, household income, and access to non-employer-sponsored and/or employer-sponsored minimum essential coverage. Non-employer-sponsored coverage includes coverage through TRICARE, Veteran's Health Benefits, Medicaid, Medicare, or benefits through service in the Peace Corps. Employer-sponsored coverage for Federal Employee Health Benefits can be verified with the Office of Personnel Management.

While the matching programs support accurate eligibility determinations, which help avoid improper payments (e.g., improper payments of tax credits to ineligible individuals), no data is available to quantify the amount of improper payments avoided. In addition, the match results are not currently used to identify or recover past improper payments. Consequently, there are no estimates of avoided or recovered improper payments in key elements 3 and 4 (i.e., the "benefits" portion) of the CBA to offset

²'Marketplace' means a State-based Exchange (including a not-for-profit Exchange) or a Federally-Facilitated Exchange established under sections 1311(b), 1311(d)(1), or 1321(c)(1) of the PPACA. For purposes of this analysis, all references to a Marketplace shall refer equally to and include a state agency that is responsible for administering the Insurance Affordability Program under which individuals and small businesses may enroll in Qualified Health Plans in the state.

against the personnel and computer costs estimated in key elements 1 and 2 (i.e., the “cost” portion) of the CBA, so the four key elements of the CBA do not demonstrate that the matching programs are likely to be cost-effective. However, the CBA describes other justifications (i.e., factors demonstrating that the matching programs are effective in maximizing enrollments in QHPs and are structured to avoid unnecessary costs) which support Data Integrity Board (DIB) approval of the matching programs. As permitted by the Privacy Act at 5 U.S.C. § 552a(u)(4)(B), the Justification section of each matching agreement requests the DIB(s) to determine, in writing, that the CBA is not required in this case to support approval of the agreement and to approve the agreement based on the other stated justifications. This underlying reality of the cost effectiveness of the Marketplace matching programs applies to all eight programs supported by this CBA.

The four key elements and sub-elements required to be addressed in the CBA are summarized on the CBA template below. The name of each key element and sub-element is highlighted in bold in the narrative portion of the CBA to indicate where that element is discussed in more detail.

A. Costs

Costs for the recipient and source agencies are primarily personnel costs associated with maintenance and operations supported by information technology resources; therefore, key elements 1 and 2 (personnel costs and computer costs) are combined in this analysis. Note that more detail on the summary figures that follow is provided in later sections of this document.

For Agencies –

- **CMS (Recipient Agency):** \$51.5 million (\$2.0 million internal costs; \$49.5 million external costs) per year.
- **Source Federal Agencies:** \$7.4 million per year (reimbursed by CMS)
- **State AEs:** No data developed.
- **Justice Agencies:** Not applicable, as these matching programs are not currently used to detect and recover past improper payments and therefore do not generate collection cases for justice agencies to investigate and prosecute.

For Clients (Applicants/Consumers), and any Third Parties assisting them –

- Opportunity costs (time required to apply for coverage) are quantified as \$610 million per year (\$42.02 per application x 14.5 million consumers enrolled in QHPs).

For the General Public –

- No data developed. Costs to the public (such as discouragement of legitimate potential participants from applying, and threats to privacy, Constitutional

rights, and other legal rights) would be less significant in these matching programs than in other matching programs, because these matching programs are intended to support enrollments and are not currently used to detect and recover past improper payments.

B. Benefits

Avoidance of Future Improper Payments

For advance payments of the premium tax credit (APTC), consumers must reconcile the tax credit at the time of tax filing, and so improper payment is mitigated. For state and federal costs associated with Medicaid coverage, the avoidance of future improper payment is not quantified here. However, the use of matching programs mitigates the risk of fraud and abuse by applicants or third parties by requiring that personal information provided on an eligibility application match known data on the individuals.

Recovery of Improper Payments and Debts

Not applicable, because data from the Marketplace matching programs are not currently used to identify and recover improper payments and debts.

C. Matching Program Structure

The Patient Protection and Affordable Care Act, Public Law No. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, Public Law No. 111-152 (ACA) requires that each state develop secure electronic interfaces for the exchange of data under a matching program using a single application form for determining eligibility for all state health subsidy programs.

CMS has entered into matching agreements with the following federal source agencies: 1) Social Security Administration (SSA), 2) Department of Homeland Security (DHS), 3) Internal Revenue Service (IRS), 4) Veterans Health Administration (VHA), 5) Department of Defense (DoD), 6) Office of Personnel Management (OPM), and 7) the Peace Corps. In addition, CMS has developed a matching program that is executed with every state AE, including state Medicaid and CHIP agencies and State-based Marketplaces. CMS designed the Federal Data Services Hub (Hub) to be a centralized platform for the secure electronic interface that connects all AEs and trusted data sources.

Without the Hub, each State AE would be required to enter into a separate arrangement with each federal agency to determine whether applicants for state health subsidy programs are eligible for coverage. If the match operations were conducted through separate arrangements outside of the Hub, the costs to CMS, the source federal

agencies, the AEs, and consumers (applicants) would be significantly greater than under the current structure.

D. Background assumptions

CMS has made the following assumptions in developing this CBA:

- The ACA does not expressly mandate the use of computer matching, but effectively requires it by requiring a single streamlined application process for consumers. Because matching must be conducted to provide the single, streamlined application process Congress required (i.e., is not optional), this CBA does not evaluate whether the matching programs should be conducted versus not conducted, but rather it evaluates whether the matching programs are efficiently structured and conducted, and whether the current structure is less costly than an alternative structure.
- Eight matching programs are currently operational. CMS receives data from seven source federal agencies (IRS, DHS, SSA, OPM, Peace Corps, VHA, and DoD) under separate CMAs. Under an eighth CMA, CMS makes the data from those seven source federal agencies, as well as CMS data regarding Medicare enrollment, available to state AEs; in addition, the eighth CMA makes state Medicaid and CHIP enrollment data available to CMS. The seven source federal agencies, CMS, and the state AEs are collectively known as the trusted data sources (TDSs). All data from the TDSs are accessed by CMS and by state AEs via the Hub platform, rather than via direct access from any AE to any TDS.
- Any alternative, non-Hub structure that could be used instead of the current Hub structure would require many more than eight CMAs, as well as many more system interconnections and data transmissions between agencies.
- For a subset of the TDSs, CMS incurs a cost as the recipient agency. The cost of each data transaction is estimated based on a prior year's matching program budget and the estimated number of data transactions occurring that year.
- In addition to the TDSs themselves, additional entities are necessary to provide support services to the Hub. CMS therefore incurs external costs in the hiring, maintenance, and associated costs of contractors to perform numerous functions related to the Hub. In addition, costs are incurred for identity proofing of applicants, troubleshooting, procedure writing, and maintenance support.
- CMS has internal costs related to the funding of CMS federal staff and associated resources to complete processes and responsibilities related to the Hub and the matching programs.
- The benefit of these matching programs is to consumers who apply for and obtain health coverage. The private benefit to them is improved health care

delivery and the expected value of the coverage (whether through private insurance, Medicaid, CHIP or a Basic Health Plan).

- Regarding the Recovery of Improper Payments and Debts (Key Element 4), CMS is not currently utilizing the data match result from the matching programs for payment and debt reconciliations; however, the benefit of the match does provide the potential to implement this capability in the future.

I. Costs

Costs for the recipient and source agencies are primarily personnel costs associated with maintenance and operations supported by information technology resources; therefore, **key elements 1 and 2 (personnel costs and computer costs) are combined in this analysis.**

E. Internal CMS Costs- \$2.0million / year

Most costs paid by CMS to implement the Marketplace matching programs and the Hub are external costs paid to contractors, which are addressed in the next section. CMS' internal costs for federal staff tasked to work on these programs are approximately \$2.0 million per year. The below chart attributes all of the costs to federal staff working in the Center for Consumer Information and Insurance Oversight (CCIIO) office; however, many teams across CMS provide support to the implementation of these programs, and CCIIO staff often have other programs in their portfolios beyond the Marketplace matching programs and the Hub.

CCIIO Team	Estimated Annual Cost
Eligibility and Enrollment (E&E)	\$760,361
SMIPG (State Policy)	\$325,869
Marketplace Information Technology (MITG/HUB)	\$977,607
Total	\$2,063,837

F. External CMS costs: Hub operations— an undetermined portion of \$49.5million/year

- Federal Data Services Hub (Hub) a portion of \$28.4million / year

The Hub is maintained by a CMS contract. While the initial build costs of the Hub were largely incurred before the implementation of the Marketplace programs in 2013, there are ongoing costs associated with system maintenance, changes necessitated by ongoing technology development and new program implementation, and general system health monitoring. In FY2022, the average annual cost of the Hub contract was \$28.4 million. The Hub supports many other Marketplace program efforts besides the matching programs, including the transmission of data to and from insurance issuers, and electronic file transfer for many programs within the Marketplace; as a result, \$28.4 million is an overestimate of the annual Hub costs associated with Marketplace matching program operations.

- Marketplace Security Operations Center (SOC) \$2.8million/ year

The Marketplace SOC is responsible for the security operations and maintenance for the Hub and the Federally-facilitated Marketplace (FFM). The current cost of the Marketplace SOC work is \$2.8 million per year. However, because the Marketplace SOC budget is not formally delineated for the Hub and for the FFM, the cost cited above is an overestimate of the costs specific to supporting Hub operations.

- Exchange Operations Center (XOC) \$12.2million / year

The Exchange Operations Center (XOC) is an entity managed under the Marketplace System Integrator contract tasked with coordinating the technical operations of the Hub and of the FFM. The XOC supports system availability, communication of system issues to stakeholders, and incident triage. Because the XOC budget line is not formally delineated for the Hub and for the FFM, the operational cost cited above is an overestimate of the costs specific to supporting Hub operations. The \$12.2 million cost estimate provided here covers both XOC operations as well as site reliability engineer and metrics costs in support of the XOC.

- Identity-Proofing Service Costs – \$6.1 million / year

Before consumer information can be submitted to a data source for data verification, a consumer’s online account must be identity proofed. Remote identity proofing (RIDP) is a service supported through the Hub for AE programs. While identify proofing is not an eligibility requirement, it is a requirement for online application submission.

G. Costs paid by CMS to TDS agencies – \$7.4 million / year

- Social Security Administration (SSA) - \$3.3 million / year The SSA is the source of numerous data elements for the Hub: verification of the applicant’s name, date of birth, citizenship, Social Security Number (SSN), a binary indicator for incarceration, Title II income (retirement and disability), and work quarters. Verification of an individual’s SSN is a required precursor to accessing consumer information through the other Marketplace matching programs.

Matching with SSA data is accomplished through a reimbursable agreement with CMS. The total cost of the SSA contract with CMS in FY 2022 was \$3,340,596 under IAA number IA22-02.

- Department of Homeland Security (DHS) – \$3.1 million /year DHS is the verification source for naturalized and derived citizenship, and immigration status. The total cost of the DHS contract with CMS in FY 2022 was \$3,049,994 under IAA number IA22-04.

The DHS charges according to a graduated fee schedule for using the database called “SAVE” (Systematic Alien Verification for Entitlements Program). There are up to 3 steps of SAVE verification process: Step 1 is a real-time “ping” to their system. Consumers who could not be successfully verified may go to Step 2, which takes 3-5 days for additional database searches. The third step requires manual touch from a DHS Status Verification Officer and requires a G-845 form. Costs are currently 50 cents per use at Steps 1, 2 and 3. Ongoing automation through DHS’s paperless initiative will impact these costs in the future.

- Veterans Health Administration (VHA) - \$1.0 million / year

Data from the VHA are used to identify current enrollment in health coverage through the VHA, which is an eligibility factor for APTC and cost sharing reduction (CSR) programs. The VHA contract with CMS is transactions-based.

The total cost of the VHA contract with CMS in FY 2022 was \$996,482 under IAA number IA22-03.

- Office of Personnel Management - \$16,800 / year
For FY 2022, OPM charged CMS a flat fee of \$16,800 under IAA number IA22-05.
- Other Trusted Data Sources
CMS does not pay the other Trusted Data Sources (IRS, DoD, Peace Corps, and State Medicaid and CHIP Agencies) for access to and use of their data.

H. Consumer opportunity costs – non-monetary, but quantified

Applying for coverage does not have a monetary cost to applicants, but does have an opportunity cost. CMS estimates that the average time for a consumer to apply for and enroll (or re-enroll) in a QHP each year averages 1.5 hours.³ At a rate of \$28.01 per hour, this opportunity cost is estimated at \$42.02 per application per year. The complete number of applications submitted each year across all AEs is not known, but the total number of QHP enrollees for Plan Year 2022 is 14.5 million,⁴ resulting in a consumer opportunity cost of approximately \$610 million. It should be noted that this estimate does not include opportunity costs for enrollees in Medicaid, CHIP, or BHP programs, or for consumers who apply but do not subsequently enroll in coverage.

II. Benefits

I. Benefits to Agencies – not quantified

The Marketplace matching programs improve the accuracy of data used for making program eligibility determinations, and ensure that individuals are correctly determined and are not inappropriately enrolled in multiple programs. Improved data quality helps ensure that eligibility determinations and other decisions affecting APTC are accurate,

³ Estimate is based on an ½ hour-average to complete an application for QHP coverage plus an additional 1 hour for the consumer to provide supporting documentation to the Marketplace should a data matching issue occur.

⁴ Enrollees in QHPs have the opportunity each year to be automatically reenrolled in a QHP or to return to the Exchange to choose a new plan – however, Marketplaces encourage enrollees to update their information and reevaluate their health coverage needs for the coming year. Furthermore, enrollees are required to report certain life changes as they occur, since they may impact coverage and/or participation in insurance affordability programs. CMS has elected to use the entire universe of 2022 QHP enrollees (14.5 million) in this CBA in order to present the most conservative case for consumer opportunity costs.

which helps avoid future improper payments. This avoidance of future improper payments fits the third cost benefit analysis key element but hasn't been quantified.

Using data made available through the Marketplace matching programs in combination with an individual applicant's attestation of his or her personal information is more reliable than relying solely on applicant attestations. The use of data matching mitigates the risk of fraud and abuse by applicants or third parties by requiring that personal information provided on an eligibility application match known data on the individuals.

J. Benefits to Enrollees of obtaining health coverage – quantified, but outside the scope of the 4 key elements

For Plan Year 2022, 14,511,077 consumers enrolled in a QHP across all Marketplaces. Of these, 89% received APTC, with an average value of \$505 per month (annualized to \$6,060 per year). In total, therefore, approximately \$78.3 billion in APTC will be provided to enrollees in Plan Year 2022.⁵

Approximately 49% of the QHP enrollees in Plan Year 2022 received financial assistance through cost-sharing reductions when enrolling in a silver-level plan. The financial estimate of this benefit is not quantified here, as it is dependent on individual utilization of medical services.

Additionally, a significant number of consumers receive health coverage through Medicaid, CHIP, or a BHP, and received eligibility determinations for that coverage based on data made available through these agreements. Because of the wide variety in state approaches to making and reporting eligibility determinations, the number of enrollees in these programs is not quantified here.

The financial benefit of having health coverage, whether through a QHP, Medicaid, CHIP, or BHP varies by individual and individual health needs, and is therefore not estimated here.

While these benefits to consumers are made possible in part by the Marketplace matching programs, the benefits are ultimately paid with federal funds (or, in the case of Medicaid and CHIP enrollees, with a combination of federal and state funds). Neither that funding nor these benefits to consumers can be considered a direct cost or benefit of conducting the Marketplace matching programs. As a result, these benefits are not directly applicable to this analysis.

⁵ 8/3/2022: Plan Year 2022 data from <https://www.cms.gov/files/document/health-insurance-exchanges-2022-open-enrollment-report-final.pdf>

K. Recovery of improper payments – not germane (not an objective) at this time

The fourth cost benefit analysis key element (recovery of improper payments and debts) is not germane to this cost benefit analysis, because data from the Marketplace matching programs are not currently used to identify and recover improper payments and debts. Annual reconciliation and recovery of improper tax payments are performed by the IRS through a process that is independent of the Marketplace matching programs and other CMS eligibility determination activities. While the Marketplace matching programs could provide for annual and monthly reporting of data by Marketplaces to the IRS and consumers for the purpose of supporting IRS's annual reconciliation, annual and monthly reporting is not currently an activity covered in the IRS-CMS CMA; rather, that information is exchanged between the agencies through Information Exchange Agreements. At most, the data used in the Marketplace matching programs has the future potential benefit of being used in an analytical form, to assist IRS in identifying and/or recovering improper payments and debts.

Consideration of Alternative Approaches to the Matching Programs

In requiring a single, streamlined application process and specifying electronic data access, the ACA effectively required use of computer matching to make eligibility determinations. As a result, wholly manual alternatives for verification of application information (such as a paper-based documentation process) are not considered as a viable alternative in this analysis.

The Marketplace matching programs currently leverage the Hub to minimize connections between AEs and the federal partners. This model has successfully met program needs by providing for a single streamlined application process for consumers, and supporting accurate eligibility determinations, which in turn increase program integrity for the Marketplace programs.

An alternative, non-Hub approach, for AEs to manage matching programs individually without using the Hub, was considered through this analysis. Without the Hub, each State AE would be required to enter into separate matching arrangements with each federal partner, and build direct connections to each system. CMS believes a non-Hub approach would involve:

- More agreements to prepare and administer (there would be one agreement per AE with each TDS, in place of one agreement per AE with CMS, and one agreement per TDS with CMS);
- More TDS data transmissions to effect and secure (there would be one TDS transmission per AE, in place of each single TDS transmission to the Hub);
- More systems to maintain and secure, to store the TDS data (there would be one system per AE, in place of the single, central Hub system); and
- More copies of TDS data to correct when errors are identified (there would be one copy to correct in each AE system, instead of the single copy in the Hub system).

Based on this analysis, CMS believes the current structure minimizes duplication of effort and is therefore less costly for CMS, federal partners, and State AEs, than an alternative structure that would not leverage the Hub.

Conclusion

The Marketplace matching programs are effectively required, not discretionary, in order to provide the single streamlined application process Congress required. As a result, Marketplace matching programs must continue in the absence of a cost-effectiveness finding.

After careful evaluation of the data presented above, CMS intends to continue using the current matching program structure, which is less costly than the alternative, non-Hub structure and achieves the primary goals of providing a single streamlined application process and accurate eligibility determinations. While CMS intends to retain the existing matching program structure moving forward, necessary changes will be made as needed to keep the matching programs compatible with changes in program operations and data flow. This cost benefit analysis and the decision to retain the current matching structure should increase the public's trust in the participating agencies as careful stewards of taxpayer dollars.

Because the Marketplace matching programs incur a net cost (i.e., do not demonstrate that the matching programs are likely to be cost-effective), the Marketplace matching agreements should be worded to provide for data integrity board (DIB) approval to be based on the other benefits and mitigating factors described in this analysis and in each individual agreement. Specifically, the agreements should provide justification for each DIB's written determination that the cost benefit analysis is not required to demonstrate cost-effectiveness for Marketplace matching programs.