

**COMPUTER MATCHING AGREEMENT  
BETWEEN  
THE DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES  
AND  
THE SOCIAL SECURITY ADMINISTRATION  
FOR  
DETERMINING ENROLLMENT OR ELIGIBILITY  
FOR  
INSURANCE AFFORDABILITY PROGRAMS UNDER  
THE PATIENT PROTECTION AND AFFORDABLE CARE ACT**

**The Centers for Medicare & Medicaid Services No. 2016-12  
The Department of Health and Human Services No. 1604  
The Social Security Administration No. 1097-1899**

**Effective: March 8, 2016  
Expires: September 8, 2017**

**I. PURPOSE**

This Computer Matching and Privacy Protection Act (CMPPA) Agreement (Agreement) establishes the terms, conditions, safeguards, and procedures under which the Social Security Administration (SSA) will disclose information to the Centers for Medicare & Medicaid Services (CMS) in connection with the administration of Insurance Affordability Programs under the Patient Protection and Affordable Care Act (Public Law (Pub. L.) No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, ACA) and its implementing regulations. CMS will use SSA data to make initial Eligibility Determinations for eligibility to enroll in a Qualified Health Plan (QHP) through an Exchange established under ACA; eligibility for Insurance Affordability Programs and for certifications of Exemption; and eligibility Redeterminations and Renewal decisions, including appeal determinations, for enrollment in a QHP through an Exchange and Insurance Affordability Programs and for certifications of Exemption. Insurance Affordability Programs include:

1. Advance payments of the premium tax credit (APTC) and cost sharing reductions (CSRs),
2. Medicaid,
3. Children's Health Insurance Program (CHIP), and
4. Basic Health Program (BHP).

As set forth in this Agreement, SSA will provide CMS with the following information when relevant: (1) Social Security number (SSN) verifications, (2) a death indicator, (3) a Title II disability indicator, (4) prisoner data, (5) monthly and annual Social Security benefit information under Title II of the Social Security Act (Act) (Title II income), (6) quarters of coverage (QC), and (7) confirmation that an allegation of citizenship is consistent with SSA records.

The terms and conditions of this Agreement will be carried out by authorized employees and contractors of CMS and SSA.

## **II. LEGAL AUTHORITY**

This Agreement is executed in compliance with the Privacy Act of 1974

(5 U.S.C. § 552a), as amended; ACA; the Act; the Federal Information Security Management Act (FISMA), as amended by the Federal Information Security Modernization Act of 2014 (Pub. L. 113-283), and the regulations and guidance promulgated thereunder; Office of Management and Budget (OMB) Circular A-130, Management of Federal Information Resources, published at 61 Federal Register (FR) 6428 (February 20, 1996); and OMB guidelines pertaining to computer matching published at 54 FR 25818 (June 19, 1989).

The following statutes provide legal authority for the uses, including disclosures, under this Agreement:

1. Section 1411(a) of ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish a program meeting the requirements of ACA to determine eligibility for enrollment in coverage under a QHP through an Exchange or certain Insurance Affordability Programs, and for certifications of Exemption. Pursuant to section 1311(d)(4)(H) of ACA, an Exchange, subject to section 1411 of ACA, must grant a certification attesting that an individual is exempt from the individual responsibility requirement or penalty imposed by section 5000A of the Internal Revenue Code (IRC). Under section 1411(c) of ACA, the Secretary of HHS shall submit certain identifying information and SSNs to the Commissioner of Social Security for a determination as to whether the information provided is consistent with the information in the records of SSA. Under section 1411(d) of ACA, the Secretary of HHS is directed to establish a system for the verification of other information necessary to make an Eligibility Determination. Section 1411(e)(1) of ACA directs recipients of the information transmitted by the Secretary of HHS to respond to the request(s) for verification in connection with that information. The Secretary of HHS has developed and implemented portions of this program through regulations at 45 C.F.R. Part 155.
2. Section 1413(a) of ACA requires the Secretary of HHS to establish a system under which individuals may apply for enrollment in, and receive an Eligibility Determination for participation in Insurance Affordability Programs or enrollment in a QHP through an Exchange. Section 1413(c) of ACA directs the use of a secure electronic system for transmitting information to determine eligibility for Insurance Affordability Programs and enrollment in a QHP through an Exchange and section 1413(d) of ACA authorizes the Secretary of HHS to enter into agreements to share data under section 1413. The program established by the Secretary under 1413 of ACA also provides for the Secretary of HHS to transmit information to the Commissioner of Social Security for verification purposes for periodic Redeterminations and Renewals of Eligibility Determinations under certain circumstances. The Secretary of HHS has developed and implemented portions of this program through regulations at 42 C.F.R. §§ 435.948, 435.949, and 457.380.
3. Section 1411(c)(4) of ACA requires HHS (herein after CMS) and SSA to use an online system or a system otherwise involving electronic exchange.

4. Section 205(r)(3) of the Act permits SSA to disclose, on a reimbursable basis, death status indicator information to a Federal agency or State agency that administers a federally-funded benefit other than pursuant to the Act to ensure proper payment of such benefit. Section 7213 of the Intelligence Reform and Terrorism Prevention Act of 2004 provides SSA authority to add a death indicator to verification routines that the agency determines to be appropriate.
5. Sections 202(x)(3)(B)(iv) and 1611(e)(1)(I)(iii) of the Act permit SSA to disclose, on a reimbursable basis, prisoner information to an agency administering a Federal or federally-assisted cash, food, or medical assistance program for eligibility and other administrative purposes under such program.
6. Section 1106(b) of the Act authorizes SSA to disclose SSA information so long as the disclosure is legally authorized and the recipient agency agrees to pay for the information requested in such amount, if any (not exceeding the cost of furnishing the information), as may be determined by the Commissioner of Social Security.
7. Section 1411(f)(1) of ACA requires the Secretary of HHS, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security to establish procedures for redetermining eligibility on a periodic basis.
8. Section 1411(f)(1) of ACA requires the Secretary of HHS to establish procedures for the periodic redetermination of eligibility for enrollment in a QHP through an Exchange, APTC, CSRs, and certifications of Exemption. Under the authority of sections 1311, 1321, and 1411 of ACA, the Secretary of HHS adopted regulations – 45 C.F.R. §§ 155.330 and 155.335 – which further address the requirements for an Exchange to redetermine eligibility for enrollment in a QHP through an Exchange and for APTC and CSRs during the benefit year based on certain types of changes in circumstances, as well as on an annual basis. Pursuant to 45 C.F.R. § 155.620, an Exchange must redetermine an individual’s eligibility for a certification of Exemption, except for the certification of Exemption described in 45 C.F.R. § 155.605(g)(2), when it receives new information from the individual. Pursuant to 42 C.F.R. §§ 435.916 and 457.343, State agencies administering Medicaid and CHIP programs must also periodically review eligibility and renew determinations of eligibility for Medicaid and CHIP beneficiaries.
9. Section 1943(b)(3) of the Act (as added by section 2201 of ACA) requires that Medicaid and CHIP agencies utilize the same streamlined enrollment system and secure electronic interface established under section 1413 of ACA to verify data and determine eligibility.
10. Section 1331 of ACA provides the authority for the BHP. Section 1331 provides that an eligible individual in the BHP is one whose income is in a certain range and who is not eligible to enroll in Medicaid for essential health benefits, nor for minimum essential coverage (as defined in section 5000A(f) of the IRC of 1986) nor for affordable employer-sponsored insurance. 42 C.F.R. § 600.300 requires BHPs to establish mechanisms and procedures to maximize coordination with the Exchange, Medicaid, and CHIP. It further requires agencies administering BHPs to establish and maintain processes to make income eligibility determinations using modified adjusted gross income, and to ensure that applications received by the agency result in eligibility assessments or determinations for those other programs. It further requires the agency administering the BHP to participate in the secure exchange of information with agencies administering other Insurance Affordability Programs.

11. The Privacy Act, 5 U.S.C. § 552a(b)(3), authorizes a Federal agency to disclose information about an individual that is maintained by an agency in an agency system of records, without the prior written consent of the individual, when such disclosure is pursuant to a routine use. SSA and CMS have routine uses in their respective systems of records to address their disclosures under this Agreement.

### **III. DEFINITIONS**

1. “ACA” means Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152) (collectively, ACA);
2. “Advance Payments of the Premium Tax Credit” or “APTC” means payment of the tax credits specified in section 36B of the IRC (as added by section 1401 of ACA), which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of ACA;
3. “Applicant” means an individual seeking enrollment in a QHP through an Exchange, eligibility for himself or herself in an Insurance Affordability Program, or an Exemption; this term includes individuals whose eligibility is determined at the time of a Renewal or Redetermination;
4. “Application Filers” means an Applicant, an adult who is in the Applicant's household (as defined in 42 C.F.R. § 435.603(f)), or family (as defined in 26 C.F.R. § 1.36B-1(d)), an Authorized Representative of an Applicant, or if the Applicant is a minor or incapacitated, someone acting responsibly for an Applicant, excluding those individuals seeking eligibility for an Exemption;
5. “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;
6. “Basic Health Program” or “BHP” means an optional State program established under section 1331 of ACA;
7. “Breach” is defined by OMB Memorandum M-07-16, Safeguarding and Responding to the Breach of Personally Identifiable Information, May 22, 2007, as the compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, loss of control, or any similar term or phrase that refers to situations where persons other than Authorized Users and for an other than authorized purpose have access or potential access to personally identifiable information, whether physical or electronic;
8. “Children’s Health Insurance Program” or “CHIP” means the State program established under Title XXI of the Act;
9. “CMS” means the Centers for Medicare & Medicaid Services;
10. “Eligibility Determination” means the determination of eligibility for enrollment in a QHP through an Exchange, Insurance Affordability Program, or Exemption, and includes the process of resolving an appeal of an Eligibility Determination;
11. “Exchange” means a State-based Exchange (including a not-for-profit exchange) or a Federally-Facilitated Exchange (FFE) established under sections 1311(b), 1311(d)(1), or 1321(c)(1) of ACA;
12. “Exemption” means an exemption from the requirement or penalty imposed by section 5000A of the IRC; pursuant to section 1311(d)(4)(H) of ACA, an Exchange, subject to section 1411 of ACA, must grant a certification attesting that an individual

is exempt from the individual responsibility requirement or penalty imposed by section 5000A of the IRC;

13. “HHS” means the Department of Health and Human Services;
14. “Insurance Affordability Program” means a program that is one of the following: (1) a State Medicaid program under Title XIX of the Act; (2) a State CHIP under Title XXI of such Act; (3) a State BHP established under section 1331 of ACA; (4) a program that makes coverage in a QHP through the Exchange with APTC; or (5) a program that makes available coverage in a QHP through the Exchange with cost-sharing reductions;
15. “Matching Program” means any computerized comparison of two or more automated systems of records or a system of records with non-Federal records for the purpose of establishing or verifying eligibility, or compliance with statutory and regulatory requirements, for payments under Federal benefit programs, or for the purpose of recouping payments or delinquent debts under Federal benefit programs;
16. “Personally Identifiable Information” or “PII” is defined by OMB M-07-16 (May 22, 2007), and means information which can be used to distinguish or trace an individual’s identity, such as name, SSN, biometric records, etc., alone, or when combined with other personal or identifying information which is linked or linkable to a specific individual, such as date and place of birth, mother’s maiden name, etc.;
17. “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 in Title 45 of the C.F.R. issued or recognized by each Exchange through which such plan is offered in accordance with the process described in 45 C.F.R. § 155 subpart K;
18. “Quarter of Coverage” or “QC” is the basic unit of Social Security coverage used in determining a worker's insured status. SSA will credit an individual with QCs based on his/her earnings covered under Social Security;
19. “Redetermination” means the process by which an Exchange determines eligibility for enrollment in a QHP and/or for an Insurance Affordability Program or certification of Exemption for an enrollee in one of two circumstances: (1) on an annual basis prior to or during open enrollment; and/or (2) when an individual communicates an update to an Exchange that indicates a change to the individual’s circumstances affecting his/her eligibility;
20. “Relevant Individual” means any individual listed by name and SSN on an application for enrollment in a QHP through an Exchange, an Insurance Affordability Program, or for an Exemption whose PII may bear upon a determination of the eligibility of an individual for enrollment in a QHP and/or for an Insurance Affordability Program or certification of Exemption;
21. “Renewal” means the annual process by which the eligibility of Medicaid and CHIP beneficiaries is reviewed for continuation of coverage;
22. “Routine Use” means an exception to the Privacy Act that allows government agencies to disclose record(s) (such as to another agency) in cases in which the use of such record is compatible with the purpose for which it was initially collected;
23. “Security Incident” is the act of violating an explicit or implied security policy, which includes: attempts (either failed or successful) to gain unauthorized access to a system or its data; unwanted disruption or denial of service; the unauthorized use of a system for the processing or storage of data; and changes to system hardware,

firmware, or software characteristics without the owner's knowledge, instruction, or consent;

24. "SSA" means the Social Security Administration;
25. "System of Records" means a group of any records under the control of any agency from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

#### **IV. RESPONSIBILITIES OF THE PARTIES**

##### **A. CMS's Responsibilities:**

1. Pursuant to sections 1411 and 1413 of ACA, CMS will develop procedures to transmit information to SSA.
2. CMS will only request data from SSA's records when necessary to make an Eligibility Determination, or for use in a Redetermination or a Renewal.
3. CMS will provide the required data elements necessary and agreed upon when requesting data from SSA, including, but not limited to: first and last name, date of birth, and SSN.
4. CMS will use the information disclosed by SSA for the purposes set forth in this Agreement.
5. CMS will ensure its use of the information SSA provides is in accordance with the Privacy Act, 5 U.S.C. § 552a, and Federal law.
6. CMS will provide Congress and OMB with notice of this Matching Program, and notice of any modification of this Matching Program, and will publish the required matching notices in the FR.
7. CMS will reimburse SSA for the costs associated with SSA's performance of this Agreement pursuant to a separately executed interagency agreement.
8. CMS will ensure the SSA-provided monthly and annual Title II benefit income information, and any information regarding detailed QC, will only be displayed when the written consent of the subject individual has been obtained during the application, Eligibility Determination, Redetermination, Renewal, or Exemption determination processes, including any related appeals processes.

##### **B. SSA's Responsibilities:**

SSA will provide the required data necessary and agreed upon when transmitting a service response to CMS for Eligibility Determinations, Redeterminations, and Renewals.

#### **V. JUSTIFICATION AND ANTICIPATED RESULTS**

##### **A. Justification**

ACA requires the use of a single, streamlined application that may be used to apply for coverage through a QHP offered on an Exchange, Insurance Affordability Programs, Redeterminations, Renewals, and Exemptions.

The parties determined that a Matching Program is the most efficient, economical, and comprehensive method of collecting, comparing, and transferring the information needed to perform Eligibility Determinations, Redeterminations, and Renewals.

## B. Anticipated Results

CMS anticipates that this Matching Program will minimize administrative burdens and produce expedited Eligibility Determinations, Redeterminations, and Renewals. The benefit of this data match is the increased assurance that CMS achieves efficiencies and administrative cost savings.

## C. Cost-Benefit Analysis

Section 552a(u)(4) of the Privacy Act provides that a cost-benefit analysis must be completed prior to the approval of this Agreement. In addition to this Agreement, CMS enters into computer matching agreements with other agencies to support Eligibility Determinations. CMS has conducted one master cost-benefit analysis related to these computer matching agreements. This cost-benefit analysis is attached as Attachment 1.

## VI. DESCRIPTION OF MATCHED RECORDS

CMS and SSA have published relevant Systems of Record Notices (SORN) that cover this data matching exchange. CMS and SSA will maintain data obtained through this Agreement in accordance with the Privacy Act and SORN requirements.

SSA's SORNs that are applicable to this exchange have routine uses to provide the information covered by this Agreement to CMS for use in Eligibility Determinations, Redeterminations, and Renewals. Upon disclosure of information from SSA to CMS, CMS is responsible for ensuring its uses and disclosures of the information comply with the Privacy Act, OMB guidance relevant to Matching Programs, and applicable Federal law.

### A. Systems of Records

1. The CMS SORN that supports this data Matching Program is the CMS Health Insurance Exchanges System (HIX), CMS System No. 09-70-0560, as amended, published at 78 FR 8538 (Feb. 6, 2013), 78 FR 32256 (May 29, 2013), and 78 FR 63211 (Oct. 23, 2013). CMS will use a streamlined application to administer the ACA application process and to obtain Applicant information. Consult this SORN for information about CMS's authority to collect and maintain information, categories of individuals covered, and CMS uses of the information.
2. The SSA SORNs listed below have routine use provisions under which SSA will disclose information to CMS for purposes of Eligibility Determinations, Redeterminations, and Renewals.
  - Master Files of SSN Holders and SSN Applications, 60-0058, 75 FR 82121 (December 29, 2010), as amended 78 FR 40542 (July 5, 2013) and 79 FR 8780 (February 13, 2014);
  - Prisoner Update Processing System (PUPS), 60-0269, 64 FR 11076 (March 8, 1999), as amended 72 FR 69723 (December 10, 2007) and 78 FR 40542 (July 5, 2013);
  - Master Beneficiary Record, 60-0090, 71 FR 1826 (January 11, 2006), as amended 72 FR 69723 (December 10, 2007) and 78 FR 40542 (July 5, 2013);
  - Earnings Recording and Self-Employment Income System, 60-0059, 71 FR 1819 (January 11, 2006), as amended 78 FR 40542 (July 5, 2013).

### B. Specified Data Elements

Applicants for enrollment in a QHP through an Exchange, Insurance Affordability Program, and certifications for Exemption are only required to provide information strictly necessary to authenticate identity, determine eligibility, and determine the amount of an APTC or CSRs. Accordingly, CMS will request a limited amount of SSA information for purposes of ACA Eligibility Determinations, Redeterminations, and Renewals.

1. For each Applicant and for Relevant Individuals, CMS will submit a request file to SSA that contains the following mandatory specified data elements in a fixed record format: last name, first name, date of birth, SSN, and citizenship indicator.
2. For each Applicant, SSA will provide CMS with a response file in a fixed record format. Depending on CMS’s request, SSA’s response may include the following data elements: last name, first name, date of birth, death indicator, disability indicator, prisoner information, Title II (annual and monthly) income information, and confirmation of attestations of citizenship status and SSN. SSA may also provide QC data when CMS requests it.
3. For Relevant Individuals, CMS will request a limited amount of SSA information. Based on CMS’s request, SSA will verify a Relevant Individual’s SSN with a death indicator and may provide a Relevant Individual’s QC data or Title II (annual and monthly) income information. CMS will not request citizenship or immigration status data for a Relevant Individual.
4. For Renewals and Redeterminations, CMS will request and SSA will verify SSNs with a death indicator, disclose Title II income information, and provide the disability indicator.
5. For self-reported Redeterminations, CMS will provide SSA with the following: updated or new information reported by the enrollee or enrolled individual, last name, first name, date of birth, and SSN. Depending on CMS’s request, SSA’s response will include each of the following data elements that are relevant and responsive to CMS’s request: last name, first name, date of birth, death indicator, disability indicator, prisoner information, Title II (annual and monthly) income information, and confirmation of new attestations of citizenship status, verification of SSN, and QC data.
6. For Individuals seeking an Exemption, CMS will provide last name, first name, date of birth, citizenship indicator, and SSN to SSA. SSA will provide CMS with a response including: last name, first name, date of birth, confirmation of attestations of citizenship status, verification of SSN, death indicator, disability indicator, prisoner information, and Title II (annual and monthly) income information.

C. Number of Records

The following table provides the base estimates for the total number of transactions in fiscal year (FY) 2016 and FY 2017, as well as the number of transactions in the estimated highest month within each of those years. These estimates use current business assumptions, as well as historical transaction data. These estimates are subject to change as business assumptions or estimates are updated and/or refined.

	FY 2016 Total	FY 2016 Highest Month	FY 2017 Total	FY 2017 Highest Month
Real-time	269,809,401	26,230,449	327,471,945	44,956,633

Batch	12,560,580	2,187,131	13,777,302	3,356,359
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D. Frequency of Matching

The data exchange under this Agreement will begin March 8, 2016 and continue through September 8, 2017, in accordance with schedules set by CMS and SSA. CMS will submit requests electronically in real-time on a daily basis throughout the year.

**VII. PROCEDURES FOR INDIVIDUAL NOTICE**

- A. CMS will publish notice of the Matching Program in the FR as required by the Privacy Act (5 U.S.C. § 552a(e)(12)).
- B. At the time of application or change of circumstances, CMS will provide a notice to Applicants for enrollment in a QHP, or an Insurance Affordability Program under ACA, on the OMB-approved streamlined eligibility application. CMS 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.
- C. When an Applicant submits an application for an Exemption, CMS will provide individual notice on the Exemption application regarding the collection, use, and disclosure of the Applicant’s PII. The Exemption application also will contain a Privacy Act statement describing the purposes for which the information is intended to be used and the authority that authorizes the collection of the information.

**VIII. VERIFICATION AND OPPORTUNITY TO CONTEST**

Information maintained or created by CMS regarding any individual that becomes part of the CMS System of Records can be corrected by contacting CMS. CMS has established and will maintain record corrections procedures consistent with the Privacy Act. CMS has established and will maintain procedures to verify information and to provide a means for individuals to contest information prior to an adverse action related to the Eligibility Determination, Renewal, or Redetermination being taken. CMS will ensure provision of the proper contact information and instructions to the individual contesting the contents of the information depending on the source and type of information being contested.

**IX. ACCURACY ASSESSMENTS**

SSA has independently assessed the benefits data to be more than 99 percent accurate when the benefit record is created. Prisoner data, some of which is not independently verified by SSA, does not have the same degree of accuracy as SSA’s benefit data. CMS will independently verify prisoner data through applicable CMS verification procedures and the notice and opportunity to contest procedures specified in Section VIII of this Agreement before taking any adverse action. Based on SSA’s Office of Quality Performance “FY 2009 Enumeration Quality Review Report #2 – The ‘Numident’ (January 2011),” the SSA Enumeration System database (the Master Files of SSN Holders and SSN Applications System) used for SSN matching is 98 percent accurate for records updated by SSA employees. Individuals applying for SSNs report their citizenship status at the time they apply for their SSNs. There is no obligation for an

individual to report to SSA a change in his/her citizenship or immigration status until he/she files a claim for a Social Security benefit.

## **X. PROCEDURES FOR RETENTION AND TIMELY DESTRUCTION OF IDENTIFIABLE RECORDS**

SSA and CMS will retain the electronic submission and response files received from the other party only for the period of time required to complete a verification necessary for the applicable Eligibility Determination, Redetermination, or Renewal under this Matching Program and will destroy all such files by electronic purging, unless the parties are required to retain the files in order to meet evidentiary requirements, for internal audits, for accuracy checks, and to adjudicate appeals. In case of such retention, the parties will retire the retained files in accordance with the applicable Federal Records Retention Schedule (44 U.S.C. § 3303a). The parties will not create permanent files or a separate system comprised solely of the data provided by the other party.

SSA will not collect or maintain PII submitted by CMS for verification, except as provided in Section XI for audit logging purposes. The submission files provided by CMS remain the property of CMS.

## **XI. SECURITY PROCEDURES**

- A. Legal Compliance: CMS and SSA will comply with the limitations on use, storage, transport, and safeguarding of data under all applicable Federal laws and regulations. These laws and regulations include the Privacy Act; FISMA, 44 U.S.C. §§ 3541-3549, as amended by the Federal Information Security Modernization Act, 44 U.S.C. §§ 3551-3558; the Computer Fraud and Abuse Act of 1986; the E-Government Act of 2002; the Clinger-Cohen Act of 1996; and the corresponding implementation regulations for each statute. Additionally, CMS will follow Federal, HHS, and CMS policies, including the HHS Information Security and Privacy Policy and the CMS Information Security Acceptable Risk Safeguards (ARS) CMS Minimum Security Requirements. SSA and CMS will comply with OMB circulars and memoranda, such as Circular A-130, Management of Federal Information Resources (November 28, 2000), and Memorandum M-06-16, Protection of Sensitive Agency Information (June 23, 2006); National Institute of Standards and Technology (NIST) 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. Both agencies recognize and will implement the applicable laws, regulations, NIST publications, and OMB directives including those published subsequent to the effective date of this Agreement.

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 agencies are responsible for oversight and compliance of their contractors and agents.

- B. Loss, Potential Loss, Incident Reporting, and Breach Notification: CMS and SSA will comply with OMB reporting guidelines in the event of a loss, potential loss, Security Incident, or Breach of PII, or by an Authorized User (see OMB M-06-19, Reporting Incidents Involving Personally Identifiable Information and Incorporating the Cost for Security in Agency Information Technology Investments (July 12, 2006); OMB M-07-16, Safeguarding Against and Responding to the Breach of Personally Identifiable

Information (May 22, 2007); and OMB M-15-01, Fiscal Year 2014-2015 Guidance on Improving Federal Information Security and Privacy Management Practices (Oct. 3, 2014)). SSA and CMS will restrict access to the matched data and to any data created by the match; such restrictions shall include role-based access that limits access to those individuals who need it to perform their official duties in connection with the uses of data authorized in this Agreement (“Authorized Users”). The party experiencing the incident will notify the other party’s System Security Contact named in this Agreement within one (1) hour of discovering the loss, potential loss, Security Incident, or Breach. If the party experiencing the loss, potential loss, Security Incident, or Breach is unable to speak with the other party’s System Security Contact within one (1) hour, or if for some reason contacting the System Security Contact is not practicable (e.g., outside of normal business hours), then the following contact information will be used:

- CMS will call SSA’s National Network Service Center toll free at 1-877-697-4889.
- SSA will contact the CMS IT Service Desk at 1-800-562-1963 or via email at [CMS IT Service Desk@cms.hhs.gov](mailto: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 making a determination of 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, that party will carry out these remedies without cost to the other party.

- C. Administrative Safeguards: SSA and CMS will advise all users 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.
- D. Physical Safeguards: SSA and CMS 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 during duty hours, as well as non-duty hours, or when not in use (e.g., door locks, card keys, biometric identifiers, etc.). Only authorized personnel will transport the data matched and any data created by the match. SSA and CMS will establish appropriate safeguards for such data, as determined by a risk-based assessment of the circumstances involved.
- E. Technical Safeguards: SSA and CMS will ensure that the data matched and any data created by the match is used under the immediate supervision and control of Authorized Users in a manner that will protect the confidentiality of the data, so that unauthorized persons cannot retrieve any data by computer, remote terminal, or other means. This includes utilizing Virtual Private Network transport with the appropriate level of encryption, as well as secure Web Service best practices. Only Authorized Users with established accounts will be allowed to access systems holding the data.
- F. Application of Policies and Procedures: CMS and SSA will adopt policies and

procedures to ensure that each party uses the information obtained under this Agreement solely as provided in this Agreement.

- G. On-Site Inspections: SSA and CMS have the right to monitor the other's compliance with FISMA and OMB M-06-16 requirements, and to make onsite inspections of the other party's systems that contain data obtained under this Agreement. Such access is for purposes of auditing compliance, if necessary, during the lifetime of this Agreement, or any extension of this Agreement. Each agency will provide the other with any reports and/or documentation relating to such on-site inspections upon request.
- H. Compliance: CMS must ensure information systems that process information provided by SSA under this matching Agreement are compliant with CMS standards contained in the Minimum Acceptable Risk Standards for Exchanges (MARS-E).
- I. The MARS-E suite of documents can be found at: <http://www.cms.gov/cciiio/resources/regulations-and-guidance/index.html>, under Minimum Acceptable Risk Standards. To the extent these documents are revised during the term of this Agreement, CMS must ensure compliance with the revised version. CMS will implement compliance monitoring procedures to ensure that information provided by SSA under this matching Agreement is properly used by CMS or by Authorized Users. Reviews of Authorized Users will be conducted at the discretion of CMS.
- J. Logging: CMS will retain a log of transactions submitted by CMS to SSA for matching under this Agreement for audit purposes. The logged information will be retained by CMS and will be made available upon request in order to conduct analysis and investigations of reported Security Incidents involving access or disclosure of information provided by SSA under this matching Agreement.
- K. Reports of Fraud and Misuse: Each party will report to the other party such incidents of fraud or misuse known to the party that involve information supplied by the other party under this matching Agreement.
- L. Security Status Sharing: Federal agencies that conduct security assessments of Authorized Users in support of ACA may also share information regarding the operational status of those entities to other Federal agencies that supply information in support of ACA operations.

## **XII. RECORDS USAGE, DUPLICATION, AND REDISCLOSURE RESTRICTIONS**

CMS and SSA will comply with the following limitations on use of the submission and response files, and data provided by the other agency under this Agreement:

This Agreement governs SSA disclosures to CMS and CMS disclosures to SSA for the purposes outlined in this Agreement. Such disclosures are distinct from CMS disclosures to other parties for purposes of Eligibility Determinations, Renewals, and Redeterminations, which are subject to and solely governed by CMS SORN(s). CMS has responsibility for safeguarding the information described in its SORN(s) and ensuring that its use of such information is in compliance with the Privacy Act, Federal law, and OMB guidance.

- A. CMS and SSA will use the data only for purposes described in this Agreement.
- B. CMS and SSA will not use the data or submission and response files to extract information concerning individuals therein for any purpose not covered by this

Agreement.

- C. The matching response files provided by SSA under this Agreement will remain the property of SSA and CMS will retain the matching response files only as described in Section X of this Agreement.
- D. CMS and SSA will not duplicate or disseminate the submission and response files, within or outside their respective agencies, without the written consent of the other party, except as required by Federal law or for purposes under this Agreement.
- E. CMS and SSA will not permit the submission and response files exchanged under this Agreement to be stored, transferred, or maintained outside of the United States, its territories or possessions, except to process Internet-based applications from individuals seeking coverage through an Exchange from a foreign location.
- F. Any individual who knowingly and willfully uses information obtained pursuant to this Agreement in a manner or for a purpose not authorized by 45 C.F.R. § 155.260 and section 1411(g) of ACA are potentially subject to the civil penalty provisions of section 1411(h)(2) of ACA, which carries a fine of up to \$25,000.

### **XIII. 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 SSA records, as necessary, in order to verify compliance with this Agreement.

### **XIV. REPORT TO CONGRESS AND OMB**

When both the HHS Data Integrity Board (DIB) and the SSA DIB approve this Agreement, CMS will submit a report of the Matching Program to Congress and OMB for review, and will provide a copy of such notification to SSA.

### **XV. REIMBURSEMENT**

- A. SSA will collect funds from CMS during FY 2016 through the Intra-Governmental Payment and Collection (IPAC) system on a quarterly basis, sufficient to reimburse SSA for the costs it has incurred for performing services through the date of billing. SSA will mail a copy of the IPAC billing and all original supporting documentation to CMS at Accounting Operations, 7500 Security Boulevard, Baltimore, MD 21244, no later than five (5) calendar days following the processing of the IPAC transaction. At least quarterly, but no later than thirty (30) days after an accountable event, SSA will provide CMS with a performance report (e.g., a billing statement) that details all work performed to date. Additionally, at least quarterly, SSA and CMS will reconcile balances related to revenue and expenses for work performed under this Agreement.
- B. This Agreement does not authorize SSA to incur obligations through the performance of the services described herein. Only the execution of Form SSA-1235, Agreement Covering Reimbursable Services, and an executed Inter-Agency Agreement (IAA), authorizes the performance of such services. SSA may incur obligations by performing services under a reimbursable agreement only on a fiscal year basis. Accordingly, attached to, and made a part of this Agreement, are an executed Form SSA-1235 and an

executed IAA that provide authorization for SSA to perform services under this Agreement in FY 2016. SSA's ability to perform work beyond FY 2016 is subject to the availability of funds.

## **XVI. DURATION, MODIFICATION, AND TERMINATION**

- A. Effective Date: The Effective Date of this Agreement is March 8, 2016, provided that the following notice periods have lapsed: 30 days from the date CMS publishes a Computer Matching Notice in the FR; 40 days from the date of the Matching Program notice that is sent to the Congressional committees of jurisdiction under 5 U.S.C. § 552a(o)(2)(A); and 40 days from the date of the Matching Program notice that is sent to OMB.
- B. Duration: This Agreement will be in effect for a period of eighteen (18) months.
- C. Renewal: The DIBs of HHS and SSA may, within three (3) months prior to the expiration of this Agreement, renew this Agreement for a period not to exceed twelve (12) months if CMS and SSA can certify the following to their DIBs:
1. The Matching Program will be conducted without change; and
  2. CMS and SSA have conducted the Matching Program in compliance with the original Agreement.

If either party does not want not continue this program, it must notify the other party in writing of its intention not to continue at least ninety (90) days before the end of the period of the Agreement.

- D. Modification: The parties may modify this Agreement at any time by a written modification, mutually agreed to by both parties and approved by the DIBs of HHS and SSA.
- E. Termination: The parties may terminate this Agreement at any time with the consent of both parties. Either party may unilaterally terminate this Agreement upon written notice to the other party, in which case the termination will be effective ninety (90) days after the date of the notice, or at a later date specified in the notice. SSA may immediately and unilaterally suspend the data flow under this Agreement or terminate this Agreement if SSA:
1. Determines that CMS or an Authorized User has used the information in an unauthorized manner;
  2. Determines that CMS has violated or failed to follow the terms of this Agreement; or
  3. Has reason to believe that CMS or an Authorized User breached the terms for security of data. If SSA suspends the data flow in accordance with this subsection, SSA will suspend the flow of data until SSA makes a final determination of a breach.

## **XVII. 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.

## **XVIII. DISPUTE RESOLUTION**

In the event of a dispute related to reimbursements under Section XV of this Agreement, SSA and CMS will resolve those disputes in accordance with instructions provided in the Treasury Financial Manual (TFM) Volume I, *Intragovernmental Business Rules* Bulletin, available on the TFM Website at <http://tfm.fiscal.treasury.gov/v1/p2/c470.pdf>.

## **XIX. POINTS OF CONTACT**

A. SSA contacts are:

1. Matching Issues:

**Sarah Reagan**

Government Information Specialist  
Office of Privacy and Disclosure  
Office of the General Counsel  
6401 Security Boulevard, 617 Altmeyer  
Baltimore, MD 21235  
Phone: (410) 966-9127  
Fax: (410) 594-0115  
Email: [Sarah.Reagan@ssa.gov](mailto:Sarah.Reagan@ssa.gov)

2. Computer Issues:

**Jessica Fitter**

Director  
DIVES/Data Exchange Branch  
Office of Earnings, Enumeration and Administrative Systems  
6401 Security Boulevard, 3-A-3 Operations Building  
Baltimore, MD 21235  
Phone: (410) 965-8834  
Email: [Jessica.K.Fitter@ssa.gov](mailto:Jessica.K.Fitter@ssa.gov)

3. Systems Security Issues:

**Michael G. Johnson**

Director  
Division of Compliance and Oversight  
Office of Information Security  
6401 Security Boulevard, 3827 Annex  
Baltimore, MD 21235  
Phone: (410) 965-0266  
Fax: (410) 597-0845  
Email: [Michael.G.Johnson@ssa.gov](mailto:Michael.G.Johnson@ssa.gov)

4. Data Exchange Issues:

**Stephanie Brock**

Agreement Liaison  
Office of Data Exchange  
Office of Data Exchange and Policy Publications

6401 Security Boulevard  
4-B-9-F Annex Building  
Baltimore, MD 21235  
Telephone: (410) 965-7827  
Email: [Stephanie.Brock@ssa.gov](mailto:Stephanie.Brock@ssa.gov)

B. CMS contacts are:

1. Program Issues:

**Elizabeth Kane**

Acting Director, Verifications Policy & Operations Branch  
Eligibility and Enrollment Policy and Operations Group  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
7501 Wisconsin Avenue  
Bethesda, MD 20814  
Phone: (301) 492-4418  
Fax: (443) 380-5531  
Email: [Elizabeth.Kane@cms.hhs.gov](mailto:Elizabeth.Kane@cms.hhs.gov)

2. Medicaid/CHIP Issues:

**Jessica P. Kahn**

Director, Data Systems Group  
Center for Medicaid and CHIP Services  
Centers for Medicaid & Medicare Services  
7500 Security Boulevard  
Baltimore, MD 21244  
Phone: (410) 786-9361  
Email: [Jessica.Kahn@cms.hhs.gov](mailto:Jessica.Kahn@cms.hhs.gov)

3. Systems Operations:

**Darrin V. Lyles**

Information Security Officer, CIISG  
CMS\OIS\CIISG  
Consumer Information and Insurance Systems Group  
7500 Security Boulevard  
Baltimore, MD 21244  
Phone: (410) 786-4744  
Phone: (443) 979-3169 (Mobile)  
Email: [Darrin.Lyles@cms.hhs.gov](mailto:Darrin.Lyles@cms.hhs.gov)

4. Privacy and Agreement Issues:

**Celeste Dade-Vinson**

Division of Security, Privacy & Governance  
Information Security & Privacy Group  
Office of Enterprise Information  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Mail Stop: N1-24-08  
Location: N1-24-07  
Baltimore, MD 21244-1849

Phone: (410) 786-0854  
Fax: (410) 786-5636  
Email: [Celeste.Dade-Vinson@cms.hhs.gov](mailto:Celeste.Dade-Vinson@cms.hhs.gov)

5. Privacy Incident Reporting:

**LaTasha Grier**

Division of Cyber Threat and Security Operations  
Information Security & Privacy Group  
Office of Enterprise Information  
Centers for Medicare & Medicaid Services  
7500 Security Boulevard  
Mail Stop: S2-26-17  
Location: N1-25-24  
Baltimore, MD 21244-1849  
Phone: (410) 786-3328  
Fax: (410) 786-5636  
Email: [Latasha.Grier@cms.hhs.gov](mailto:Latasha.Grier@cms.hhs.gov)

6. Security Issues:

**Tae H. Rim**

Information Technology Specialist  
Enterprise Infrastructure & Operations Group  
Office of Technology Solutions  
7500 Security Boulevard  
Baltimore, MD 21244-1859  
Phone: (410) 786-3911  
Phone: (443) 847-0342 (Mobile)  
Email: [Tae.Rim@cms.hhs.gov](mailto:Tae.Rim@cms.hhs.gov)

## **XX. INTEGRATION CLAUSE**

This Agreement, including the Form SSA-1235 and the executed IAA, constitutes the entire Agreement of the parties with respect to its subject matter and supersedes all other data exchange agreements between the parties existing at the time this Agreement is executed that pertain to the disclosure of the following specified data elements between SSA and CMS for the purposes described in this Agreement: SSN verification, death indicator, Title II disability indicator, confirmation of consistency of citizenship declaration, monthly and annual Title II benefit, QC, and prisoner data. SSA and CMS 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.

## **XXI. SEVERABILITY**

If any term or other provision of this Agreement is determined to be invalid, illegal, or incapable of being enforced by any rule or law, or public policy, all other terms, conditions, or provisions of this Agreement shall nevertheless remain in full force and effect, provided that the Matching Program contemplated hereby is not affected in any manner materially adverse to any party. Upon such determination that any term or other provision is invalid, illegal, or incapable of being enforced, the parties hereto shall negotiate in good faith to modify this Agreement so as

to effect the original intent of the parties as closely as possible in an acceptable manner to the end that the transactions contemplated hereby are satisfied to the fullest extent possible.

**XXII. APPROVALS**

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)

\_\_\_\_\_  
Karen M. Shields  
Deputy Center and Operations Director  
Center for Consumer Information & Insurance Oversight  
Centers for Medicare & Medicaid Services

Date: \_\_\_\_\_

Approved By (Signature of Authorized CMS Program Official)

---

Timothy Hill  
Deputy Director  
Centers for Medicaid and CHIP Services  
Centers for Medicare & Medicaid Services

Date: \_\_\_\_\_

Approved By (Signature of Authorized CMS Approving Official)

---

Emery Csulak  
Senior Official for Privacy  
Information Security and Privacy Group  
Office of Enterprise Information  
Centers for Medicare & Medicaid Services

Date: \_\_\_\_\_

B. DIB: Department of Health and Human Services

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 Approving Official)

---

Colleen Barros  
Acting Chairperson  
Data Integrity Board  
U.S. Department of Health and Human Services

Date: \_\_\_\_\_

C. Social Security Administration Approving Official

The authorized approving 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 the organization to the terms of this Agreement.

Approved By (Signature of Authorized SSA Approving Official)

---

Mary Ann Zimmerman  
Acting Deputy Executive Director  
Office of Privacy and Disclosure  
Office of the General Counsel

Date: \_\_\_\_\_

D. DIB: Social Security Administration Approving 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 SSA DIB Official)

---

Glenn Sklar  
Acting Chairperson  
Data Integrity Board  
Social Security Administration

Date: \_\_\_\_\_

Attachments:

1. Cost-Benefit Analysis
2. Form SSA-1235
3. MARS-E
4. Inter-Agency Agreement

## Cost-Benefit Analysis: Eligibility Verifications with Federal Agencies

### I. BACKGROUND

#### *Statutory Requirements*

This cost-benefit analysis covers computer Matching Programs used by CMS to provide “eligibility verification” hub services required to implement provisions of the Patient Protection and Affordable Care Act (ACA) related to verifying individuals’ eligibility for enrollment in Qualified Health Plans (QHP) with or without advance payments of the premium tax credit (APTC) or cost-sharing reductions (CSRs); in Medicaid; in the Children’s Health Insurance Program (CHIP); or in Basic Health Plans (BHP). Section 1411(a) of ACA requires the Secretary of the Department of Health and Human Services (HHS) to establish a program to determine eligibility for enrollment in coverage under a QHP through an Exchange or certain State health subsidy programs<sup>1</sup>, and for certifications of Exemption from the individual responsibility requirement or the penalty imposed by section 5000A of the Internal Revenue Code. Section 1411(c) requires the verification of certain identifying information against the records maintained by the Social Security Administration (SSA), the Department of Homeland Security (DHS), and the U.S. Department of the Treasury. Section 1411(d) directs HHS to establish a system for the verification of other information necessary to make an Eligibility Determination. Section 1413 requires HHS to establish a streamlined enrollment system and secure electronic interface to verify data and determine eligibility for State health subsidy programs. Section 2201 requires that Medicaid and CHIP agencies utilize this streamlined enrollment system.

#### *Design of Computer Matching Program*

To implement these provisions regarding verifying consumer information related to Eligibility Determinations, CMS selected a computer Matching Program design that minimizes burdens for all parties and better ensures the integrity and security of the data. Specifically, CMS enters into separate Computer Matching Agreements (each a CMA) with each of the following Federal agencies: SSA, DHS, Internal Revenue Service (IRS), Veteran’s Health Administration (VHA), the Department of Defense (DoD), the Office of Personnel Management (OPM), and the Peace Corps (each a trusted data source or TDS). These CMAs address with specificity the data provided by each Federal agency to CMS for use by CMS and State-based entities administering State health subsidy programs (Administering Entities) in performing eligibility determinations. CMS receives data covered under these CMAs through the CMS Data Services Hub (Hub), which provides a single data exchange for Federal and State-based agencies administering State health subsidy programs to interface with Federal agency partners. Administering Entities can request data matches through this Hub pursuant to a separate CMA entered into between each State and the District of Columbia and CMS. CMS uses the same CMA for each State, with the CMA specifying the allowed uses of data elements shared through the Hub, depending on which State health subsidy program the State administers (e.g., the CMA only authorizes a State to use

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<sup>1</sup> State health subsidy programs means the program for the enrollment in qualified health plans offered through an Exchange, including the premium tax credits and cost-sharing reductions; a State Medicaid program; a State Children’s Health Insurance Program (CHIP); and a State program under section 1331 establishing qualified basic health plans.

certain data to perform verifications related to BHPs if the State administers a BHP). This CMA also provides for Medicaid and CHIP programs to provide data to CMS for use in eligibility determinations.

This design achieves efficiencies by allowing Administering Entities to access data matches from Federal TDSs without each Administering Entity having to execute separate CMAs with each TDS. Furthermore, the use of the Hub to perform data matches under the program ensures adherence to Federal and industry standards for security, data transport, and data safeguards, as well as CMS policy for Exchanges, and makes it unnecessary for each State to develop and support separate verification processes through which they can receive, store, and secure the data provided by the source Federal agencies. Additionally, this design ensures that all parties are using the same data to perform Eligibility Determinations, which better ensures data integrity.

### *Methodology of Cost-Benefit Analysis*

Although the cost-benefit analysis of this computer Matching Program design is based on limited data and includes estimates that have not been confirmed by studies, it addresses all four key elements identified in GAO/PEMD-87-2 (i.e., Personnel Costs; Computer Costs; Avoidance of Future Improper Payments; and Recovery of Improper Payments and Debts). The analysis includes estimates of CMS's labor and system costs as both the recipient agency in relation to the aforementioned trusted data sources, and recipient and source agency in relation to State-based Administering Entities; costs incurred by TDSs; and costs to Administering Entities (Medicaid/CHIP agencies, Marketplaces, and agencies administering the BHP) to support the Hub services. It also includes qualitative benefits to the parties, including clients and the public at large. Where data are unavailable to produce informed estimates, the analysis also describes types of costs and benefits that are not quantifiable at this time. At this time, the only quantified benefits are cost savings achieved by using the existing Matching Program instead of a manual process for eligibility verifications.

The timeframe for the analysis is fiscal year 2015 – which programmatically aligns with eligibility and enrollment activities during Open Enrollment 2015 through just before 2016 Open Enrollment. CMS anticipates that operational experience beyond 2015 will provide additional data from which other quantifiable benefits could be estimated for future cost-benefit analyses of this computer Matching Program.

The methodology used compares the costs and benefits of performing eligibility verifications manually, without computer matching (i.e., without the single, streamlined computer system mandated by ACA, which depends on use of computer matching), versus electronically, with computer matching. The hypothetical manual process is one in which no electronic data would be used for verification and consumers would be required to submit paper documentation to verify data, as specified in ACA. Because CMS has no choice but to use computer matching to comply with the ACA mandate to provide a single, streamlined computerized eligibility verification process, this cost-benefit analysis also describes savings realized by the choice of design used to affect the computer Matching Programs. However, we do not have data to quantify these savings at this time.

The methodology for specific estimates is described in the following section.

## **II. COSTS**

### *Key Element 1: Personnel Costs*

*For Agencies –*

Note: CMS serves as both a recipient agency (with respect to TDS and certain Medicaid/CHIP programs) and a source agency (with respect to Administering Entities). Many of CMS's costs cannot be cleanly attributed to its role as either a source or a recipient agency. Therefore, we have listed all of CMS's personnel costs together in a separate category. In addition, certain Medicaid and CHIP agencies play a dual role, as a source and recipient agency. We have grouped their costs in the recipient agency category.

- *Source Agency:* We estimate that personnel costs for source agencies total approximately \$21.7 million. CMS does not collect information from each source agency about their personnel costs; therefore, this estimate is built off personnel cost assumptions based on Hub service context, TDS partnership history, and known ongoing work. We believe a decentralized computer Matching Program would require source agencies to designate additional personnel to accommodate the burden of supporting separate computer Matching Programs with each State.
- *Recipient Agencies:* We estimate that the personnel costs associated with the computer Matching Program to recipient agencies (including State-based Marketplaces, Medicaid/CHIP agencies, and BHPs) is \$215 million. We do not require recipient agencies to submit personnel costs to CMS. This estimate is based on assumptions from CMS operational engagement with these agencies. In contrast, a manual process would require additional personnel to manually review and verify consumer information. We estimate that a manual process would require just over one billion dollars in personnel costs to recipient agencies. This estimate is based off the cost of the current cost of manually verifying consumer information today for Marketplaces and the BHP. The Medicaid/CHIP cost is mitigated by the assumption that without the current Hub, Medicaid/CHIP would use the decentralized data connections they had pre-ACA with TDSs. Overall, however, a decentralized computer Matching Program would likely require recipient agencies to spend more on personnel costs than the existing Matching Program, but less than a manual process. We have not quantified the associated costs.
- *CMS:* We quantified two categories of personnel costs for CMS: (1) personnel costs associated with verification services generally and providing support to the TDSs; and (2) personnel costs associated with providing State-based Administering Entities with technical assistance. Note, that these estimates focus on the operational, technical, and policy support to the eligibility verification services; they do not include all personnel costs associated with the computer Matching Program. For example, we have not included an estimate of costs associated with preparing the CMAs. We estimate that the computer Matching Program includes personnel costs for category (1) of approximately \$1.5 million, and for category (2) of approximately \$400,000. This estimate is based on current staffing from policy, operational, and technical support teams and their contractors that directly support the eligibility verification services, the source agencies, and the recipient agencies. We believe a manual system would increase the personnel costs in category (1), but decrease the personnel costs devoted to State technical assistance, for a net increase in personnel costs of approximately \$200,000. We believe a decentralized computer Matching Program would similarly decrease the personnel costs related to State technical assistance to CMS (while significantly increasing personnel costs for source and recipient agencies), but would not result in significant savings in category (1), as CMS would continue to require roughly the same personnel to support the verifications services for the Federally-Facilitated Marketplace (FFM), and would continue to provide similar support to TDSs.

Additionally, certain personnel costs incurred by source agencies are transferred to CMS. We estimate these computer costs at \$2.1 million. These costs were not included in the personnel costs estimated for source agencies above.

- *Justice Agencies:* Because, as described in section III, data from this computer Matching Program is not used to recover improper payments, we are aware of no personnel costs to justice agencies associated with this computer Matching Program.

*For Clients:* When a data match through the eligibility Hub services identifies a data inconsistency, clients (consumers) are given an opportunity to produce documentation showing they are eligible for the applicable program. We believe that the centralized, electronic/real-time computer Matching Program produces more accurate verifications than either a manual system or a decentralized computer Matching Program, minimizing the amount of time clients must spend responding to inaccurate verifications. We have quantified that cost at \$408 million, using the estimated time to gather and mail documents and the standard hourly wage to quantify an average client's time. In addition to saving clients' time, we believe the more efficient centralized computer Matching Program design will reduce the frustration experienced by clients in trying to verify their data.

*For Third Parties:* No data was developed regarding costs to third parties; however, we would expect that overall the increased accuracy of data matches that is achieved through this CMA results in lower personnel costs to third parties, for example, Navigators that assist consumers with an applicant, than either a manual process or a decentralized computer Matching Program.

*For the General Public:* We are not aware of personnel costs to the general public associated with the Matching Program.

#### Key Element 2: Agencies' Computer Costs

Note: CMS serves as both a recipient agency (with respect to each TDS and certain Medicaid/CHIP programs) and a source agency (with respect to Administering Entities). Many of CMS's costs cannot be cleanly attributed to its role as either a source or a recipient agency. Therefore, we have listed all of CMS's computer costs separately. In addition, certain Medicaid and CHIP agencies play a dual role, as a source and recipient agency. We have grouped their costs in the recipient agency category.

- *Source Agencies (with exception of CMS and Medicaid/CHIP agencies):* We estimate the computer costs associated with the computer Matching Program to be \$7.0 million for source agencies. We did not quantify the computer costs to source agencies if the computer Matching Program relied on a decentralized design through which each Administering Entity established separate connections with the source agency or used existing connections. However, we anticipate that the centralized design of the computer Matching Program achieves economies of scale that result in significant savings to the source agencies.
- *Recipient Agencies (with exception of CMS):* We estimate that the computer (system) associated with the computer Matching Program to recipient agencies (including State-based Marketplaces, Medicaid/CHIP agencies, and BHPs) is \$647 million, versus \$431 million with a manual verification process. We do not require recipient agencies to submit system costs to CMS. This estimate is based on assumptions from CMS operational engagement with these agencies. While a manual process to review and verify consumer information has most of its cost from personnel, systems would likely still exist to maintain consumer information, such as a consumer account system in

addition to system connections that would be triggered manually, for example, accessing the DHS/SAVE system through the manual user interface.

- *CMS:* We estimate the computer (system) costs of maintaining the Hub that facilitates the computer Matching Program is \$136.8 million. In contrast, we estimate the computer costs associated with a manual verification process would be \$1.8 billion. This estimate is based on the average cost to process a paper or manual verification today (\$17 per verification) multiplied by the number of eligibility verifications performed on an application times the number of applicants. The number of eligibility verifications depends upon applicants who were not seeking financial assistance (9%) versus those applicants who were seeking financial assistance. We also added an assumption that there would be a 10% reduction of applicants seeking financial assistance with the added burden of a manual verification process.

We note that under this manual process many of the costs would be transferred from CMS to States. If instead of the current streamlined and centralized computer Matching Program, CMS required each Administering Entity to establish its own secure connection with TDSs to receive data (or use an existing connection), CMS would still need to establish a secure connection with each TDS for its own use in performing Eligibility Determinations for the FFM. While the costs of maintaining the Hub would likely be lessened due to the absence of data match requests for Administering Entities, there are economies of scale achieved by allowing the Administering Entities to use the Hub.

Additionally, certain computer costs incurred by the source agencies are transferred to CMS. We estimate these computer costs at \$6.8 million. These costs were not included in the computer costs estimated for source agencies above.

- *Justice Agencies:* We are not aware of any computer costs incurred by justice agencies in connection with this Matching Program.

### III. BENEFITS

#### Key Element 3: Avoidance of Future Improper Payments

*To Agencies –*

- *Source agencies:* Source agencies do not receive benefits related to the avoidance of future improper payments, with the exception of CMS, which receives these benefits in its role as a recipient agency (i.e., as the operator of the FFM). These benefits to CMS are described in the recipient agencies section below.
- *Recipient agencies:* We believe that our electronic verification sources are a more accurate and efficient means of verifying a consumer's information compared to both the manual review of consumer-provided documentation and the use of multiple decentralized computer Matching Programs between each Administering Entity and each TDS. The real-time data matches allowed by the computer Matching Program increase the efficiency with which we verify a consumer's information, allowing for increased avoidance of improper payments for the FFM, State-based Marketplaces, Medicaid, CHIP, and BHPs. For example, real-time capabilities mean the front-end application can be dynamic to the consumer responses, as well as the data received real-time to correct data and/or reduce the need for manual follow-up. Specific examples of this efficiency include a prompt to an applicant to check his/her Social Security number if it doesn't match the first time, allowing a consumer to correct 'fat finger' mistakes in seconds rather than go through a lengthy manual process, or requesting specific documentation

number follow up information about a consumer who has attested to being a lawful immigrant in a specific category. By increasing the accuracy of our verifications, we (1) avoid improper payments being made to individuals who are ineligible; and (2) reduce the additional time spent by staff at the aforementioned agencies in addressing incorrectly identified data inconsistencies. Finally, we believe this computer Matching Program deters fraud and abuse on applications for State health subsidy programs, future avoiding future improper payments. We do not currently have reliable data to quantify these avoided improper payments. As the program matures, we anticipate having data that likely could be used to calculate an approximate calculation of the increased accuracy of online verifications. The Office of Financial Management-led improper payment rate methodology for the Marketplace may be one source of this valuable information. We are exploring the possibility of leveraging the computer Matching Program for use in eligibility determinations for other public benefit programs. If we were to expand the program, we anticipate even more benefits for consumers and the agencies that support such consumer programs.

- *Justice Agencies:* We assume that by enabling the FFM and Administering Entities to identify individuals who are ineligible for enrollment in Medicaid, CHIP, and BHPs, or receipt of APTC or CSRs earlier than if a paper-based system was used, the Matching Program reduces the number and amount of cases referred to the Departments of Justice. At this time, we do not have enough information to quantify these benefits.
- *To the General Public:* We believe that the use of a centralized, streamlined, electronic computer Matching Program increases the general public's confidence in State health subsidy programs; a manual process would be laughable given present-day electronic capabilities and the pervasiveness of electronic, real-time processes.

*To Clients:* Data from the computer Matching Program are used to determine the amount of APTC for which an individual is eligible. Consumers who receive APTC must file an income tax return to reconcile the amount of APTC (based on projected household income) with the final premium tax credit for which the individual is eligible (based on actual household income). Some consumers, particularly those with liquidity constraints, may have trouble repaying improperly paid APTC. The benefit of avoiding improper payments of APTC to these consumers is not quantifiable.

Additional benefits from the Matching Program to clients are also not quantifiable. By building public confidence in the State health subsidy programs, the computer Matching Program decreases the stigma of participating in a State health subsidy program.

#### *Key Element 4: Recovery of Improper Payments and Debts*

Data from the Matching Program is not currently used to identify and recover improper payments. Annual reconciliation and recovery of improper payments is ultimately performed by the IRS through a process that is also independent from CMS's eligibility activities, including this computer Matching Program. Because data matches under this computer Matching Program are not used for recovery of improper payments, there are no benefits to estimate in this category. While annual and monthly reporting by Marketplaces to the IRS and consumers is a way through which Marketplaces provide data to support IRS's reconciliation, annual and monthly reporting is not an activity covered in the IRS-CMS CMA, or any other CMAs covered under this cost-benefit analysis, and therefore, is outside the scope of this study. As these uses are not allowed under the CMAs being entered into at this time, there are currently no benefits to quantify in this category for agencies, clients, or the general public.

Attachment 2

Social Security Administration

AGREEMENT COVERING REIMBURSABLE SERVICES											
JOB NUMBER	CAN:		SOC:								
	SSA/ DUNS/BPN		SSA TAS:								
	SSA BETC:		SSA ALC:								
	SSA EIN:										
REQUESTING ORGANIZATION											
PROGRAM CONTACT NAME/ADDRESS		FINANCIAL CONTACT NAME/ADDRESS									
ACCOUNTING DATA (for Government Agencies)		EMPLOYER IDENTIFICATION NUMBER (EIN):									
<table border="1"> <tr> <td>Appropriation/TAS:</td> <td></td> </tr> <tr> <td>ALC:</td> <td></td> </tr> <tr> <td>BETC:</td> <td>DISB</td> </tr> <tr> <td>DUNS/BPN:</td> <td></td> </tr> </table>		Appropriation/TAS:		ALC:		BETC:	DISB	DUNS/BPN:		BEGINNING AND ENDING DATES	
Appropriation/TAS:											
ALC:											
BETC:	DISB										
DUNS/BPN:											
TYPE OF SERVICE REQUESTED											
PROJECT TITLE OR KIND OF SERVICES											
DESCRIPTION OF SERVICES											
REFERENCES TO CORRESPONDENCE ON THIS MATTER:											
SSA PROJECT COORDINATOR											
NAME:		OFFICE:									
SSA CONTACT FOR INFORMATION PERTAINING TO THIS AGREEMENT											
NAME:		OFFICE:									
ESTIMATED COST AND FINANCING OF SERVICES											
ESTIMATED COST OF SERVICES:	FINANCING (Check one):	ADVANCE (in Full) PAYMENT	<input checked="" type="checkbox"/>								
		Quarterly									
		IPAC									
SSA AUTHORIZATION											
PRINTED NAME TITLE											
SIGNATURE			DATE								
ACCEPTANCE FOR USE OF REQUESTING ORGANIZATION											
Please provide the services requested above. We agree to pay you the full cost of such services in the amount estimated above prior to any work being performed; and we also agree to all of the terms and conditions stated in the accompanying Memorandum of Agreement.											
NAME OF ORGANIZATION'S PROJECT COORDINATOR		TITLE									
NAME & SIGNATURE OF APPROVING OFFICIAL		TITLE	DATE								